Bundle Quality, Safety & Experience Committee 16 July 2019

9.30am Boardroom, Carlton Court LL17 0JG

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 09:30 - QS19/95 Chair's Opening Remarks : Mrs Lucy Reid

1.2 09:32 - QS19/96 Declarations of Interest

1.3 09:33 - QS19/97 Apologies for Absence

1.4 09:34 - QS19/98 Minutes of Previous Meeting Held in Public on the 21st May 2019 for Accuracy, Matters Arising and Review of Summary Action Log

QS19.98a Minutes QSE 21.5.19 Public V0.02.docx

QS19.98b Summary Action Log QSE Public Live.docx

1.5 09:44 - QS19/99 Patient Story - Welsh Language Communication : Mrs Deborah Carter

QS19.99 Patient Story Welsh Language Communication 3.7.19 amended version.docx

2.0 FOR DISCUSSION

2.1 Performance Items

2.1.1 09:54 - QS19/100 Integrated Quality & Performance Report : Dr Jill Newman

Recommendation:
The Committee is asked to note the report.

QS19.100a IQPR coversheet.docx

QS19.100b IQPR.pdf

2.1.2 10:14 - QS19/101 Annual Plan 2019-20 Progress Monitoring Report : Dr Jill Newman

Recommendation:
The Committee is asked to note the report.

QS19.101a Annual Plan 2019-20 Progress Report May 2019_coversheet.docx

QS19.101b Annual Plan 201920 Progress Report May 2019 FINALamended.pdf

2.2 10:24 - QS19/102 Quality and Safety in Primary Care : Dr Chris Stockport

Recommendation:
It is recommended that the QSE Committee:
1. Confirms the core indicators meet the requirements of the Committee
2. Notes the actions taken in terms of the core indicators
3. Notes the progress in relation to the health & safety of GP practices
4. Considers any 'focus on' topics that the Committee would find useful
5. Notes the example provided in relation to quality improvement

QS19.102 Q&S in Primary Care_combined coversheet & paper_approved by CS.doc

2.3 10:39 - QS19/103 Infection Prevention Report Q4 (January to March 2019) Incorporating the Infection Prevention Annual Report for 2018 -2019 : Mrs Deborah Carter

Recommendation:
The Committee is asked to:
1. Note the Infection Prevention Q4 report
2. Note the Annual Report for 2018/19

QS19.103a IP Q4 report v2.docx

QS19.103b IP Appendix 1_amended.docx

2.4 10:54 - QS19/104 Occupational Health and Safety (OHS) Annual Report 1st April 2018 -31st March 2019 : Mr Peter Bohan (for Sue Green)

Recommendation:
The Committee is asked to:
1. Note the position outlined in the Annual Report.
2. Support the proposed improvement plan and full review of OHS systems through a gap analysis of legislative compliance and subsequent proposed project plan and time line.

QS19.104 OHS Wellbeing Report April 2018-March 2019_updated recommendations 10.7.19.docx

2.5 11:14 - QS19/105 Listening & Learning from Experience Report : Mrs Deborah Carter

Recommendation:
The Committee is asked to:
1. Endorse the improvement actions identified within this report and provide feedback in relation to additional interventions which may address the identified issues and risks, especially in relation to developing improvement organisational and operational accountability for Listening, Learning and Acting on patient and service user experience.

QS19.105 Listening and Learning report v0.6.docx

2.6 11:29 - Comfort Break

2.7 11:34 - QS19/106 Patient & Service User Experience Strategy 2019-2022 : Mrs Deborah Carter

Recommendation:
The Committee is asked to :
1. Endorse the ratification of the Patient and Service User Experience Improvement Strategy for organisational and operational delivery to be adopted across BCUHB.

QS19.106a PSUE Strategy_coversheet amended.docx

QS19.106b PSUE Strategy 3.7.19.docx

QS19.106c PSUE EQIA 6.6.19.doc

2.8 11:54 - QS19/107 Mental Health Quality Safety and Experience Report [including progress against Quality Improvement Governance Plan, Together for Mental Health Strategy and Performance : Mr Andy Roach

Recommendation:
The Committee is asked to:
1. Note the contents of the report

QS19.107 Mental Health QSE July 2019 v1.0.docx

2.9 12:14 - QS19/108 Quality Improvement Strategy : Mrs Deborah Carter and Dr Evan Moore

Presentation

2.10 12:29 - QS19/109 Children's Services Update : Dr Chris Stockport

Recommendations:
The Committee is asked to note:
1. The progress that is being made to services for children, young people and their families.
2. The risks that are identified and being managed through the Area Teams.
3. The external reviews of CAMHS during 2018-19 with a fuller report to be provided

QS19.109 Children's Services_combined coversheet & paper.doc

2.11 12:49 - QS19/110 Update paper following National audit of Handover of Care at Emergency Departments - Health Board Related Recommendations : Mrs Deborah Carter

Recommendations:
The Committee are asked to note the report which provides assurance that:
1. regular review of the ambulance handover performance and actions are embedded within existing process.
2. structures are in place to effectively monitor patient safety within the Emergency Departments particularly in times of escalation.
3. systems are supporting data capture to identify harm and recording performance impact

QS19.110 WAST Handover of Care_combined cover and paper.docx

2.12 13:04 - Lunch Break (attendees are reminded to bring their own lunch)

3.0 FOR CONSENT

3.1 13:24 - QS19/111 Policies, Procedures or Other Written Control Documents for Approval

Recommendation:
The Committee is asked to approve the attached written control documents for implementation within BCUHB.

QS19.111a Policies_coversheet.docx

3.1.1 Community Treatment Order Policy MHLD0051

QS19.111b CTO Policy.doc

QS19.111c CTO Policy EQIA.doc

3.1.2 Seclusion Policy

QS19.111d Seclusion Policy MHLD 0002 Final.docx

QS19.111e Seclusion Policy _EqIA.doc

3.1.3 Consent to Examination or Treatment Policy MD01

QS19.111f Consent for Examination or Treatment Policy v3.04.docx

QS19.111g Consent for Examination or Treatment EQIA.doc

3.1.4 Restricted Items Policy

QS19.111h Restricted Items policy - Mental Health Inpatient Wards & Community V5.docx

QS19.111i Restricted Items policy_EQIA.doc

3.2 13:34 - QS19/112 Quality Safety Group Assurance Reports : Mrs Deborah Carter

QS19.112 QSG Chair's reports_combined May and June.doc

3.3 13:44 - QS19/113 Progress report of Recommendations Arising from HASCAS Independent Investigation and Ockenden Governance Review : Mrs Deborah Carter

Recommendation:
The Committee is asked to:
1. note the progress of the recommendations to date

QS19.113a HASCAS & Ockenden Review_progress report_coversheet.docx

QS19.113b HASCAS & Ockenden update report v2 FINAL.docx

4.0 13:54 - FOR INFORMATION

4.1 QS19/114 Issues Discussed in Previous In Committee Session

Recommendation:
The Committee is asked to:
1. Note the information in public.

QS19.114 In Committee items reported in public.docx

4.2 QS19/115 Documents Circulated to Members

28.5.19 Updated safeguarding annual report

4.3 QS19/116 Issues of Significance to inform the Chair's Assurance Report

4.4 QS19/117 Date of Next Meeting

Tuesday 24.9.19 @ 9.30am in Carlton Court

4.5 QS19/118 Exclusion of Press and Public

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

Quality, Safety and Experience (QSE) Committee

Minutes of the Meeting Held in public on 21.5.19 in The Boardroom, Carlton Court, St Asaph

Present:

Mrs Lucy Reid	Independent Member (Chair)
Cllr Cheryl Carlisle	Independent Member (*part meeting)*
Mrs Lyn Meadows	Independent Member

In Attendance:

Mrs Deborah Carter	Acting Executive Director of Nursing and Midwifery
Mrs Michelle Denwood	Associate Director Safeguarding (*part meeting*)
Mrs Kate Dunn	Head of Corporate Affairs
Mrs Sue Green	Executive Director of Workforce and Organisational Development (OD)
Mrs Grace Lewis-Parry	Board Secretary (*part meeting*)
Dr Evan Moore	Executive Medical Director
Dr Jill Newman	Director of Performance (via *VC for part meeting)*
Miss Teresa Owen	Executive Director of Public Health
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Mr Mark Thornton	Chair of Community Health Council (CHC)

Agenda Item Discussed	Action By
QS19/61 Chair's Opening Remarks The Chair welcomed everyone to the meeting and noted some adjustments would be made to the order of the agenda in response to availability of presenters.	
QS19/62 Declarations of Interest None declared.	
QS19/63 Apologies for Absence Apologies were received for Mr G Evans, Mrs G Harris, Mrs J Hughes and Dr M Maxwell.	
QS19/64 Minutes of Previous Meeting Held in Public on the 19th March 2019 for Accuracy, Matters Arising and Review of Summary Action Log	

QS19/64.1 The minutes were agreed as an accurate record pending the following amendments: • Amend QS19/32.2 to read "Learning Disabilities" not "Learning Difficulties" • Amend date on QS19/42.1 to 3.11.18 **QS19/64.2** Updates were provided and noted within the summary action log.	
QS19/65 Patient Story **QS19/65.1** The Committee received a video presentation from a family sharing their experience over a number of years of the services provided by the Mental Health and Learning Disabilities Division. The story related to an individual with a diagnosis of autism with challenging behaviours who was admitted to a villa environment within Bryn y Neuadd Hospital and how these behaviours significantly improved upon the change in his living experience in 2010. The individual was able to take more control of his own time, and plan his daily life. **QS19/65.2** The story was well-received by the Committee and the Chair agreed to draft a letter of thanks to contributors. A wider conversation around patient stories ensued with members keen to see a balance of positive stories and those where there were lessons to be learned. In addition, it was noted that outcomes were key and that over time the Committee would wish to be assured how the learning was rolled out and impacted more widely across BCUHB.	LR
QS19/66 Integrated Quality and Performance Reports **QS19/66.1** The Director of Performance presented this agenda item and confirmed that two reports had been provided to include a year-end position as well as the monthly report. She confirmed that all national indicators had been aligned with the Board's operational plan, and a cross-check made as to relevance with Committees' terms of reference. She set out challenges in terms of ensuring timely reporting now that the QSE Committee met every two months. **QS19/66.2** Questions were invited on the year-end report. In terms of pressure ulcers and the collaborative it was confirmed that this was not a Welsh Government (WG) indicator. The Committee requested that this be continued as a local indicator for reporting of performance trends in each IQPR report and to also add narrative update reports on the work of the collaborative to the cycle of business in September and March. In terms of clinical coding, the Executive Medical Director confirmed that he was confident the target would be reached as set out. [*Cllr C Carlisle left the meeting].* A conversation took place regarding the range of qualitative reports that were also submitted to WG and members were informed that the majority were monitored and reported to other Committees or Forums. However it was noted that the report on Improving the Health and Well-being of Homeless and Specific Vulnerable Groups was not currently received elsewhere and that this subject was and important area for the QSE Committee. It was agreed that the latest report would be circulated. A question was raised regarding the 30 day concern target and whether there were any specific areas of	JN DC JN

concern across the divisions. The Acting Executive Director of Nursing and Midwifery indicated that in terms of actual numbers, the acute sites were most challenged in meeting the trajectory and there was a notable change in the complexity of complaints. The Chair raised queries around the accompanying narrative for the Patient Safety Notices and Alerts and the Executive Medical Director confirmed that a lead had been identified for PSA009, and that a decision around PSN046 was expected at the next Quality Safety Group (QSG) meeting. In respect of immunisations and children's vaccines, clarification on the terminology around "treatment queues" was provided and the Executive Director of Public Health confirmed that performance was positive. An error was noted on slide 28 regarding the Mental Health Measure in that the arrow should indicate a deterioration. Reference was made to the mental health related helplines and members were advised that the numbers did not relate to the actual numbers of calls received. There were also challenges in relation to the criteria for monitoring, for example calls to the dementia helpline from family members under the age of 40 are not counted in the figures. Members suggested that awareness of the various helplines could be improved. **QS19/66.3** Questions were then invited on the April report. It was clarified that the patient falls data incorporated community information too, and the reduction was welcomed. In terms of nurse staffing, members were advised that the new graduate recruitment weekend in March had gone very well and a number of nurses had been recruited. However, the Executive Director of Workforce and OD reminded members that the organisation was still losing more nurses than were being recruited, therefore retention was a key challenge. The Chair of the CHC enquired if there was a view as to the success of the Nurse Staffing Levels (Wales) Act 2016 and it was acknowledged that it provided better benchmarking opportunities, although it was noted the Act did not apply universally to all wards. The Executive Director of Public Health added that other professions had an important skillset to offer in terms of ward staffing which was not taken into account within the definitions of the Act. An increase in EColi infections was noted and it was confirmed there was a similar picture nationally and that actions had been taken to address. It was highlighted that the sepsis six bundles performance indicator was shown as red, however, the Director of Performance confirmed that performance was marginally above plan and should have shown as green. **QS19/66.4 It was resolved that** the Committee note the report.	
QS19/67 Infection Prevention and Control - Safe Clean Care Update **QS19/67.1** The Acting Executive Director of Nursing and Midwifery presented the slides which provided a summary of the work ongoing in terms of Safe Clean Care. She added that Ms Jan Stevens was currently undertaking her revisit to BCUHB and her report would hopefully be available for the July QSE meeting. Members were keen that it was also shared at Board level. Members acknowledged how the Safe Clean Care programme had been positively received by staff across a range of teams. The Chair of the CHC suggested that sustainability and maintaining the positive momentum would be the key challenge	

and the Acting Executive Director of Nursing and Midwifery set out a range of actions to address this including the re-profiling of teams to ensure they also cover community services, increasing the number of infection prevention champions, and onward monitoring through local infection groups up to QSG. *[Dr J Newman left the meeting]* **It was resolved that** the Committee note the information presented.	
QS19/73 Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19 *[Agenda item taken out of order at Chair's discretion]* *[Mrs Michelle Denwood joined the meeting]* **QS19/73.1** The Associate Director of Safeguarding presented the report and highlighted the challenges and achievements against the key drivers of the HASCAS and Ockenden reviews. She suggested that 4 of the 6 specific safeguarding recommendations were now fully implemented and confirmed that the 2 outstanding actions related to the corporate safeguarding structure and Deprivation of Liberty Safeguards (DOLS). She highlighted progress in terms of the appointment of Best Interest Assessors. The Committee's attention was drawn to the potential impact on activity in terms of commissioned services in care homes, due to amendments to the Mental Capacity Act. Finally, the Associate Director confirmed that all 9 outstanding recommendations from the internal audit review had now been implemented. **QS19/73.2** A discussion ensued. Generally, members acknowledged the progress made within safeguarding to support and enhance the protection of vulnerable people. In terms of the alleged abuse data it was suggested that it would be helpful in future for the report to include outcome information to provide context and progress. A typographical error was noted in paragraph 4.6 which should read "priority for 2019-20". The Chair noted there were challenges as BCUHB was not the lead agency for safeguarding. The Chair of the CHC queried the status terminology against the HASCAS and Ockenden recommendations and it was confirmed that "actioned" meant there was ongoing action with an intention to recommend closure to the Committee as part of the next report. The Acting Executive Director of Nursing and Midwifery reminded members that progress against the HASCAS and Ockenden recommendations were reported separately to the Committee and the Health Board. **QS19/73.3 It was resolved that** the Committee: 1. Note the progress made this year within the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations. 2. Note the emphasis of the Corporate Safeguarding Team on embedding continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way. 3. Approve the Corporate Safeguarding Priority Action Plan for 2019-20 for delivery.	

QS19/68 All Wales Standards for Accessible Communication and Information for People with Sensory Loss - Update on Implementation **QS19/68.1** The Acting Executive Director of Nursing and Midwifery presented the report which set out how the Board was meeting the all Wales standards of service delivery that people with sensory loss should expect when they access healthcare. She indicated that the organisation had received some positive informal feedback from WG on how this agenda was being addressed in BCUHB. **QS19/68.2** Members welcomed the update. It was acknowledged the report was based on a national template, however, members asked that additional self-assessment narrative be included to help readers reconcile the risks that the report was highlighting. **QS19/68.3 It was resolved that the Committee** support the recommendations in the organisational action plan to embed the actions where possible in the wider organisation and governance performance framework	DC
QS19/69 Clinical Audit : The Proposed Way Forward **QS19/69.1** The Executive Medical Director presented the paper and confirmed that as a result of work to realign executive portfolios, the responsibility for clinical audit now lay within the Office of the Medical Director which would strengthen links with the development of the Board's Clinical Strategy. The paper detailed the three tiers of audit (national, corporate and divisional) and the role of the Audit and QSE Committees in the clinical audit agenda. It was also highlighted that a summary of actions from the Joint Audit and QSE Committee meetings had been included. Finally, members' attention was drawn to the conclusions and next steps as set out. **QS19/69.2** A discussion ensued. Members were supportive of realigning responsibility to the Office of the Medical Director but sought assurance that momentum would be maintained once a new Executive Director was appointed. It was noted that Dr Melanie Maxwell (Associate Medical Director) would have a key lead role for clinical audit. The Committee Chair felt there would need to be further conversations regarding the clarity of the roles of the respective Committees including the Joint Audit, Quality and Safety Committee and noted that the paper would also be considered by the Audit Committee on the 30th May. **QS19/69.3 It was resolved that** the Committee: 1. Endorse the proposed way forward in terms of managing the clinical audit function; 2. Endorse the proposals in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019.	

QS19/70 Quality Assurance "CLIICH" Report **QS19/70.1** The Committee Chair suggested that this paper be considered alongside the Putting Things Right (PTR) Annual Report as she had found that gaps within assurances in the CLIICH report had been supported by information within the PTR report. The Acting Executive Director of Nursing and Midwifery presented the paper and indicated that feedback to improve future reports would be welcomed. **QS19/70.2** Members acknowledged that the report was evolving and made a range of detailed and specific comments which were captured and would be reflected within the next version. The Chair highlighted that the report needs to include more analysis and details of lessons learnt in order to provide assurance on organisational learning. More general comments were made in that members were surprised that the category of 'abuse of staff by patient's' was in the top three themes for reported incidents. The Executive Director of Workforce and OD suggested there may be a need to undertake some work to strip out the non-patient elements from this report and would look into this further. It was also requested that any outstanding never events or regulation 28s carry forward into the next report and a longer timeframe included to provide trend analysis. The amount of work being undertaken to address outstanding actions from Healthcare Inspectorate Wales (HIW) reports was acknowledged, however the detail in relation to the actions should be clearer. The Chair of the CHC noted that 1,200 falls had been reported in the reporting period of three months and enquired whether this was of concern. The Acting Executive Director of Nursing and Midwifery assured the Committee that this benchmarked well with other Health Boards and that falls with actual harm were very low. **QS19/70.3 It was resolved that** the Committee note the content of the report and requested further improvements in the quality going forwards.	DC SG
QS19/72 Putting Things Right Annual Report *[Agenda item taken out of order at Chair's discretion]* **QS19/72.1** Following on from the discussion of item QS19/70, the Acting Executive Director of Nursing and Midwifery presented the annual report, noting that it included a brief update on the response to HASCAS and Ockenden reports as requested by WG. In response to a question regarding sustainability, she added that actions were being developed as 'SMART' actions which could provide organisational-wide learning. **QS19/72.2** The Committee Chair referred to several sections of the report which she felt gave a better level of analysis and detail which could be used to inform the format of the 'CLIICH' report. These related to redress, lessons learnt from incidents, never events and clinical negligence claims. The Acting Executive Director of Nursing and Midwifery welcomed the feedback and would reflect how to utilise the best practice within the CLIICH report.	

QS19/72.3 It was resolved that the Committee approve the annual report.	
QS19/71 Review of Corporate Risks Assigned to the QSE Committee : Executive Leads **QS19/71.1** A general concern was raised that the target risk score dates were not achievable based upon the narrative and age of the risk. It was noted however that a review is being undertaken of risk management processes across BCUHB and this could be addressed as part of that review. A discussion on the specific risks ensued: • CRR02 Infection Control – noted that this remained a significant risk area for the organisation although there had been a good level of progress. • CRR03 Continuing Health Care – the Executive Director of Primary and Community Services indicated that progress was being made and hopefully a reduction in risk score could be recommended shortly. • CRR05 Patient Experience – noted that the narrative was due for review and that the operational group would consider this risk. • CRR13 Mental Health - noted that a briefing note had been circulated from the Division to explain the recommended reduction in risk score, however, the Committee had outstanding concerns that sufficient assurance had not been provided to warrant a reduction from 12 to 8. The Committee Chair would raise with the Division as to the expectations of the Committee. • CRR16 Safeguarding - noted.	LR
QS19/74 Reducing Avoidable Mortality - Update on Progress **QS19/74.1** The Executive Medical Director presented the paper and summarised that the organisation remained on an improving journey to get to a position where morality rates were better than expected. He drew members' attention to specific areas where mortality rates required a higher level of focus, namely – stroke, myocardial infarction, hip fracture and sepsis. **QS19/74.2** The Committee Chair fed back a range of comments on the format and flow of the report, and expressed a concern about the overall quality of the report and that at times the information was difficult to interpret. She requested that these points be addressed in future reports and suggested that one author take ownership of the preparation of the paper and ensure that the information was presented clearly with meaningful analysis in order to provide the Committee with assurance. **QS19/74.3 It was resolved that** the Committee note the report for information	EM
QS19/75 Review of Maternity Services at Cwm Taf Health Board (15-17 January 2019) – Report Published by Welsh Government on 30th April 2019 **QS19/75.1** The Executive Director of Public Health thanked the Committee Chair for enabling an update paper to be provided at short notice to sight the Committee on this issue which had recently received a high media profile across Wales. She	

confirmed that the paper provided the background and a link to the full report. Welsh Health Boards had been required to submit assurances to WG regarding maternity services in their areas, and thanks were expressed to officers for completing this within the short timeframe available. The Committee was reminded that maternity services had been de-escalated from special measures within BCUHB some time ago but that robust monitoring of quality and safety within the service had continued. As part of responding to the Cwm Taf report, further work had been identified around estates; timely care; bereavement care pathways; recruitment and retention; the requirement for challenges to the quality of data by Independent Members and Board training in corporate manslaughter. **QS19/75.2** A discussion ensued. Members welcomed the timely update. Reference was made to recommendation 7.4 on the assurance template regarding monitoring of clinical practice and the point raised whether there were additional mechanisms other than those listed. The Executive Director of Public Health undertook to work to strengthen the recording of evidence within any future narrative updates. With regards to recommendation 7.11 relating to mandatory attendance at meetings it was confirmed that the quorums were monitored and mandated. With regards to recommendation 7.13 concerning the identification of a clinical lead for governance it was confirmed that overall this would fall to the Director of Midwifery and Women's Services. In view of the current situation with clinical audit, a query was raised regarding how the Board gained assurance of the quality and safety of maternity and neonatal services (recommendation 7.25). The Executive Director of Public Health acknowledged the question however she was content with the green status as noted within the document. Finally, a query was raised as to how ownership by the consultant on-call could be evidenced (recommendation 7.38), and the Executive Director of Public Health undertook to discuss with the Director of Midwifery and Women's Services. **QS19/75.3 It was resolved that** the Committee 1. Note the assurances provided by the Directorate and support the identified areas for improvements. 2. Recommend that the amber actions be specifically highlighted to the Health Board with a copy of the full response being shared with all Board members	TO TO TO
QS19/76 Health and Safety Update Report **QS19/76.1** The Executive Director of Workforce and OD presented the update paper and highlighted that the new Associate Director had now taken up his post and was identifying a range of areas for focus and improvement, building on the work already done. She was confident that the Health and Safety annual report and improvement plan would be available for the July QSE Committee and Board meetings. She referenced a growing area of concern around security services which had formerly been managed within the estates teams and that there remained an element of unhelpful separation. She indicated that the initial priority would be to identify a new provider on acute sites and manage the associated contract change. It was noted that the scope for a formal security review was being prepared and until this had taken place, she did not recommend	

commencing any significant new work relating to security. Finally, the Executive Director drew members' attention to the detail of the HSE inspection following a breach within Women's Services. She confirmed that the inspector was positive about how the Board had engaged with the review. **QS19/76.2** A discussion ensued. Members were keen to see how the new Strategic Health and Safety Group would develop, noting that it would be chaired by the Executive Director of Workforce and OD and would be a joint group with Trade Union partners. It would meet on a monthly basis for the first 12 months and would be supported by an operational group chaired by the Associate Director. With regards to the arrangements for security services, the Executive Director of Workforce and OD reminded members of the former and current providers, and that clarity on the scope and expectations was essential. Finally, it was acknowledged that enforcement of the smoke free legislation would have a significant impact on estates teams in particular. The Committee acknowledged the progress being made to improve the management of health and safety across BCUHB and recognised that it would take time to fully embed these improvements. **QS19/76.3 It was resolved that** the Committee note the position outlined in the report.	
QS19/77 HMP Berwyn Health and Well-Being Annual Quality and Performance Report 2018-19 **QS19/77.1** The Executive Director of Primary and Community Services presented the report and highlighted key points to the Committee. He noted that the Did Not Attend (DNA) and Could Not Attend (CNA) rates across all health appointments may appear high but they were in line with expectations within a prison environment. Some operational issues impacted adversely on CNA rates with challenges in terms of the prison estate and recruitment and retention. He reported that the longest waits related to dental care, and that it was only recently that the second dental chair had been utilised due to estates issues within the prison. He confirmed though that this had not affected the provision of urgent dental care. He reported that the medication data for the prison was consistent with other prison sites, and that the peer mentorship programme had been well-received. Members were informed that an early draft report from HIW and HM Inspector of Prisons appeared to be positive overall. Finally, it was reported that confirmation had been received that HMP Berwyn would be taking remand prisoners in future. This was a matter of concern due to the significant impact on workload and challenges in terms of recruitment and retention. **QS19/77.2** A discussion ensued. A member noted that there was no mitigation of risks set out in the paper and it was confirmed this would be detailed within the internal risk register. Reference was made to previous concerns regarding the Liverpool prison and it was noted the Committee had received an update in September 2018. A question was asked whether length of stay was taken into account when prioritising the needs of the men under Part 2 of the MH Measure relating to active care and treatment plans. The Executive Director of Primary	CS

and Community Services would respond to the Committee Chair outside of the meeting. The Executive Director of Public Health noted that she could not find reference within the report to a new health needs assessment on the prison population which was commissioned in 2018-19. Finally, it was noted that it was not anticipated that the prison would be up to capacity even when it started taking remand prisoners. **QS19/77.3 It was resolved that** the Committee receive and note the report	
QS19/81 Continuing NHS Health Care (CHC) Assurance Report *[Agenda item taken out of order at discretion of Chair. Mrs Grace Lewis-Parry joined the meeting]* **QS19/81.1** The Board Secretary presented the paper which followed a familiar format of reporting to the Committee. She informed members that she was seeking clarification from WG as to which indicators the organisation was required to report on, and to benchmark the format against other Boards' reports to develop the template for the future. She went onto highlight the use of a system called Broadware which now held all new cases and the majority of historic cases, and which would be tested in terms of generating data and reports from around July onwards. She reminded the Committee that the Board spent around £100m on continuing health care each year and cared for about 400 patients in care homes. **QS19/81.2** A discussion ensued. Members welcomed the helpful paper and the intent to strengthen and improve the format and content for the future. They sought assurances around how the organisation would be addressing the fragility of the residential sector more widely. The Board Secretary indicated that this approach was multi-stranded and would include methodology for fees, workforce aspects and collaboration with Local Authorities. She acknowledged there was a degree of variability across Local Authority areas but there were no significant issues of concern. **It was resolved that** the Committee: 1. Note issues identified in the report 2. Note the development of Corporate CHC Team and Functions 3. Note the current position of the Health Board on the processing of retrospective claims; 4. Note the review of national policy and delivery systems that may include a review of the role of the National Complex Care Board; 5. Note the Health Board position on the current WG mandated performance measures, and the work underway which aims to embed CHC performance within the wider outcomes frameworks in future years. 6. Note the immediate priorities for the CHC department *[Mrs G Lewis-Parry left the meeting]*	

QS19/78 Policies, Procedures or Other Written Control Documents for Approval Committee members raised concerns at the volume of policies coming through the Committee and that there were issues around quality assurance of the documents including formatting and grammatical errors, lack of clarity over consultation and the quality of the associated Equality Impact Assessment documentation. It was suggested that where amendments to an existing policy were being submitted there should be a mechanism to draw out and highlight those specific changes. It was also suggested that a cover sheet should be provided at the front of every policy to provide explicit sign off by the Executive Lead confirming that the document had received sufficient scrutiny such that its status is appropriate for Committee approval. The Executive Director of Workforce and OD referred to a recent paper approved by the Remuneration and Terms of Service Committee which offered a proposed solution to ensuring a manageable and timely approach to policy approval, and suggested this might be appropriate for the QSE Committee also. It was agreed that this would be reviewed to see if it was suitable to be adopted by this Committee. Subject to these comments from Members, it was agreed that the following policies would be approved by the Committee.	SG
QS19/78.1 Pandemic Influenza Plan Distribution - Collection and Delivery of Antivirals **It was resolved that** the Committee approve the policy for implementation.	
QS19/78.2 Cardiopulmonary Resuscitation (CPR) Policy **It was resolved that** the Committee approve the changes to the Cardiopulmonary Resuscitation Policy	
QS19/78.3 PTR1 Concerns Policy (Complaints, Claims and Incidents) **It was resolved that** the Committee approve the policy.	
QS19/78.4 Policy for Administration and Use of Emergency and Non Emergency Oxygen in Adults in Managed Services **It was resolved that** the Committee approve the policy.	
QS19/78.5 Unlicensed Medicines Policy **It was resolved that** the Committee approve the policy.	
QS19/78.6 Medicines Policy **It was resolved that** the Committee approve the policy	

QS19/78.7 Mental Health and Learning Disabilities Division Section 17 Leave of Absence Policy **It was resolved that** the Committee approve the policy for implementation.	
QS19/78.8 Mental Health and Learning Disabilities Division Therapeutic Engagement and Observation Policy **It was resolved that** the Committee approve the policy for implementation.	
QS19/79 Quality Safety Group Assurance Reports March and April 2019 **QS19/79.1** The Acting Executive Director of Nursing and Midwifery presented the reports, noting that the format had been reviewed to allow for better identification of themes. **QS19/79.2** A discussion ensued. With regards to the Gosport report, members were informed that assurances had been received from the Pharmacy and Medicines Management team, however, a short contextual explanatory note and assurance as to whether prescribing patterns were within expected levels would be circulated. In terms of the Reducing Avoidable Deaths Group, members were assured that these meetings were now taking place. Clarification was provided as to the significance of the stated secondary care radiology risk in that this related to the ability to recruit to specialist clinicians. A member noted that DBS checks had been flagged as an issue within the Mental Health and Learning Disabilities Division, and it was confirmed this was an issue across all organisations and that the Executive Director of Workforce and OD would need to work with others in terms of the levels of checks. A question was also asked about whether independent contractors were required to register with the on-line service and it was agreed that this would be checked.	EM SG
QS19/80 Progress report of Recommendations Arising from HASCAS Independent Investigation and Ockenden Governance Review **QS19/80.1** The Acting Executive Director of Nursing and Midwifery presented the progress report which built upon previous submissions. She highlighted that a self-assessment RAG rating had been undertaken against each recommendation with some red ratings having now moved to amber (eg; records and psychotic medication). A paper was being prepared for Executive Team discussion seeking additional resources to try and move actions on further. The Acting Executive Director of Nursing and Midwifery also reported that teams were testing what the Board had committed to achieving and whether these messages had filtered through more widely. **QS19/80.2** The CHC Chair suggested that a target date for closure and a 'percentage complete' indication for actions would help demonstrate how far off the Board was from achieving the whole suite of recommendations and delivering	

outcomes. This would be taken into consideration however it was acknowledged that there were complexities in translating the broad recommendations into timely and deliverable actions and reporting clearly against each of these. **QS19/80.3 It was resolved that** the Board note the progress against the recommendations to date	DC
QS19/82 Annual Quality Statement (AQS) 2018-19 **QS19/82.1** The Acting Executive Director of Nursing and Midwifery presented the Annual Quality Statement and set out a range of ongoing challenges to ensure the content and format met the statutory requirements whilst also being meaningful and appropriate for a public audience. She indicated the possibility that there may be national changes to the requirements for the AQS in future. **QS19/82.2** A discussion ensued. It was noted that the Committee Chair would need to agree a statement for inclusion. A comment was made regarding the section on concerns and incidents and that the narrative could be improved to provide a balanced view of the year rather than just stark figures. This would be taken on board. **QS19/82.3 It was resolved that** the Committee: 1. Approve the AQS. 2. Note that the final formatting will take place following approval in preparation for publication on 31st May 2019.	LR DC
QS19/83 Issues Discussed in Previous In Committee Session It was resolved that the Committee note the information within the paper.	
QS19/84 Documents Circulated to Members Details of documentation circulated between meetings was noted.	
QS19/85 Issues of Significance to inform the Chair's Assurance Report To be agreed with Chair.	
QS19/86 Date of Next Meeting **QS19/86. 1** Noted as Tuesday 16th July 2019 @ 9.30am. The Chair noted that routinely the duration of the meeting was likely to be extended to a full day meeting to ensure that the Committee had sufficient time to deal with its business.	

QS19/86.2 In her closing remarks the Chair extended her thanks to Dr Evan Moore who was stepping down from his Executive role shortly.	
QS19/87 Exclusion of Press and Public **It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

BCUHB QUALITY, SAFETY& EXPERIENCE SUB COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
29th November 2018				
G Harris	**QS18/174.1** Circulate details of actions that had been taken in relation to the public interest report regarding complaints handling as detailed within the PSOW annual letter	March May 2019	Briefing note sent to Committee Chair 15.1.19. 22.1.19 Committee Chair indicated she was not happy to close the action as the briefing note wasn't specific to the public interest report in question. It was agreed that the Executive Director of Nursing & Midwifery would follow this up. 12.2.19 Update received from Assistant Director Service User Experience as follows. The review of this case found that whilst an investigation had been completed in line with PTR, an SIR report had not been produced but instead the findings of the investigation had been captured in a PTR response letter. The briefing note previously sent described the improvements made/being made that would address this. 19.3.19 Complaints action plan now in place which addresses themes from that complaint. 2nd letter from Ombudsman re Annual Review letter – DC updated during meeting stating that an updated report was being presented to Board. Agreed paper to be prepared for next QSE meeting.	

			21.5.19 DC confirmed this information would be provided for the July meeting. 9.7.19 Copy of letter from BCU Chair to PSOW circulated.	July
J Newman D Carter	**QS18/185.3** Arrange for exception report within IQPR on the backlog for sign-off of incidents	January	22.1.19 Not included within IQPR but will be worked upon for the March meeting. 19.3.19 JN apologised for the exception report not being included with QSE papers and confirmed that an update would be circulated outside the meeting and would be included in the version being presented to March Board. Next iteration to QSE to contain exception report. 21.5.19 Noted that IQPR contains the numbers of incidents but the narrative of what was being done to address them was still lacking. DC suggested that a further slide be included within the IQPR for July meeting. 4.7.19 Director of Performance confirmed will be incorporated into July report.	May Closed
A Roach S Green	**QS18/178.1** Provide a briefing note on email to explain the recommendation to decrease the corporate risk register score (CRR13)	December	22.1.19 Committee noted that this action remained outstanding. To be followed up urgently with Director of MHLDS 6.2.19 Briefing note circulated on behalf of Director of Nursing MHLDS. 19.3.19 – Committee wish to keep this action open pending wider risk register/management review. This work is being overseen by the newly established Risk Management Group who ultimately will report to the Board in due course. 21.5.19 Committee not content with indicative timeline of April 2020 and suggested this matter	Complete ~~Indicative timeline April 2020~~

			be aligned to the development of the risk management strategy.	
22nd January 2019				
D Carter	**QS19/8.4** Provide briefing note on the improvement plan and trajectories relating to concerns 30 day target (including explanation of how far over the 30 days the breaches are)	February	19.3.19 To be circulated outside meeting. 24.4.19 Spreadsheet has been provided to the Chair who has requested a narrative providing the background to the position, the improvement plan that is in place, age profile and how this will be monitored. 13.5.19 Further briefing provided to Committee Chair. 21.5.19 Awaiting Chair's approval. 12.6.19 Copy of further briefing circulated to Committee members via email.	CLOSED
D Carter	**QS19/9.2** Feedback to Ann Jones (clinical pharmacist) that the covert administration of medication policy was not approved and requires the EQIA and agreed amendments to be completed for circulation to QSE Committee members on email with option of then taking Chair's action to approve.	February	Feedback has been provided. Amended policy awaited for circulation with the associated EQIA 19.3.19 – keep open. 21.5.19 Amended policy still awaited. Chair's action to be taken upon receipt. 1.7.19 – Chair's Action completed	CLOSED
19th March 2019				
J Newman	**QS19/32.2** Ensure members' comments were incorporated into future iterations of the IQPR, and that the correct Executive Leads were listed.	May	21.5.19 JN confirmed that some questionnaires had been returned. Highlighted that the ongoing changes to exec portfolios meant some timing issues to ensuring correct exec leads were identified.	Closed
~~T Owen~~ C Stockport	**QS19/32.2** Provide CAMHS divisional update to next meeting.	May	21.5.19 IMs were surprised to learn of the change in Exec lead. An apology was offered that this hadn't been formally reported. Noted it	

			would need to be reported to RATS Committee. Divisional update to be provided to QSE July. 1.7.19 Paper will be presented to the Committee by the CAMHS team on 16.7.19	July Closed
C Stockport	**QS19/32.2** Discuss the accuracy of the performance being reported within the IQPR for GP practice opening hours with the Director of Performance.	April	21.5.19 CS reported that the dataset was a national annual dataset and there were a variety of methods to inform it which did increase the margin for error. Work was ongoing to standardise methodology.	Closed
S Green	**QS19/34.5** Reconsider the scoring of the Health & Safety risk alongside an updated risk description.	May	14.5.19 Review of Risk to be considered by Strategic Health and Safety Group on 31st May 2019	
L Reid K Dunn	**QS19/36.2** Arrange workshop for Committee role and cycle of business	June	Provisional date of 20th June 21.5.19 LR reported that provisional date would need to rescheduled. Suggestion made that the IMs meet on the 10.6.19 for initial discussion. 12.6.19 Workshop held of IMs. Outputs to be shared at further workshop on the rise of the July Committee meeting.	Closed
L Reid (B Owen)	**QS19/37.4** Prepare a further Pharmacy Medicines Management report for the September meeting that this would feature on the cycle of business going forward (in addition to the Annual report being presented in March). The Chair to discuss the detail of the report with the Chief Pharmacist outside the meeting.	Sept	2.7.19 The Committee Chair has discussed future reporting requirements for QSE with the Chief Pharmacist and agreed that the Committee would receive a pan-BCUHB wide report on medicines management twice a year.	Closed
B Owen	**QS19/37.5** Give further consideration to how a safety programme in Wrexham regarding suspected medication-related admissions might be rolled out across all three sites in	July	21.5.19 Noted is also a board action and in hand via Louise Howard-Baker.	

	North Wales and linking in with the Quality Improvement Hub.			
A Roach S Forsyth	**QS19/38.4** Provide a supplementary divisional update addressing additional areas of improvements within Mental Health	May	21.5.10 LR reported she had met with the Director of MHLDS to review reporting arrangements.	Closed
D Carter S Green	**QS19/49.1** Discuss further the suggestion that new nursing job descriptions have lost the standardised message regarding accountability for safeguarding, and the medical staff job description has lost the wording regarding notifying organisation of any police investigations.	April	14.5.19 Generic Job Descriptions for majority of Nursing posts agreed and on the Job Description Library. Reference to Safeguarding is contained within the "General Requirements" section of the All Wales Job Description Templates. All contracts of employment include requirement to notify the employer of police investigations. This would not be appropriate in the Job Description. 21.5.19 Further clarification provided that all nursing JDs did have a section included regarding safeguarding. The issue of concern was around the potential for including section within medics' JDs to notify employer of any police investigations.	Closed
21st May 2019				
K Dunn	**QS19/64.2** Ensure mechanism to provide copies of briefing notes within ibabs agendas, when they arise from an action within action log	Immediate	Relevant briefing notes are uploaded for members' attention only	Closed
L Reid	**QS19/65.2** Draft a letter of thanks regarding the patient story	June	2.7.19 The letter of thanks has been drafted and will be reviewed with the Acting Executive Director of Nursing prior to distribution.	
J Newman D Carter	**QS19/66.2** Include pressure ulcer performance as local indicator within IQPR and in addition provide	July	4.7.19 Director of Performance confirmed that the IQPR will include the HAPU as a local indicator from July 2019.	Closed

	narrative report on the collaborative for September and March			
J Newman	**QS19/66.2** Circulate the Homeless & Vulnerable Groups qualitative report to Committee Members	July	Circulated on 9.7.19	Closed
D Carter	**QS19/68.2** Add an additional self-assessment narrative to the accessible communication / sensory loss reporting format for next submission.		This will be incorporated into next planned report	Closed
D Carter	**QS19/70.2** Reflect on detailed comments regarding the CLIICH report format for next submission	Sept	The report will be refreshed following the discussion.	Closed
S Green / (D Carter)	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of category 'abuse of staff by patients', for next submission	Sept		
L Reid	**QS19/71.1** Raise concern with the MHDLS division regarding lack of assurance to warrant reduction in risk score from 8 to 6 for CRR13	June	2.7.19 The review of risks delegated to the QSE Committee will be undertaken as part of the Health Board review of the corporate risk register. A discussion has been held with the MHLDS division on future reporting requirements to QSE which will include current risks and issues relevant to the service.	Closed
E Moore	**QS19/74.2** Reflect on comments regarding format and flow of mortality report including the need to ensure a single author/owner for next submission.	Sept		
T Owen	**QS19/75.2** Ensure that evidence was strengthened within any future narrative updates relating to	As required	8.7.19 The Director of Midwifery & Women's Services has since met with the Committee Chair to go through the narrative and evidence	Closed

	maternity services (following the Cwm Taf report).		submitted to support the local benchmarking action plan that was presented at the May meeting and agreed to provide a formal update to QSE in September. As assurance the benchmarking exercise against the RCOG Review of Maternity Services in Cwm Taf and the related local improvement plan is managed as a live documents and is continuously updated with the relevant evidence by the Women's Directorate	
T Owen	**QS19/75.2** Discuss with the Director of Midwifery & Women's Services how ownership by the consultant on-call could be evidenced against recommendation 7.38 in the Board's response to Cwm Taf report.	June	8.7.19 This requirement is detailed in relevant job descriptions and in the roles & responsibilities section in the new staff induction pack. To note the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call, but may not always perform the antenatal ward round. For example, a registrar may be allocated to perform the antenatal ward round with consultant oversight. Where a daily review is delegated the reviewer should feedback promptly to the consultant any concerns they have about a patient. On discussion with the All Wales Head of School, Associate Dean for O&G and RCOG Fellows Representative for Wales, it has been considered appropriate to use board rounds and suitable delegation when a single consultant is on call for obstetrics and gynaecology	Closed

			emergency cover with responsibilities for an antenatal and gynaecology ward round. It has been agreed that this will be taken to the RCOG by NSAG for further discussion. The use of board rounds and appropriate delegation should be considered based on the NHS England's document: Seven Day Services Clinical Standards (Last updated September 2017). https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf Included in these standards is the following: "Use of Board rounds and delegation: There should be consultant-led Board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan (based on written protocols for individual conditions) that is updated daily at the Board round. At the Board round the consultant decides which, if any of the patients' reviews that day can be delegated to another competent clinician, such as a specialist nurse or senior medical trainee. The following are considerations that may be used to exclude individual patients from requirement for daily consultant review: • The patient's physiological safety (low early warning score (EWS)).	

			• The patient's level of need for further investigations and revision of diagnosis. • The patient's level of need for therapeutic intervention. • The level of need for communication with patient, carers, clinical colleagues. • Their likelihood of imminent discharge. For example patients who are medically fit for discharge and awaiting a social care placement (delayed transfers of care) may not need daily consultant review unless there are signs of clinical deterioration. The effective use of the skills and experience of a multidisciplinary team should be preserved, and this group will still need daily review with access to same day consultant advice. Where a daily review is delegated the reviewer should feedback promptly to the consultant any concerns they have about a patient." In addition, team consultant job plans are under review to assess whether additional consultant cover could be provided on mornings to allow for dedicated consultant ward rounds.	
T Owen	**QS19/75.2** Provide copy of the organisational response to the Cwm Taf maternity report with the whole Board	June	The Women's Directorate within BCUHB has formally presented the findings of the RCOG Review of Maternity Services at Cwm Taf, the Service's local benchmarking exercise against the recommendations in the report and local areas for improvements, with updates, to the Board Workshop held on 6th June 2019.	Closed

			The Service has subsequently submitted its self assessment as required to HIW in advance of their maternity unannounced visits to all Health Boards scheduled between end of June and December 2019. At the Board Workshop it was made explicit that the benchmarking exercise and identified improvement plan would be monitored via the Health Board's QSE Committee. The first update was presented on the 21st May, 2019. The Director of Midwifery & Women's Services has since met with the Chair of QSE to go through the local benchmarking action plan, the CHC maternity concerns log and agreed to provide a formal update to the September QSE Sub Committee. The Service will also be meeting with CHC colleagues on the 30th July 2019 to review maternity concerns that they have highlighted for further discussion and assurances.	
C Stockport	**QS19/77.2** Respond directly to Committee Chair as to whether length of stay was taken into account when prioritising the needs of prisoners under Part 2 of the Measure relating to active care and treatment plans.	June	25.6.19 Email provided to Committee Chair confirming that men who have who have an imminent release date are prioritised by the mental health team at HMP Berwyn to ensure that appropriate discharge arrangements are in place and a referral to the patient's community mental health team is made	Closed
S Green	**QS19/78**	June	4.7.19 Copy of paper circulated.	Closed

	Share details of the Remuneration & Terms of Service Committee proposals regarding streamlining policy approval at Committee level.			
E Moore	**QS19/79.2** Provide a short explanatory note giving context to Gosport issue (as per QSG report) and assurances as to whether prescribing patterns were within expected levels.	June	9.7.19 Briefing note circulated	Closed
S Green	**QS19/79.2** Follow up wider issues around DBS checks (as flagged within QSG report)	June	The Policy for updating DBS checks is subject to review on an All Wales basis. WOD Directors are linked into this work and will advise on the proposal when it is made.	Closed
D Carter	**QS19/80.2** Continue to refine the HASCAS and Ockenden progress report, to try and include a target date for closure and a "percentage complete" status.	July	The report has been refined to include additional detail	Closed
L Reid	**QS19/82.2** Agree Committee Chair's statement for inclusion within the Annual Quality Statement.	End of May	2.7.19 The statement has been included within the AQS	Closed
D Carter	**QS19/82.2** Take on board comments regarding improving the narrative within concerns/incidents section of AQS to provide a more balanced view.	End of May	This has been amended to reflect the comments.	Closed

Betsi Cadwaladr University Health Board
Patients' Stories Transcript Form

Who took the patient's story:	**Name: Carolyn Owen** **Contact details: Carolyn.Owen@wales.nhs.uk 01978 726157**
Sensitive issues to be aware of:	Welsh language Consent Active offer Communication
Brief summary of the story:	My father in law (Arthur) was a larger than life character with a huge sense of humour, he was passionate about everything he was involved in from painting to Bee keeping. He had 3 great loves: his wife, his family and the sea, he ran away to sea at 15 and worked his way up from galley boy to chief steward/purser in the merchant navy, he eventually went to work on oil rigs in the same role and then in the late eighties he purchased his own boat and ran trips around St Tudwal's island and Bardsey, his wife Hefina, who was his first love, would often join him both at sea and on his trips around the islands. He was well known in Abersoch for his sense of humour and his tireless work for the Abersoch harbour committee of which he was chair. A lot of the improvements to the jetty and facilities were due to his efforts. Ultimately it was his family he lived for, we enjoyed many happy years with him in and around the sea, we went on family picnics often to Mona for the car boot, where Hefina loved to buy crockery! He was always there with a bit of pocket money for the kids, buying special clothes for his birthday meals and making sure we all had everything we needed. He was not just Taid but dad to not only his own children but to both me and Mike, his daughter's partner. We had both lost our fathers some time ago, mine over 30 years ago and Mike more recently. He was kind, thoughtful, funny and grumpy at times, always generous, always loved and always missed. My Father in law was admitted to the Emergency Department (ED) in Ysbyty Glan Clwyd with vomiting and diarrhoea. As a first language Welsh speaker we explained to staff that this was my father in law's first and preferred language. We as a family were dissatisfied and unhappy with the way he was treated and managed in ED but just wanted to get my father in-law better.

	Despite our request no Welsh speaker was provided while he was in ED and this meant that my father did not have a great understanding of what was happening with his care and treatment. He was in a great deal of pain and distress and this clearly exacerbated his level of understanding of English. He was admitted and transferred to a ward, this was a Wednesday. The first thing we asked when he was admitted was for a Welsh speaker along with an explanation to the staff that my father in law spoke very minimal English (whilst giving the impression that he did). Contact details and telephone numbers of all family members were provided to ensure that staff were able to inform us as a family of any changes, treatment and procedural plans. However no one contacted us at any time despite the repeated request to do so as we understood how anxious he would be feeling. On Friday night I received a phone call to say that my father in law had become very distressed when they tried to insert a nasogatric tube. . (He had been for a CT scan earlier in the evening which showed a partial obstruction). He wouldn't have really understood what they were intending to do as there was no Welsh speaker. I believe this would have caused him to become extremely upset as he would not have been able to communicate well enough. I asked again for a Welsh speaker to be present when dealing or explaining things to my father in law. We visited over the weekend and again supplied a full list of family mobile numbers and reiterated that we would be available any time if needed. We explained that Arthurs default position was to reply Yes, if anything was asked him, he would not necessarily have understood what was going on as due to previous difficulties (when in Africa) he was in the habit of accepting anything he was told. On Monday (still no Welsh language) my father in law was taken to theatre. My father in law managed to contact his grandson and consequently Hefina was able to see him just before the surgery but had no real opportunity to say goodbye. The decision to take my father in law to theatre was not discussed with or communicated to anyone in the family by the ward. The consent process was communicated with my father in law in English. On the Friday morning my father in law passed away. As a family we are devastated to have lost him. He was the most valued husband, father, father in law and grandfather anyone could wish for. His loss to us all is beyond words.

	We feel that had communication from start to finish been better and in a language he understood(Welsh) then there may have been a different outcome, that he would have survived the surgery and we would have had an opportunity to come to terms with the prognosis. The opportunity for us to say goodbye was taken from us and him and he missed the event that would have given him the most joy—the birth of his first great grandchild. Welsh is very important to us a family, it is the language that was and still is spoken at home and the language he was most comfortable with. We feel that our wishes as a family were ignored and no effort made to try and support our needs.
Key themes emerging:	• *Receiving sufficient Information* such that patient and family members were able to be fully, *informed and involved* in *decisions* made in relation to Arthur's care. • *Welsh Language/Communication in Welsh* – clear failure to respect Arthur's communication needs resulting in lack of information about, and involvement in decision concerning ongoing care (see above) and non-compliance with the (Welsh Language Measure (Wales), WG 2011) in so far as Welsh was treated less favourably than English. • *Consent* give the themes identified above it is difficult to argue that consent in any form or function informed • *Staff Attitude/Knowledge & Skills;* there was a complete lack of empathy and response to Arthur's stated communication needs, it did not appear that anyone was prepared to take responsibility for these, and indicative of a complete lack of understanding of BCUHB's statutory responsibility in relation to the (Welsh Language Measure (Wales), WG 2011). Why didn't 'someone' take responsibility for informing the family members, why were they left isolated, why were their needs not acted on – complete lack of candour in relation to a responsibility to communicate honestly, transparently and with integrity? • *Interdisciplinary Working;* implicit and underpinning this story is a care plan which appeared to lack integration, and regular review as Arthur's condition deteriorated – symptomatic of a poor organisational/clinical leadership. • *Quality of care*; clearly for the reasons stated above the care fell well below BCUB's statutory obligations, and it is concerning that the employment of the surgeon was terminated shortly after Arthur's admission.
Lessons learnt:	**In line with BCUHB Welsh Language policy and protocol** Where a patient's first language is Welsh all efforts to accommodate the patient's wishes utilising Welsh speaking staff members should be made. Should this not be possible, then Language line can be used or WITS for face to face interpretation as described above.

	Listening and hearing the patient and family's voice and concerns Ensuring that Welsh language staff or translators are in place to support the patient's preferred language **Interpretation Services** When and how to arrange for interpretation services – a guide to services available **When** • If a patient cannot communicate effectively in English or Welsh information about treatment (any activity requiring consent) needs to be communicated • Or when other vital information needs to be communicated for example information at the time of discharge from hospital If there are any concerns that the patient (who needs the interpreter) is regarded as a 'vulnerable person' then a registered independent interpreter will be required. Vulnerable persons could include: • Children • Vulnerable adults • Patients who have been subjected to domestic abuse and/or violence; • Other e.g. for a mental health assessment when face to face interpretation is necessary Adran yr Iaith Gymraeg / Welsh Language Section There are options available for obtaining interpretation services • Telephone Interpretation Service • Face to Face Interpretation Service • Wales Interpretation and Translation Service (WITS) Montgomery principle and consent: • Causation in informed consent case is often very difficult and very fact specific. Therefore it is vitally important that the Patient understands the proposed procedure that they are consenting to *Put yourselves in the shoes of the patient at the point they would have made the decision* • Consent must be more patient-focused • Crucial that there has been proper consent and good documentation of that process

Shared with:	Quality Safety Group
Proposed action:	Share the story widely and include in Patient and Service User digital story library Cascade widely through PALS teams in all regions to support the importance of using interpretation WITS language line to all staff in all areas and inform Patients' and Service Users of the facilities available when there are no Welsh speaking staff available to represent the Patient's requirements.
Responsibility:	Carolyn Owen

Quality, Safety & Experience (QSE) Committee

16.7.19

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

To improve health and provide excellent care

Report Title:	Integrated Quality & Performance Report
Report Authors:	Mr Ed Williams, Head of Performance Assurance Dr Jill Newman, Director of Performance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Performance and Planning
Public or In Committee	Public
Purpose of Report:	This report provides the committee with a summary of key quality and performance indicators.
Approval / Scrutiny Route Prior to Presentation:	This paper has been scrutinised, approved and signed off by the Executive Director of Planning and Performance.
Governance issues / risks:	Our report outlines the key performance and quality issues that are delegated to the QSE Committee. The Summary of the report is now included as an Executive Summary within the report itself.
Financial Implications:	N/A
Recommendation:	The Committee is asked to note the report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

This paper supports the revised governance arrangements at the Health Board and supports the Board Assurance Framework by presenting clear information on the quality and performance of the care the Health Board provides. It also addresses key indicators for mental health and primary care.

Equality Impact Assessment

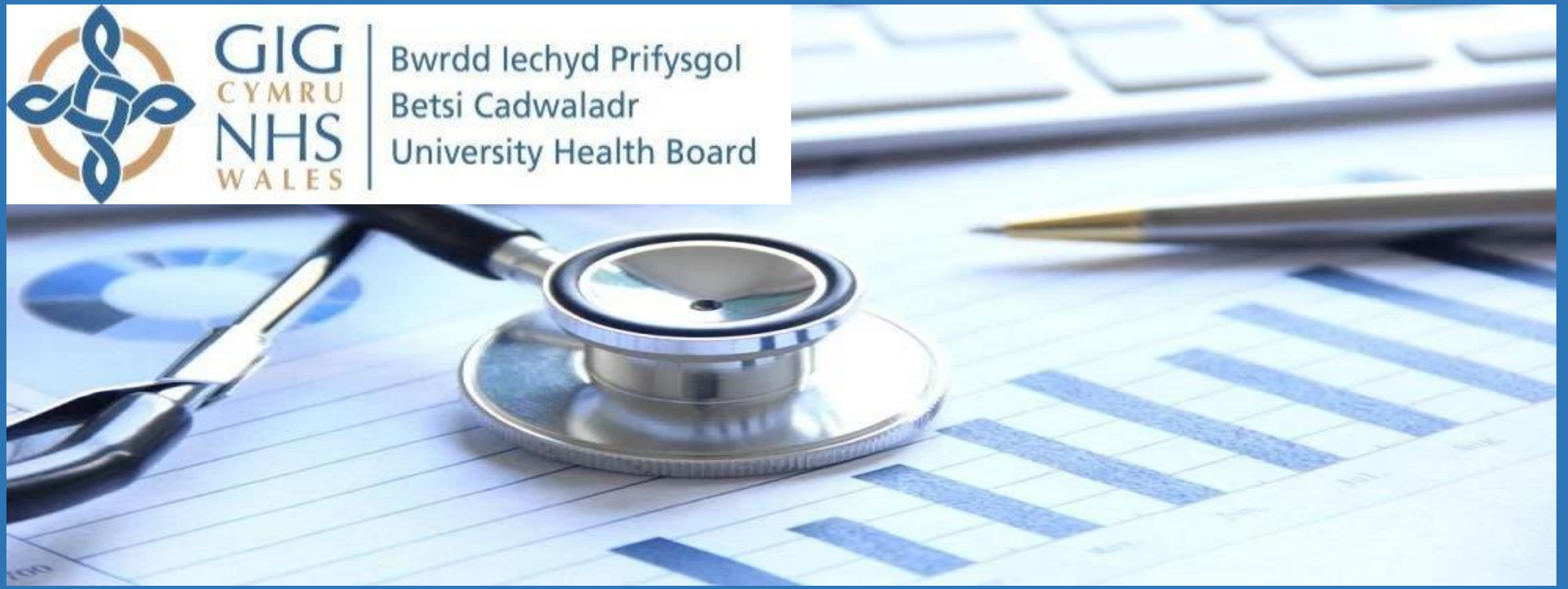
The Health Board's Performance Team are establishing a rolling programme to evaluate the impact of targets across the Equality & Diversity agenda.

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Integrated Quality and Performance Report – Quality, Safety & Experience Committee

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



July 2019

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Integrated Quality and Performance Report
Quality, Safety & Experience Committee Version

July 2019

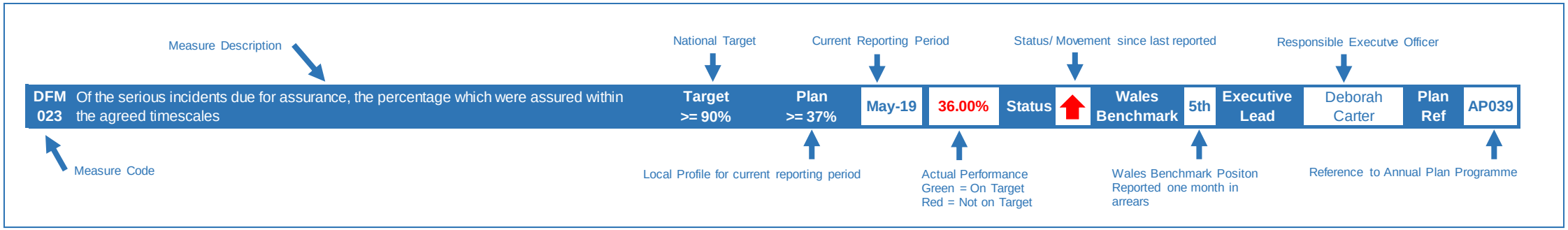
About this Report

Section 1: Report Structure

This **Integrated Quality & Performance Report (IQPR)** is intended to provide a clear view of current performance against a selected number of **Key Performance Indicators (KPI)** that have been grouped together to triangulate information. This report should be used to inform decisions such as escalation and de-escalation of measures and areas of focus. Actions for escalation should be captured in the Chairs report for the Board and minutes of the committee.

The measure code relates to the code applied within the NHS Wales Annual Delivery Framework, which Welsh Government hold the Board accountable for delivering. A key difference in the structure of the IQPR for 2019/20, in comparison to 2018/19 is that it is that the report reflects the organisational priorities as set out in the Operational Plan approved by the Board . The report maps each the measures included against the corresponding work programme within the Annual Plan for 2019/22. This is done via a reference number at the right hand side of the Measure Component Bar (shown below). The next page contains a list of all the Programmes in the Annual Plan in the order of the reference numbers.

Description of the Measure Component Bar:



Status Key:

Not Achieved Better	Not Achieved Worse	Not Achieved Static	Achieved Static	Achieved Worse	Achieved Better
↑	↓	←	→	↓	↑

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About this Report

Section 3: Report Content for 2019/20

Profiles
The Executive sponsor has confirmed the profile of performance expected to be delivered during the year based on the actions and resourcing set out in the operational plan. The report will track performance against this profile . It is noted that profile set will reflect the reporting requirement and rate of change of performance expected. Therefore some indicators are annual, others bi-annual, quarterly, bi-monthly or monthly. In addition the executive sponsor is 'RAGP' rating the monthly progress of their actions in the Annual Plan and therefore this report should be read alongside the Annual Plan monitoring report.

Escalated Exception Reports
When performance on a measure is worse than expected, the Lead for that measure is asked to provide an exception report to assure the relevant Committee that they have a plan and set of actions in place to improve performance, that there are measurable outcomes aligned to those actions and d) that they have a defined timeline/ deadline for when performance will be 'back on track', preferably demonstrable through a recovery trajectory. Although these are normally scrutinised by Quality & Safety or Finance & Performance Committees, there may be instances where they need to be 'escalated' to the Board. These will be included within the relevant Chapter on an 'as-required' basis.

Statistical Process Control Charts (SPC)
Where possible SPC charts are used to present performance data. This will assist with tracking performance over time, identifying unwarranted trends and outliers and fostering objective discussions rather than reacting to 'point-in-time' data.

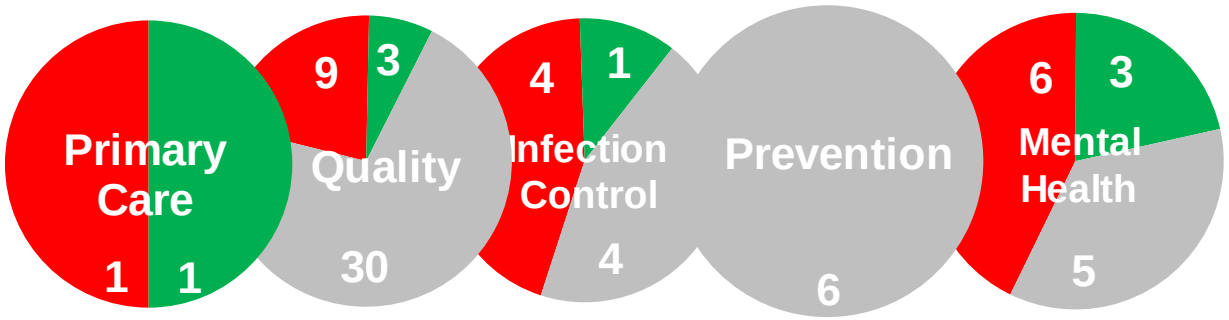
Cycle of business
This report demonstrates performance against profile for May 2019 where the measure and profile is reportable monthly.
This report also includes the local indicator ; Healthcare Acquired Pressure Ulcers from July 2019.
An additional slide is provided this month on the actions being taken to address the backlog incidents requiring closure.
In addition to this report all committees are provided with a RAGP self-assessment of progress against the actions within the Annual Plan. This committee will receive this additional report from its July meeting.

About this Report

Operational Plan Programmes 2019/2022 linked to Measures within the remit of QSE

Annual Plan No	Annual Plan Programme
AP001	Smoking Cessation Opportunities increased through 'Help Me Quit' programmes
AP004	Delivery of ICAN Campaign promoting mental well-being across North Wales communities
AP005	Implement the 'Together for Children and Young People Change Programme'
AP006	Improve outcomes in first 1000 days programmes
AP007	Further develop strong internal and external partnerships with focus on tackling inequalities
AP009	Put in place agreed model for integrated leadership of clusters in at least three clusters, evaluate abd develop plan for scaling up
AP013	Develop and implement plans to support Primary Care sustainability
AP015	Implementation of RPB Learning Disability Strategy
AP025	Fully realise the benefits of the newly established SuRNICC Service
AP027	Develop Rehabilitation Model for people with Mental Health or Learning Disability
AP039	Implement Year Three of the'Quality Improvement Strategy'
AP045	Develop a 'Strategic Equaility Plan for 2020-2024
AP047	Develop an integrated workforce development model for key staff groups with health and social care partners
NIP	Not in Plan *i.e. Mesures are required by NHS Wales Delivery Framework, but are not linked to Actions in the Operational Plan*

Overall Summary Graphic Summary



Most Improved

Measure	Status	(Target)
Serious Incidents: Pressure Ulcers	0	0
New Never Events	0	0
Universal Mortality Reviews	90.90%	>= 95%

Of Most Concern

Measure	Status	(Target)
Infection Prevention: MSSA	17	<= 11
Incidents: % Assured within agreed timescales	39.00%	>= 90%
Total Healthcare Acquired Pressure Ulcers (HAPU)	177	AP
Sepsis Six Bundle: Emergency Department	51.55%	Improve

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Executive Summary

This report contains the measures reportable to the committee based on the end of May reported performance. The majority of indicators are quarterly, biannual or annual measures and so are shown greyed out in the report.

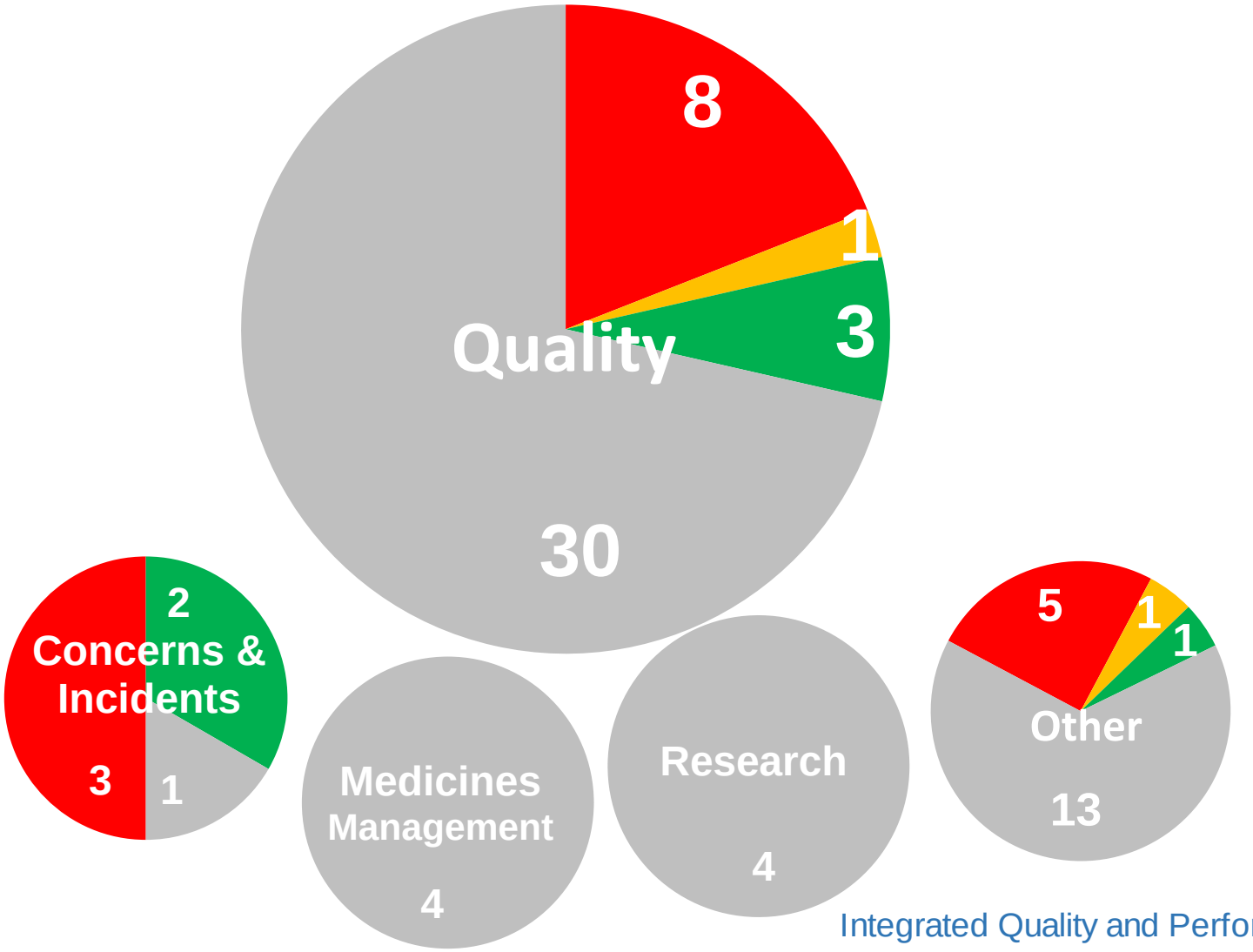
The report covers measures under the chapters of Quality, Infection Control and Mental Health. The prevention chapter is not reported as there are no monthly indicators in this chapter.

Quality: Compared to the previous reporting period performance improved in May for 3 of the measures and deteriorated for 8 measures. Anew local measure has been introduced to include the total number of healthcare acquired pressure ulcers. It is pleasing to note full compliance with the 3 indicators delivering the national target i.e. 100% compliance with the Sepsis 6 in patient bundle, 0 never events and 0 serious incident reportable pressure ulcers. Details of actions being taken to improve performance for the indicators not meeting the national targets is outlined in the exception reports.

Infection Control: Of the 5 measures reportable monthly 1 is delivering the national target but 4 have deteriorated in performance this month. Graphs for the number of infections over time have been included to inform the committee of the volume of patients affected by these infections each month,

Mental Health: 3 of the mental health measures are delivering the national target this month, including CAMHS Assessments within 28 days. Where the targets are not being met exception reports are provided.

Chapter 1 – Quality Graphic Summary



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Chapter 1 – Quality Summary Page 1

Measure	Status		(Target)
Alcohol Attributed Admissions			0%
Learning Disabilities Annual Health Check			0%
Disclosure and Barring Checks: Children			N/A Bi
Disclosure and Barring Checks: Adults			N/A Bi
Hospital Admissions mention Self Harm in Children &			N/A A
Amenable Mortality Rate			N/A A
Spesis Six Bundle: Inpatients	100%	→	100%
Spesis Six Bundle: Emegrgency Department	51.55%	↓	>= 68%
Preventable Hosptial Acquired Thrombsis			N/A Q
Opiod Average daily quantities per 1,000 patients			N/A Q
Antipsychotic Prescriptions for Over 65s			N/A Q

Measure	Status		(Target)
Antibacterial Items er 1,000 STARPUS			N/A Q
Combined 4 Antibacterial items prescribed			N/A Q
Patient Safety Solutions Wales Alerts and Notices			N/A Q
Serious Incidents Assured within timescales	39.00%	↑	>= 90%
Serious Incidents: Patient Falls	12	↑	AP
Serious Incidents: Pressure Ulcers	0	↑	AP
Total Number of Healthcare Acquired Pressure Ulce	177	N/A	AP
Total Number of New Never Events	0	→	0
Universal Mortality Reviews within 28 Days	90.90%	↑	>= 95%
Crude Mortality Rate (Under 75 years of age)	0.83%	↓	<= 0.70%
New Medicines made available			N/A Q

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Chapter 1 – Quality Summary Page 2

Measure	Status	(Target)
Number of Clinical Research Studies		N/A Q
Number of Commercial Research Studies		N/A Q
Number recruited to clinical studies		N/A Q
Number recruited to commercial studies		N/A Q
Survey Results: Satisfaction with Health Services		Improve
Number of Postopned Procedures (Non-clinical)	**2,451** ↑	Reduce
Evidence of Responding to service user experience		N/A
Concerns Replies within 30 Days		N/A Q
Over 65's with Dementia registered with GP		AP
Survey Results: Dignity and Respect		N/A A
Survey Results: Satisfaction with GP care		N/A A

Measure	Status	(Target)
Survey Results: Satisfaction with Hosptal Care		N/A A
NHS Staff Dementia Training		AP
GP Practice Dementia Training		AP
Qualitative Report: Advancing Equality		N/A Bi
Qualitative Report: Health & Wellbeing		N/A Bi
Qualitative Report: Accessible Communication		N/A Bi
Qualitative Report: Welsh Language		N/A Bi
Ward Staff Fill Rate (Nursing)	**86.00%** ↑	>= 95%
Ward Staff Skill Mix (Nursing)	**55.00%** ←	>= 60%

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Chapter 1 – Quality

Sepsis Six Bundles

DFM 014	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Target Improve	Plan 100%	May-19	100%	Status	➡	Wales Benchmark	1st	Executive Lead	Evan Moore	Plan Ref	AP039
DFM 015	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Target Improve	Plan >= 68%	May-19	51.55%	Status	⬇	Wales Benchmark	3rd	Executive Lead	Evan Moore	Plan Ref	AP039

Actions:

- Meetings now in place for all acute site emergency departments to review sepsis cases, identify areas of issue and make required improvements
- Further sepsis collaborative dates set for 2019/20
- Sepsis dashboard in use at all meetings
- Support provided to each site meeting by senior members of the Health Board Quality Improvement team
- Bi-monthly meetings held across BCUHB to discuss and drive improvements with sepsis and responding to the deteriorating patient

Outcomes:

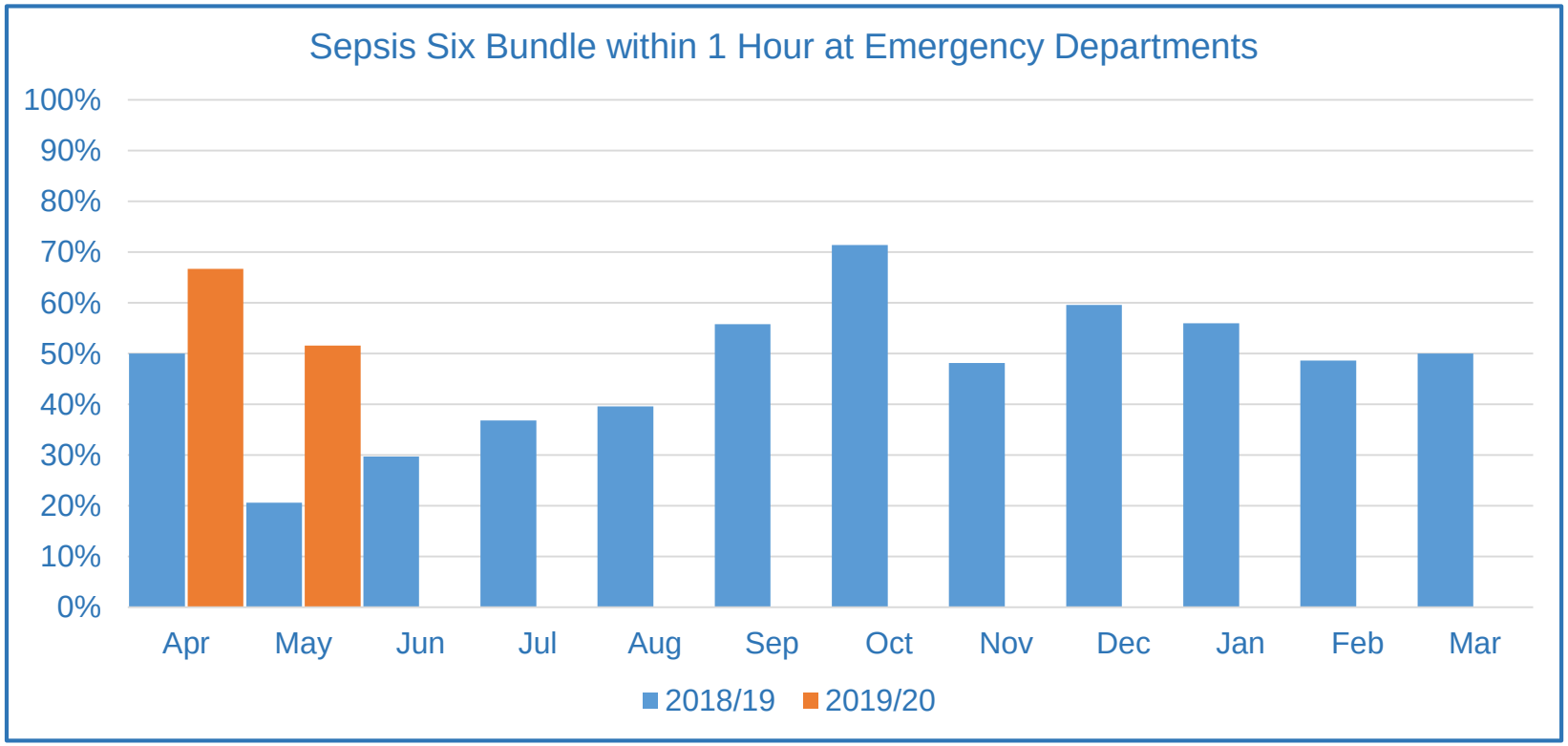
- With the continuation of the collaborative this will support further improvement in sepsis 6 compliance for emergency departments across BCUHB
- All emergency departments will have access to the dashboard and will be able to monitor compliance for there department with sepsis 6 bundle

Timelines:

- Work will continue on this throughout 2019/20 to support sepsis work in emergency departments
- Dates for the sepsis collaboratives throughout the remainder of 2019/20 have been set as 5th Sep 2019, 10th Dec 2019 and 11th Feb 2020.

Chapter 1 – Quality

Sepsis Six Graphs



Chapter 1 – Quality Incidents

DFM 023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Target >= 90%	Plan >= 39%	May-19	39.00%	Status	Wales Benchmark	6th	Executive Lead	Deborah Carter	Plan Ref	AP039

Actions:

- Weekly Incident Review Meeting in place which is ensuring a more focused approach to managing major and catastrophic incidents. Also focusing on over due incidents which have been reported to Welsh Government (WG).
- Review of model for corporate and governance teams to allow greater support to the wider incident management

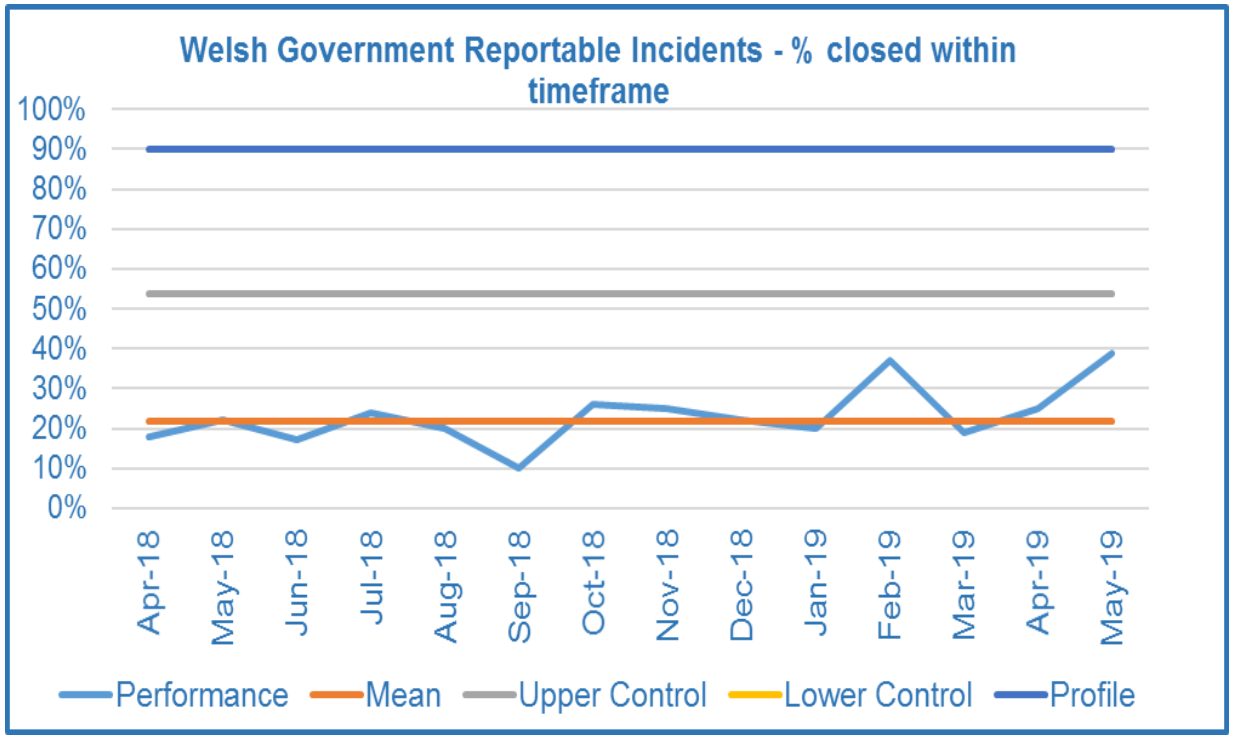
Outcomes:

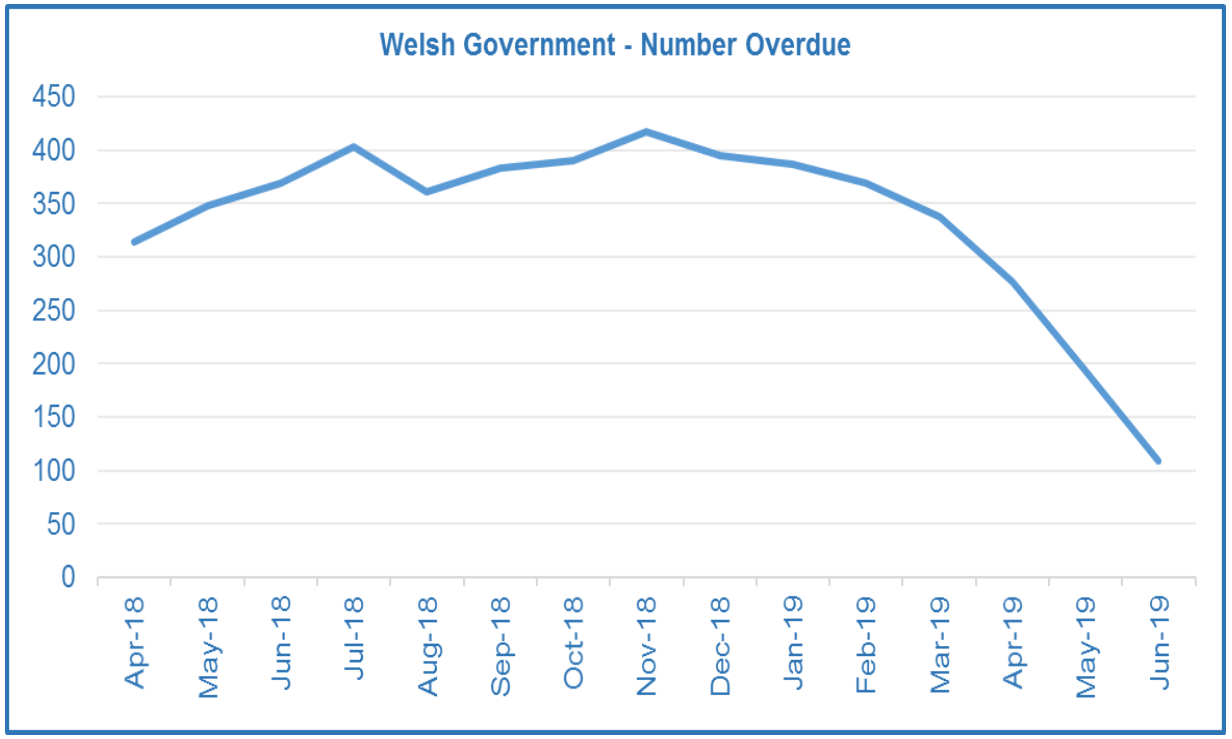
- Reduction in the number of incidents significantly overdue for closure
- Reduction in the number of major/catastrophic incidents
- Improvement in the total number of overdue Welsh Government Incidents
- Improvements in the standard/quality of closure forms being submitted
- Single senior lead for incidents management across BCUHB

Timelines:

New trajectories have been issued to each of the Divisions with expectation that they will be in line with these by 31st August 2019

Chapter 1 – Quality Incidents Graphs





Actions:

Actions taken to address incidents:

All major, catastrophic, WG reportable or never event incidents are subject to a rapid review within 72 hours in order to:

- Make safe for patient and staff
- Mitigate any further risk
- Escalate to senior staff
- Close the incident if no further investigation required
- This prompt review will reduce the volume of incidents becoming overdue in future.

2. Workshops & training has been implemented to support staff in effectively and efficiently closing incidents. The training includes:

- Application of “PTR”
- Investigation training
- Closure form workshops
- Datix clinics
- These are aimed to support staff in timely incident management.

3. Use of performance trajectories

- These have been set up to demonstrate the impact of the learning on the closure rate and to establish a performance measure which the divisions are to deliver with the support provided.

Chapter 1 – Quality

Serious Incidents: Patient Falls

LM02 3a	Number of Patient Falls reported as Serious Incidents	Target AP	Plan AP	May-19	12	Status	Wales Benchmark	7th	Executive Lead	Deborah Carter	Plan Ref	NIP

Actions:

- Health Board Falls Faculty established – multidisciplinary;
- Masterclass to launch the collaborative with the wards June 11th attended by cohort wards representative of all areas across the Health Board identified via data and Quality Improvement (QI) work;
- Collaborative aim to reduce inpatient falls by 15% by the end of November 2019;
- The collaborative will develop a toolkit of evidence based interventions that are individualised to meet the needs of patients following risk assessment;
- All Wales Falls Assessment tool agreed prior to digitalisation to be shared with cohort wards.

Outcomes:

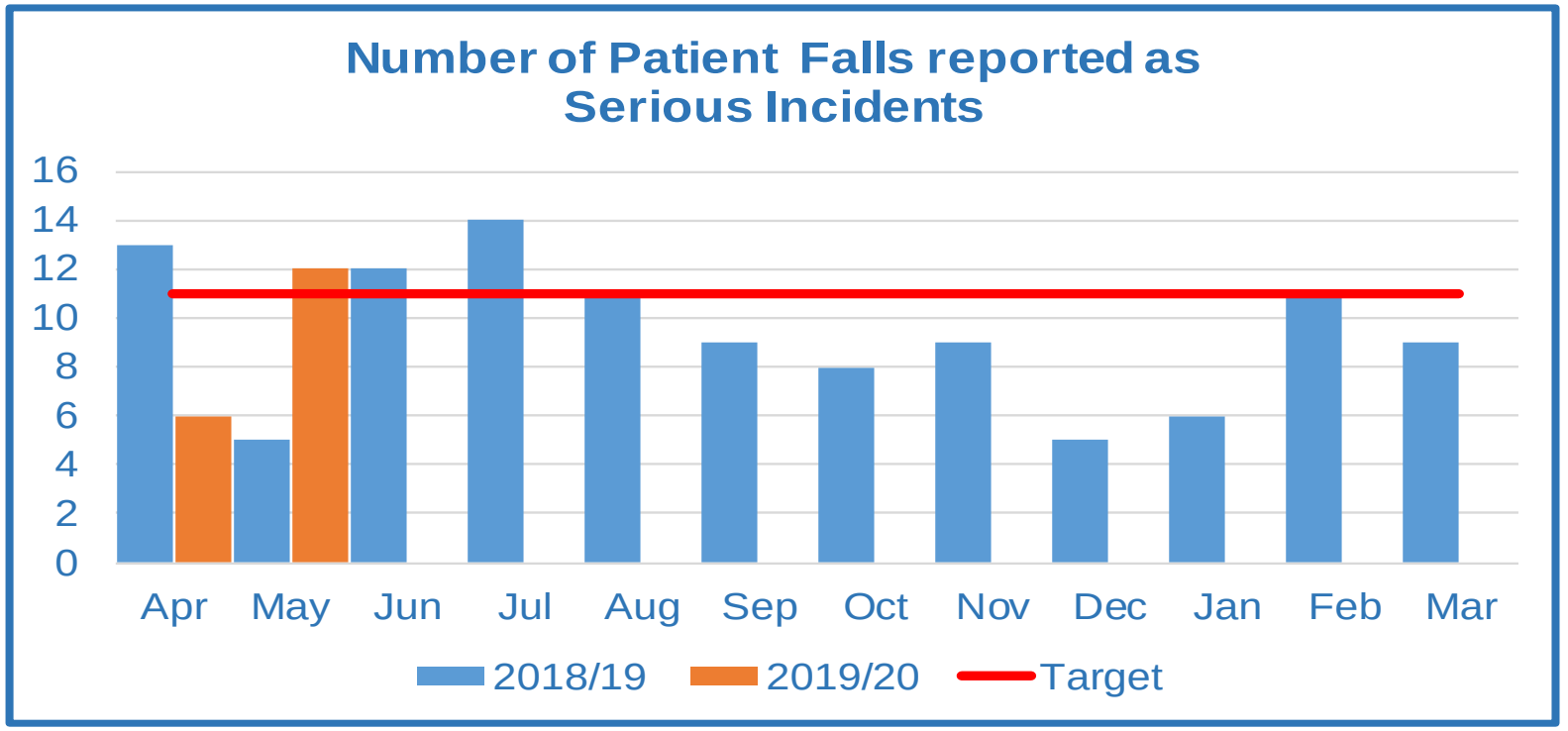
- Wards undertaking first tests of change following MDT engagement at ward level;
- All Wards adopting the tools developed by HAPU collaborative as cross over are you chair aware;
- Standardise reporting of inpatient falls via Datix to support local QI work;
- Falls collaborative dashboard developed to support QI as a cohort and as individual ward-data captured for all inpatient falls by:
  - Severity
  - Location
  - Type

Timelines:

Cohort wards due to feedback outcomes of tests of change at second masterclass 17th July 2019.

Cohort presentation due October following 3 months of testing to determine interventions as standard practice for the Health Board.

Serious Incidents: Patient Falls Graphs



Chapter 1 – Quality

Serious Incidents: HAPU (Healthcare Acquired Pressure Ulcers)

LM02 3b	Number of Healthcare Acquired Pressure Ulcers reported as Serious Incidents	Target AP	Plan AP	May-19	0	Status	↑	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP
LM02 3c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	Target AP	Plan AP	May-19	177	Status	N/A	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP

Actions:

- Collaborative with original cohort inpatient wards continues;
- Health Board launch in May across all acute sites and attended by Area teams and Primary Care teams;
- Launch included the Health Board standards of:
  - Situation Background Assessment Recommendation (SBAR) reporting format for Datix inc Rout Cause Analysis tool
  - Training Needs Analysis tool for Staff inc Are you Chair aware and standardised staff resources
  - Preparation for the implementation of the all Wales risk assessment tool Purpose T;
  - Revised Tissue Viability resources.

Outcomes:

- Over 130 staff members attended launch
- Resources updated on intranets and to be communicated in more detail in masterclasses across the HB
- Cohort wards have seen a reduction in inpatient falls as a feature of their work on HAPU's

Timelines:

- Masterclasses planned for July/August 2019 across HB to:
  - Share all Wales risk assessment Purpose T, care plans/pathways;
  - Successful interventions tested by the cohort wards

DFM 027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	Target >= 95%	Plan >= 95%	May-19	90.90%	Status ↑	Wales Benchmark	2nd	Executive Lead	Evan Moore	Plan Ref	AP039
DFM 028	Crude hospital mortality rate (74 years of age or less)	Target Reduce	Plan <= 0.70%	May-19	0.83%	Status ↓	Wales Benchmark	4th	Executive Lead	Evan Moore	Plan Ref	AP039

Actions:

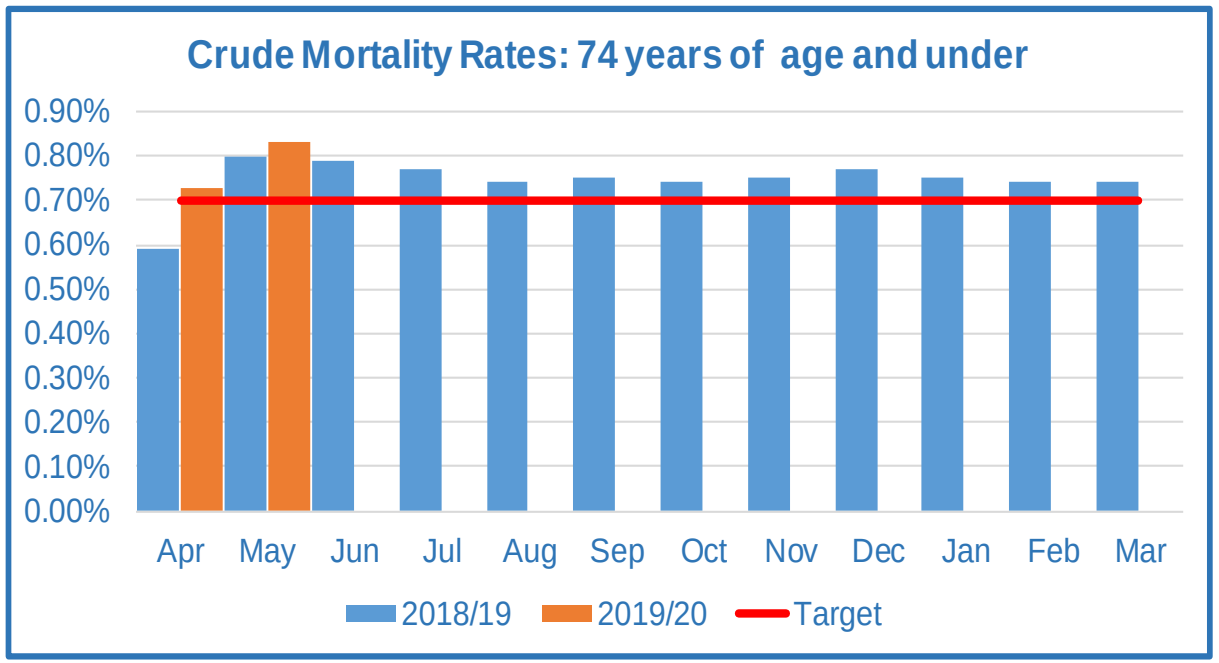
- Phased introduction of the DATIX mortality review module stage 1- go live in YGC 16th July 2019, other sites to be confirmed following discussions with site leads
- Development of the stage 2 hybrid structured judgement review tool which will be moved across to DATIX system during 2019/20
- Sepsis collaborative throughout the remainder of 2019/20 dates have been set as 5th Sep 2019, 10th Dec 2019 and 11th Feb 2020.
- Acute Kidney Injury collaborative development during 2019/20
- Development of an automated AKI alerts system and dashboard

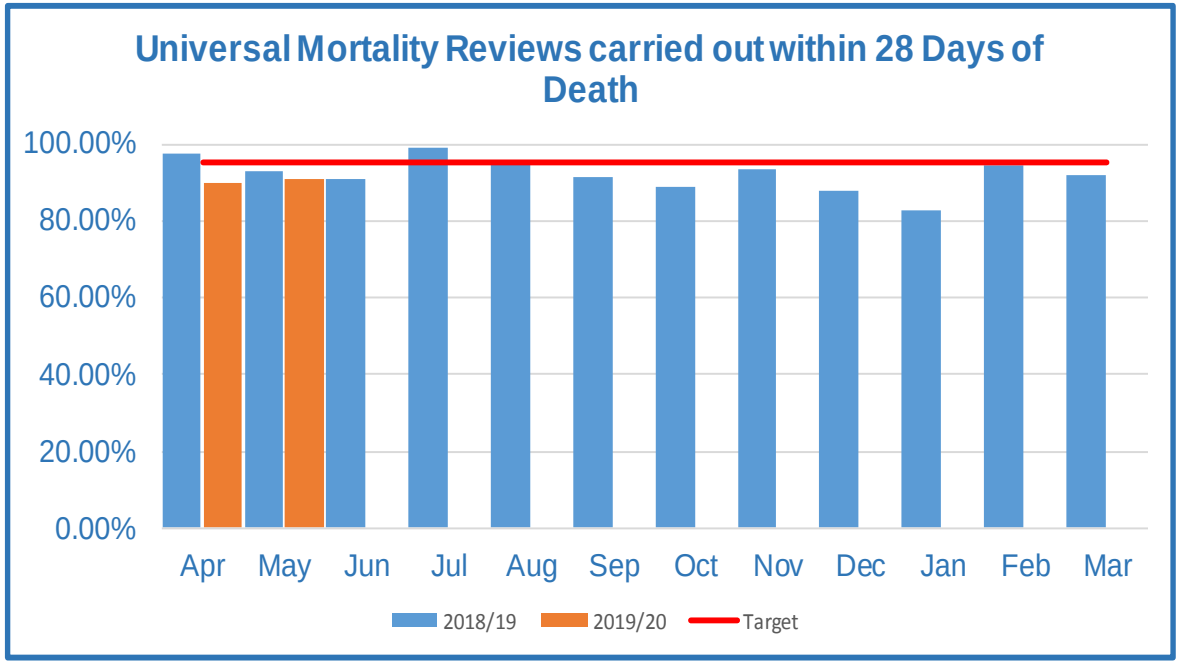
Outcomes:

- Improve timeliness of mortality reviews through the introduction of DATIX during 2019/20
- Acute Kidney Injury patients now identified and followed up more rapidly due to the automated e-alerts system

Timelines:

- Throughout 2019/20 for the stage 1 roll out (acute hospitals), with stage 2 going over into 2020/21
- Acute Kidney Injury Collaborative dates to be confirmed


Crude Mortality Rates: 74 years of age and under
0.90%
0.80%
0.70%
0.60%
0.50%
0.40%
0.30%
0.20%
0.10%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018/19
2019/20
Target


Universal Mortality Reviews carried out within 28 Days of Death
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018/19
2019/20
Target

Chapter 1 – Quality Postponed Procedures

DFM 038	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	Target Reduce	Plan Reduce	12 Months to Mar-19	2,281	Status	↓	Wales Benchmark	4th	Executive Lead	Evan Moore	Plan Ref	AP025

Actions:

- Develop and strengthen the theatre 6:4:2 Standard operating Procedure and meeting agenda
- Develop Standard Operating Procedure for supporting weekly theatre scheduling
- A clear process for escalation and approval or not) for on the day non clinical cancellations
- Capacity planning for elective beds linked to non-elective pressures
- Review pre-operative pathway including workforce
- TCI reminder call reviewed for challenged specialties such as Orthopaedics

Outcomes:

- Reduction in short notice cancellations and Did Not Attend
- Increase average case per list. Better management and planning of lists
- Reduce avoidable cancellations
- Right bed available to accommodate case mix. Ability to change case mix to respond to non-elective bed pressures
- Minimise cancellations due to medical fitness (unfit on the day)
- Reduction in patient initiated short notice cancellations
- Work towards zero tolerance for cancer cancellations and then by Q4, all cancellations

Timelines:

- Q2-Q3
- Q2-Q3
- Q2-Q3
- Q3-Q4
- Q4
- Q3-Q4
- Q4

WGM 001	Ward Staff Fill Rate Percentage	Target >= 95%	Plan AP	May-19	86%	Status	↑	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP
WGM 002	Ward Staff Skill Mix Ratio of Registered v Non-Registered Percentage	Target >= 60%	Plan AP	May-19	55%	Status	←	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP

Actions:

- BCUHB representation at national nursing events to promote Train Work Live campaign e.g. Nursing Times events in Birmingham and Manchester , RCN Congress Meeting and national conferences. Representation also at local events such as agricultural shows.
- BCUHB “Meet & Greet” events targeted at new graduates, both North Wales and North West England universities invited to attend.
- Local E-roster scrutiny against agreed KPIs to ensure efficiency within rosters.
- Nurse bank support with bank usage and agency where there are RN gaps.
- Exit interviews to be undertaken.

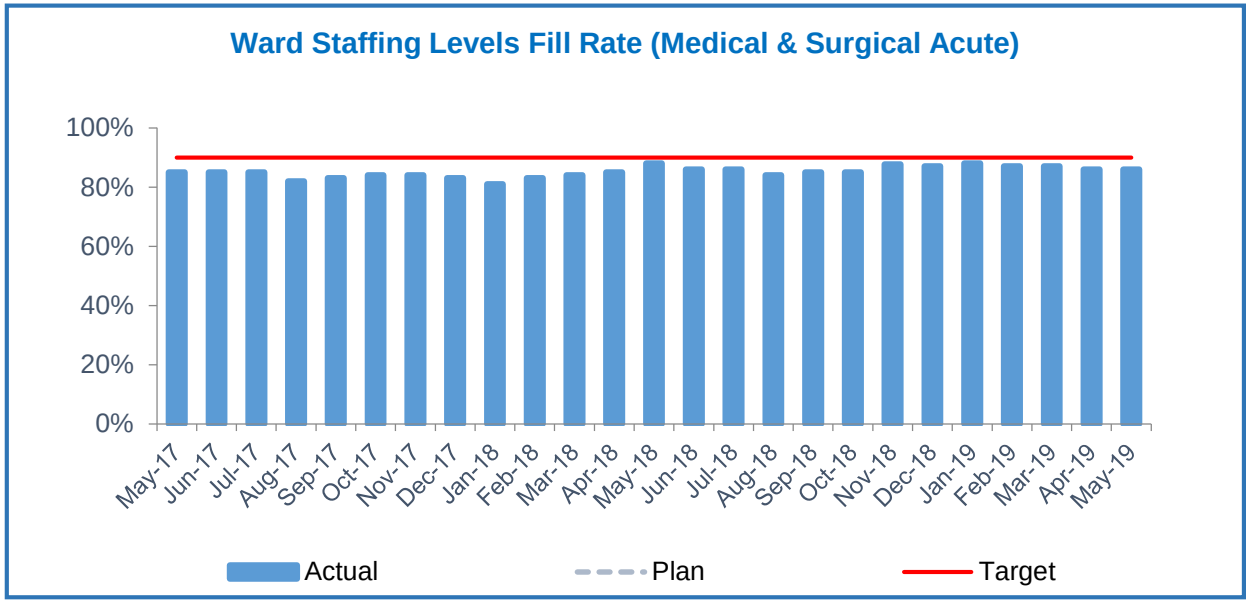
Outcomes:

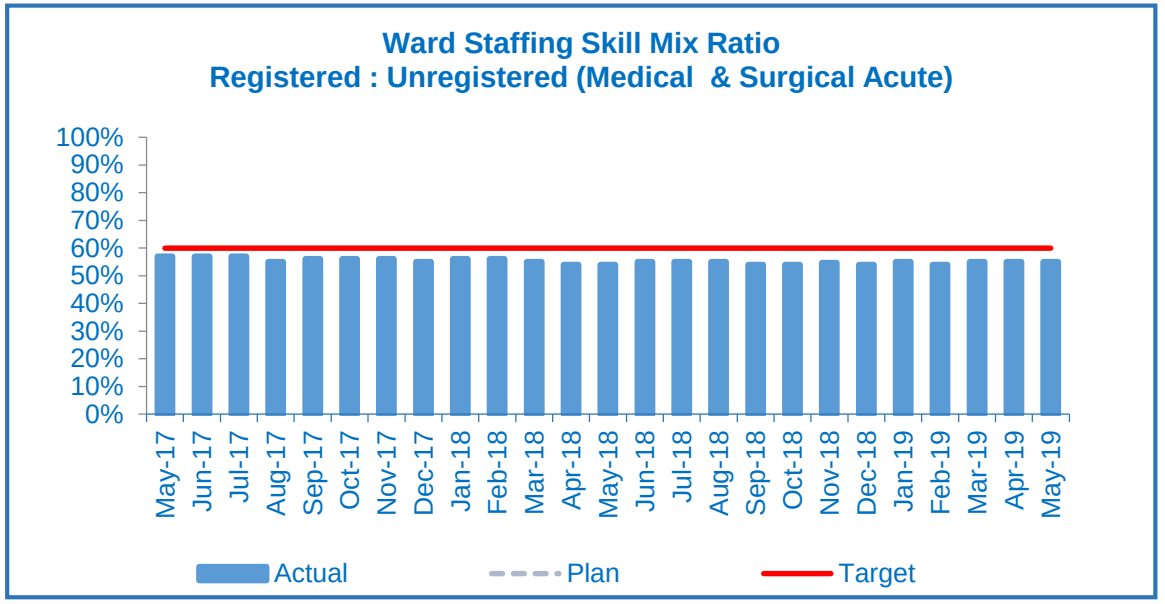
- Overall aim is to reduce Registered Nurse vacancies and encourage external recruitment. 47 recruited Feb – March 2019. Current RN vacancies across 3 acute sites = 295fte.
- Successful recruitment will improve ward skill-mix percentages.
- Successful recruitment will improve compliance with the Nurse Staffing Act and allow correct nurse:patient ratios.
- Efficient e-rosters will improve compliance against agreed Key Performance Indicators such as Annual Leave percentages, unused hours, reduction in additional shifts being created.
- Improved staffing to support reduction in patient harm such as HAPU, Medication Never Events, improved Infection Prevention Control performance, reduction in falls.

Timelines:

- New graduates recruited (130) to be with expected start dates end Sept 2019. Preceptorship period would mean new recruits no longer super-numerary from late December 2019 – January 2020 onwards.

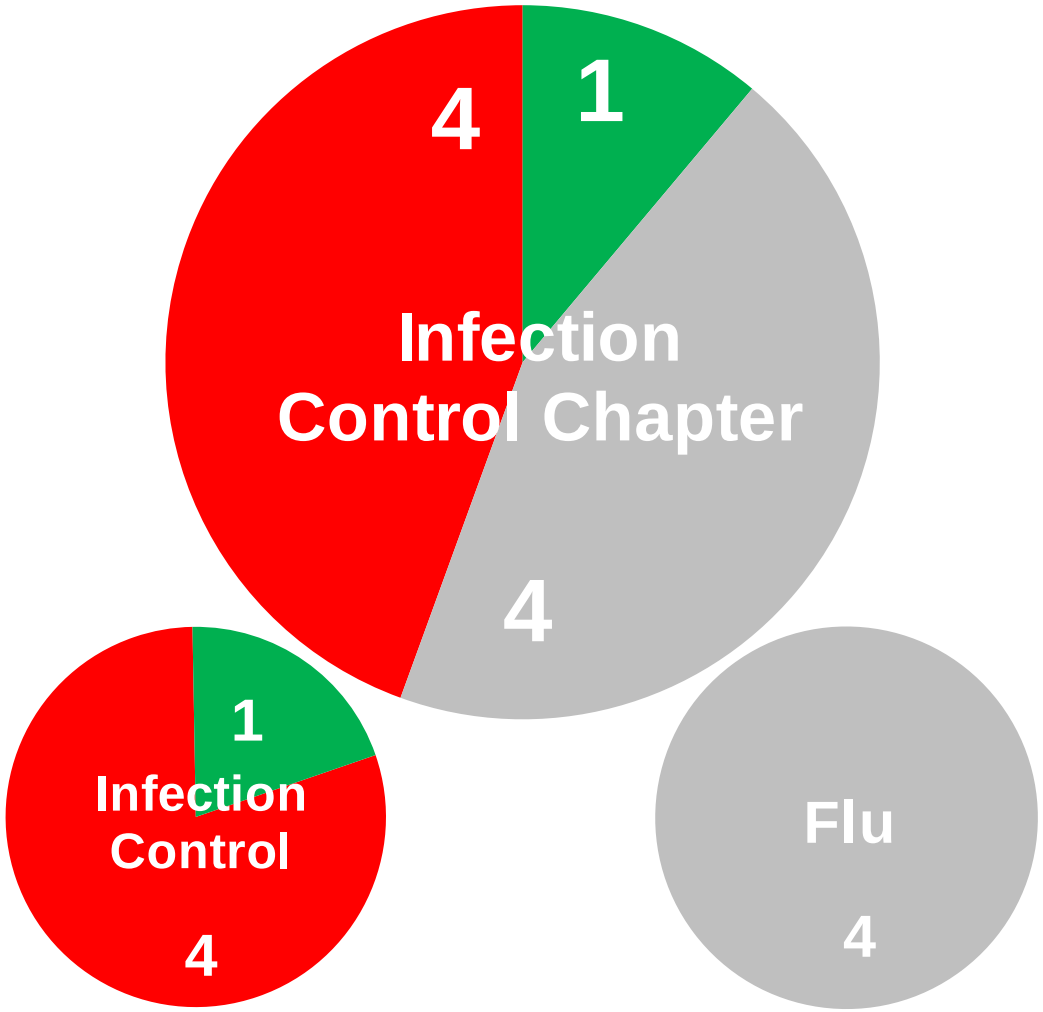
Ward Staffing Levels Graphs





Chapter 2 – Summary

Infection Control



Measure	Status		(Target)
Rate: E.Coli	88.38	↓	<= 39
Rate: S.Aureus	29.29	↓	<= 12
Rate: C.Difficile	25.42	↓	<= 14
Rate: Klebsiela	16.75	↓	<= 9
Rate: Aeruginosa	1.73	↑	<= 3
Flu Vaccination: 65's and Over			N/A S
Flu Vaccination: Uner 65's at Risk			N/A S
Flu Vaccination: Pregnant Women			N/A S
Flu Vaccination: Health Care Workers			N/A S

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Chapter 2 – Infection Control Measures

DFM 021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	Target <= 39	Plan <= 39	Jun-19	88.38	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	Target <= 12	Plan <= 12	Jun-19	29.29	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1b1	Number of laboratory confirmed MRSA cases	Target 0.00	Plan 0	Jun-19	1	Status	→	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1b2	Number of laboratory confirmed MSSA cases	Target <= 11	Plan <= 11	Jun-19	18	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	Target <= 14	Plan <= 14	Jun-19	25.42	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1c	Number of laboratory confirmed C.difficile cases	Target AP	Plan AP	Jun-19	19	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021d	Cumulative rate of laboratory confirmed Klebsiela cases per 100,000 population	Target <= 9	Plan <= 9	Jun-19	16.75	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021e	Cumulative rate of laboratory confirmed Aeruginosa cases per 100,000 population	Target <= 3	Plan <= 3	Jun-19	1.73	Status	↑	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	AP039

* Not published yet

Chapter 2 – Infection Control Report

Actions:

- In depth review of all Healthcare Acquired Infections for April 2019 to look for trends, particularly in relation to the Central locality, Klebsiella, E coli and MSSA. Dedicated Infection Prevention and Control staff now allocated to community hospitals, mental health and learning disabilities and other community health care provision.
- Clean your hands promotional work for w/c 6th May 2019.
- Post infection reviews are carried out for all C. difficle infections (CDI) and blood stream infections associated with health care. Some of these are presented to the HCAI Executive reviews held monthly.
- Provisional trajectory figures considered until WG provide for 2019/20. Monitor population sizes and demographics in relation to infection rates and trajectories.
- Dedicated review for inpatient areas on all invasive devices.
- Start smart then focus promoted to also include removal of vascular cannulas.
- Meeting took place with Welsh Ambulance regarding a trail of safe/unsafe cannulation so removal is carried out in admission area.
- Decant area now available to provide uninterrupted infection prevention.

Outcomes:

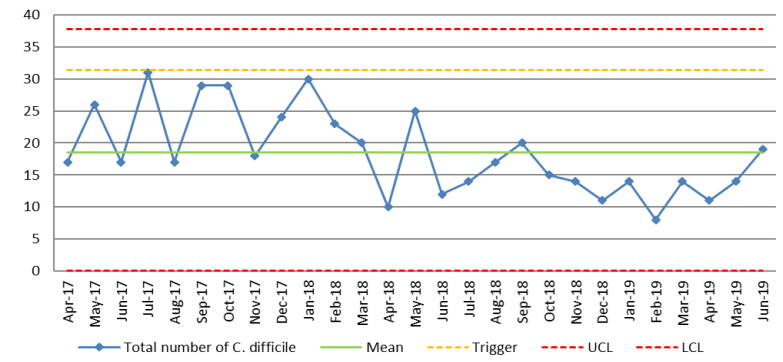
- Recognising the trends that maybe linked to increase in gram negative blood stream infections.
- Monitor population sizes and demographics in relation to infection rates and trajectories.
- Keep hand hygiene and bare below the elbows “everyday business” and accountability for providing safe, clean care.
- Performance framework populated for the 6 organisms with associated trajectories.
- Scrutiny and learning from focused HCAI executive review.
- Reduction and removal of unnecessary devices and associated risks.

Timelines:

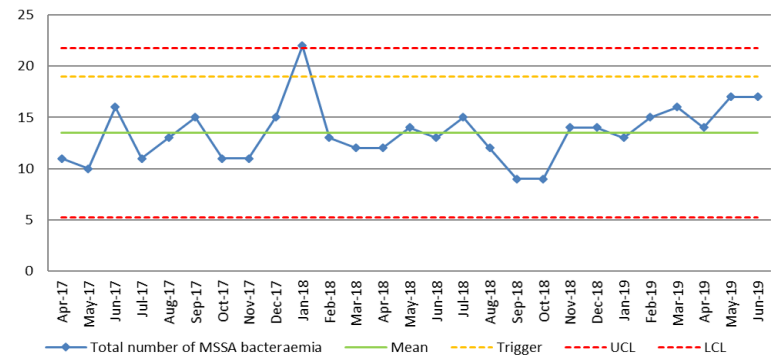
- Continually monitor rates and innovative practice in reducing avoidable infection/harm and remain focused on reducing avoidable infections.

Chapter 2 – Infection Control Graphs

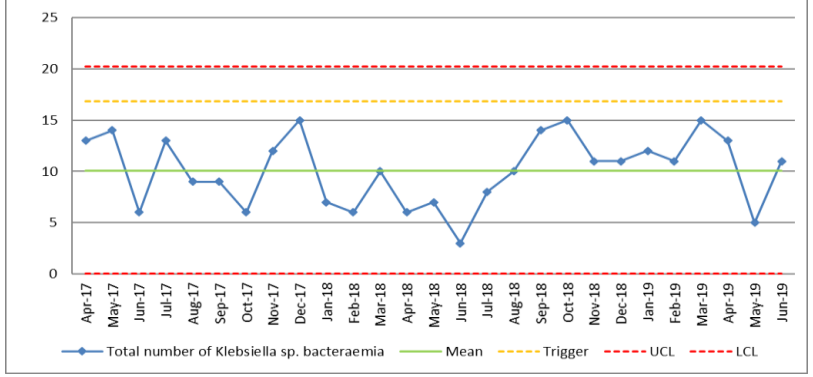
BCUHB
Total monthly number of C. difficile



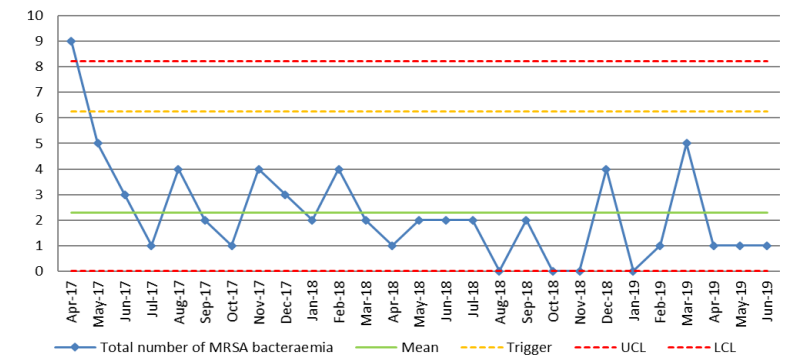
BCUHB
Total monthly number of MSSA bacteraemia



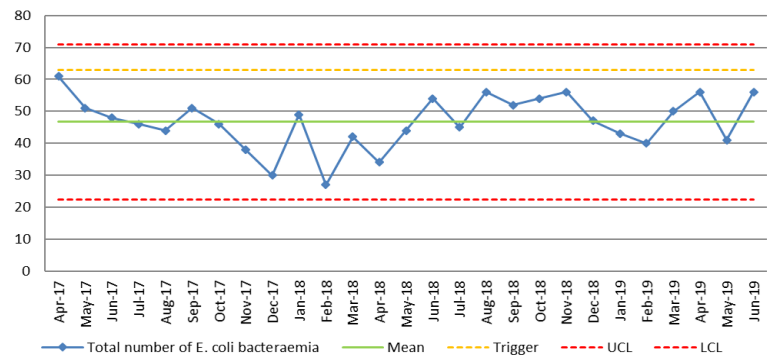
BCUHB
Total monthly number of Klebsiella sp. bacteraemia



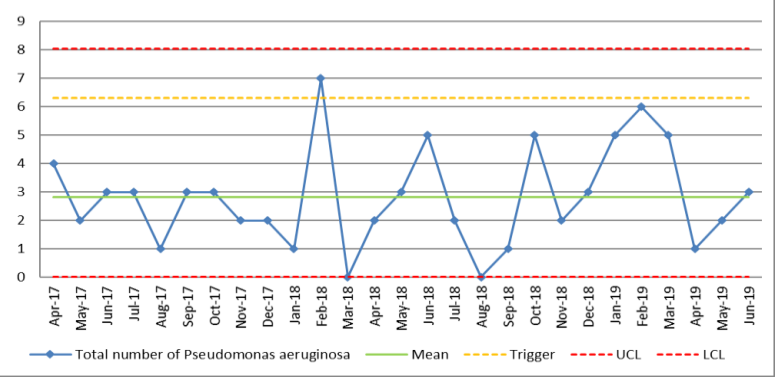
BCUHB
Total monthly number of MRSA bacteraemia



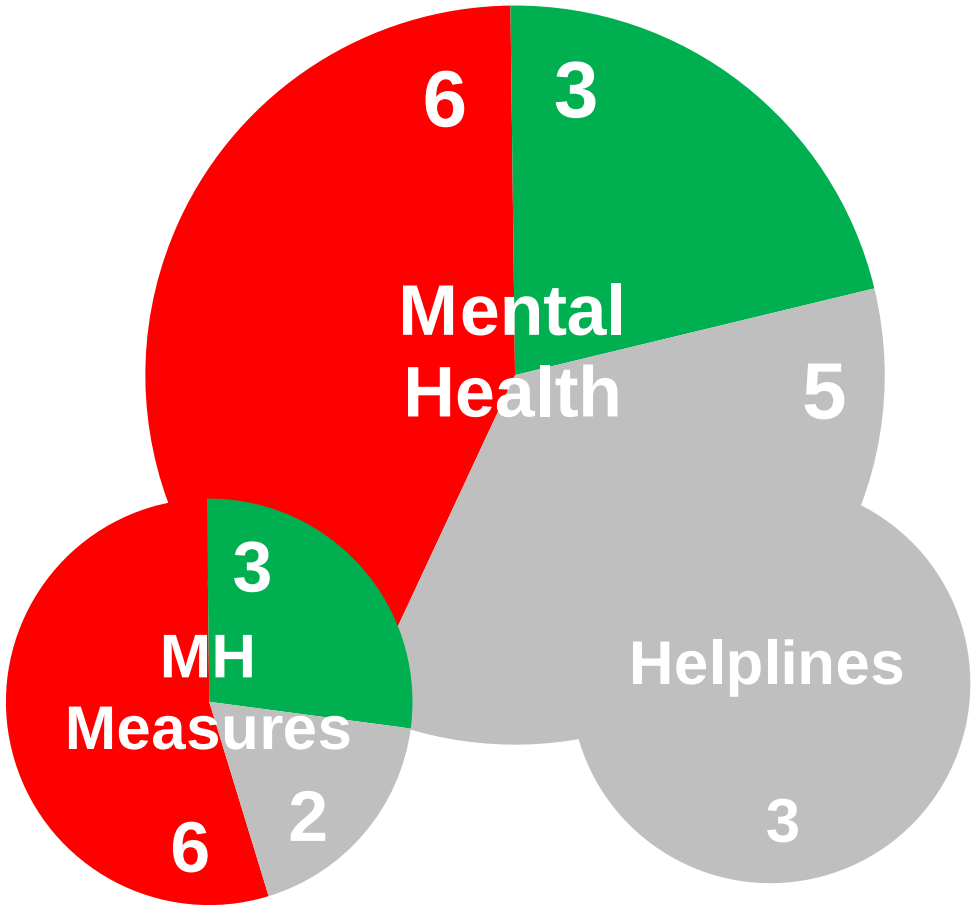
BCUHB
Total monthly number of E. coli bacteraemia



BCUHB
Total monthly number of Pseudomonas aeruginosa



Chapter 4 - Summary



Mental Health

Measure	Status		(Target)
26 Week Wait: Adult Specialist Mental Health Psychological Therapy			AP
26 week Wait: Children and Young People Neurodevelopment Assessment			AP
MHM1a - Assessments within 28 Days (Combined)	**74.57%**	↓	>= 80%
MHM1b - Therapy within 28 Days (Combined)	**70.25%**	↑	>= 80%
MHM1a - Assessments within 28 Days (Adult)	**73.82%**	↓	>= 80%
MHM1b - Therapy within 28 Days (Adult)	**71.13%**	↑	>= 80%
MHM1a - Assessments within 28 Days (CAMHS)	**80.15%**	↑	>= 80%
MHM1b - Therapy within 28 Days (CAMHS)	**63.24%**	↓	>= 80%
MH Advocacy	**100%**	→	100%
MHM2 - Care Treatment Plans (CTP)	**89.90%**	↓	>= 90%
MHM3 - Copy of Agreed plan within 10 Days	**100%**	→	100%
Helplines: CALL			N/A Q
Helplines: DAN			N/A Q
Helplines: Dementia			N/A Q

Integrated Quality and Performance Report
Quality, Safety & Experience Committee Version

July 2019

Chapter 4 – Mental Health

Assessment and Therapy Adult

LM06 0a	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Adult)	Target >= 80%	Plan >= 71%	Apr-19	73.82%	Status	↓	Wales Benchmark	5th	Executive Lead	Andy Roach	Plan Ref	AP027
LM06 1a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	Target >= 80%	Plan >= 67%	Apr-19	71.13%	Status	↑	Wales Benchmark	6th	Executive Lead	Andy Roach	Plan Ref	AP027

Actions:

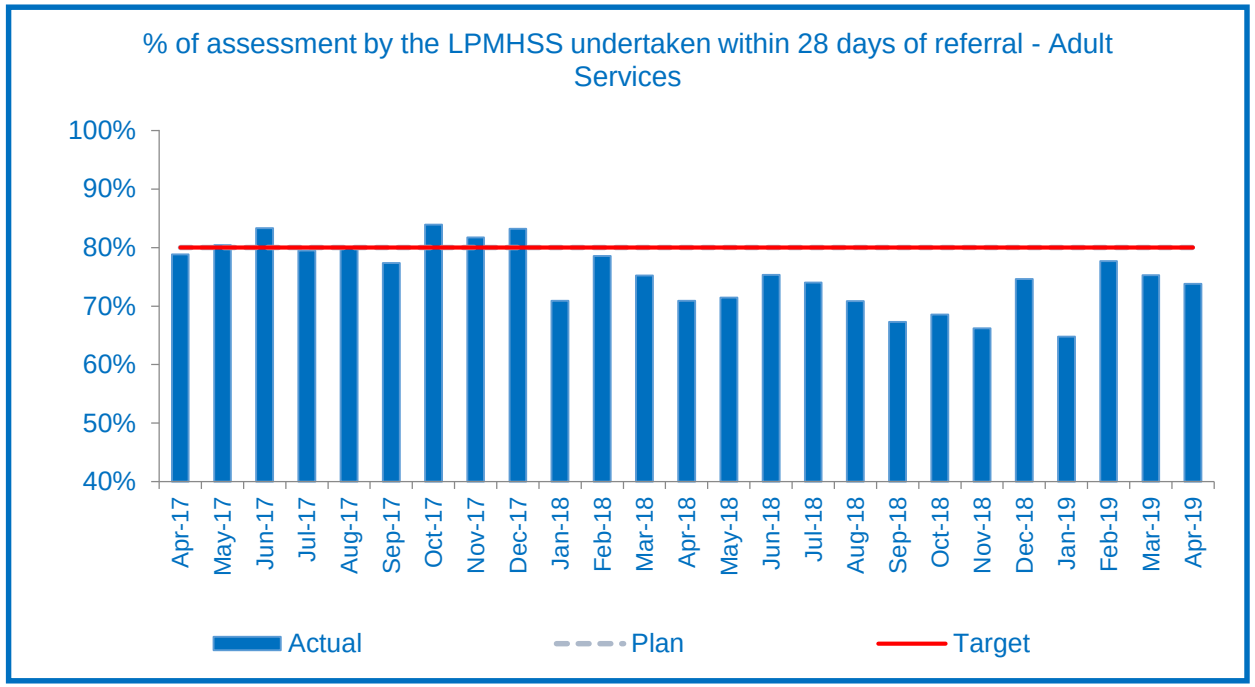
- Patients are treated by clinical priority has been widely adopted which has impacted on performance but is clinically the right action for patients
- Timely weekly reporting direct to area teams
- MHM Lead(s) supporting area to increase focus on specific issues / actions plan
- Closer monitoring & scrutiny of referral activity
- Increased Senior Manager focus & support
- Clinical & Social care staff deployed to focus on areas performing below target
- Support Time and Recovery workers are now (or, recruited to awaiting start dates) in post and working through the interventions backlog identifying patients who still require interventions
- Developed and implemented local action plans to improve targets
- Exploring ways to increase our establishment to reflect demand/backlog

Outcomes:

- Further education
- Correct & validated information
- Teams timely informed and engaged
- Decreased waiting times
- Recruitment

Timelines:

The MHLD division continues to work on achieving the target across all teams, however, high referral rates, sickness and recruitment to vacancies continues to impact on delivery. The recent deep dive analysis has highlighted that a large percentage of patients are assessed and discharged with advice, information or signposting elsewhere, in some teams this is over 60%. The solution to target achievement is a complete service transformation for this identified group which is currently been worked through via the strategy implementation.


% of assessment by the LPMHSS undertaken within 28 days of referral - Adult Services
100%
90%
80%
70%
60%
50%
40%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
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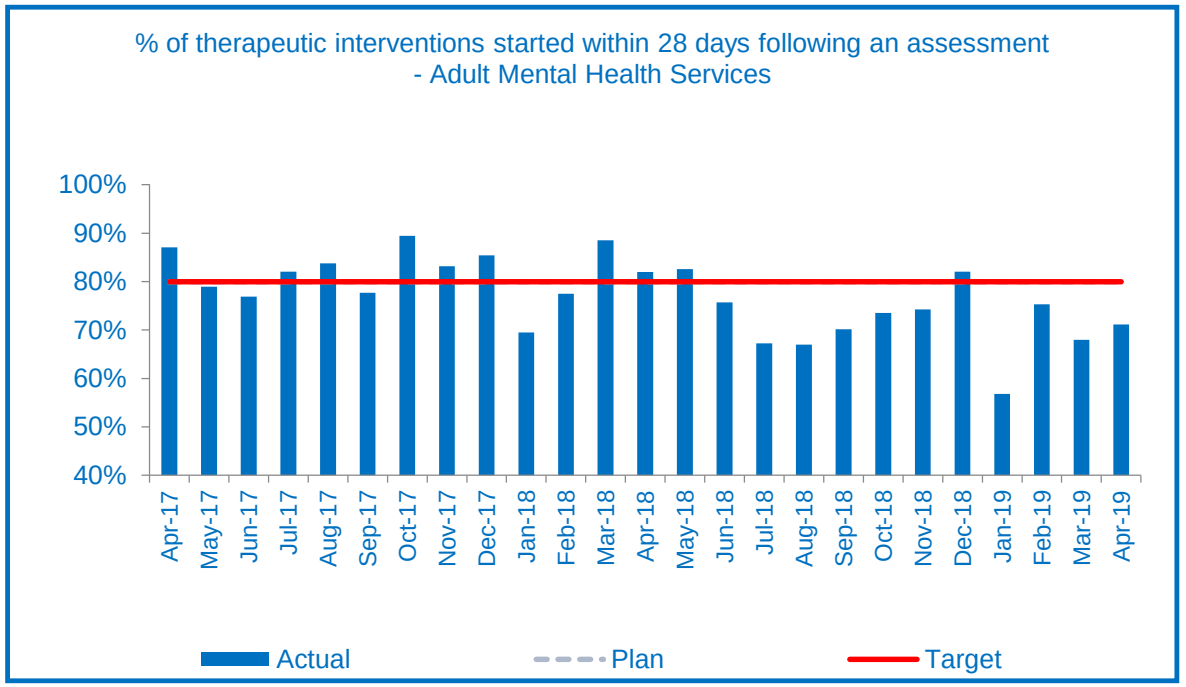
Feb-19
Mar-19
Apr-19
Actual
Plan
Target


% of therapeutic interventions started within 28 days following an assessment - Adult Mental Health Services
100%
90%
80%
70%
60%
50%
40%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
Actual
Plan
Target

Chapter 4 – Mental Health

Care & Treatment Plan (CTP) Adult

DFM 082	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	Target >= 90%	Plan >= 88%	Apr-19	89.90%	Status	Wales Benchmark	4th	Executive Lead	Andy Roach	Plan Ref	AP027

Actions:

- Detailed & timely reports disseminated to teams and individual care coordinators.
- The Mental Health Measure Leads are aligned to local areas to improve performance and overall quality of services to patients.
- Regular data cleansing & caseload validation
- Close and regular monitoring of activity and compliance rates.
- Developed and implemented local action plans to improve targets.
- Exploring ways to increase our establishment to reflect demand/backlog

Actions:

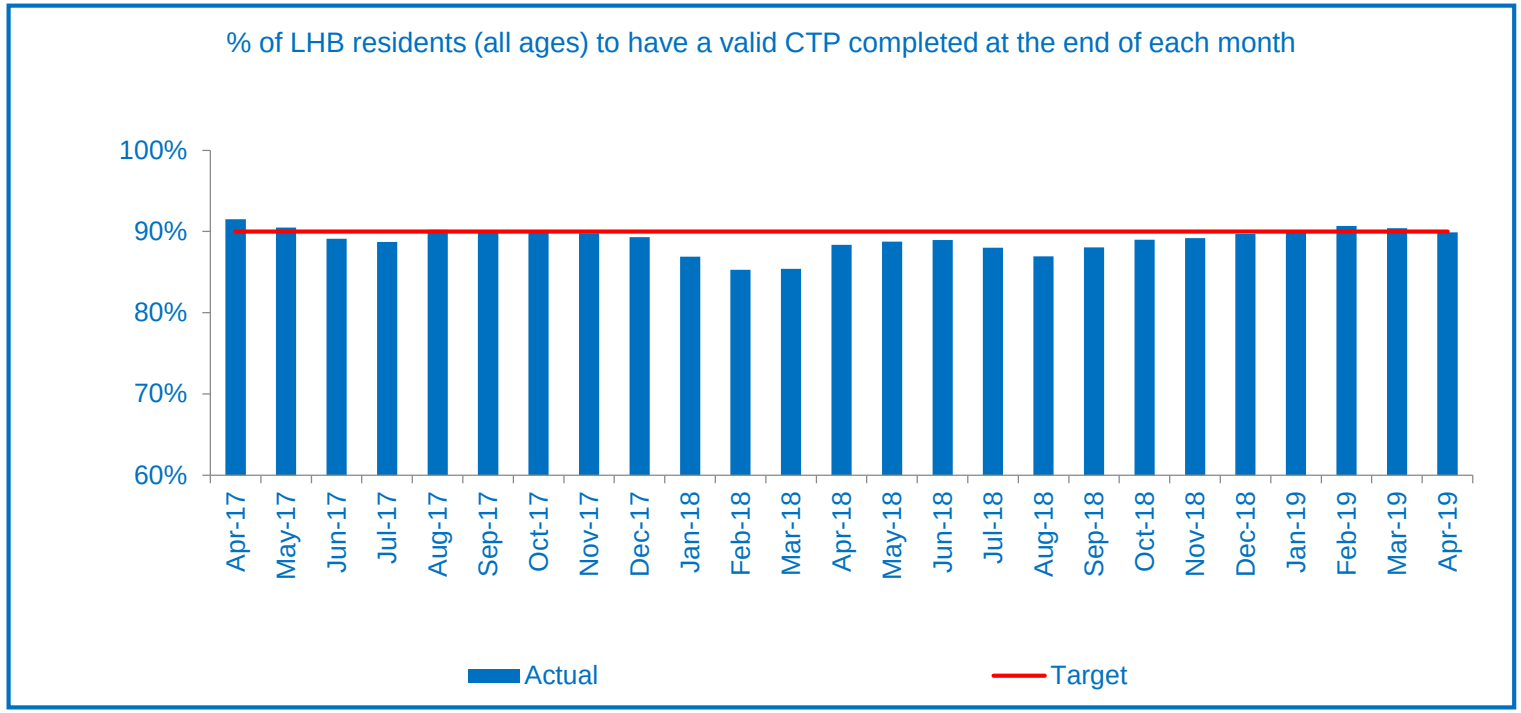
- Further education
- Correct & validated information
- Teams informed and engaged

Actions:

With sustained focus, the Division expects to be compliant in Q2

Chapter 4 – Mental Health

Care & Treatment Plan Graphs



Chapter 4 – Mental Health

Assessment and Therapy CAMHS 33

LM06 0b	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (CAMHS)	Target >= 80%	Plan AP	Apr-19	80.15%	Status	↑	Wales Benchmark	N/A	Executive Lead	Chris Stockport	Plan Ref	AP027
LM06 1b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	Target >= 80%	Plan AP	Apr-19	63.24%	Status	↓	Wales Benchmark	N/A	Executive Lead	Chris Stockport	Plan Ref	AP027

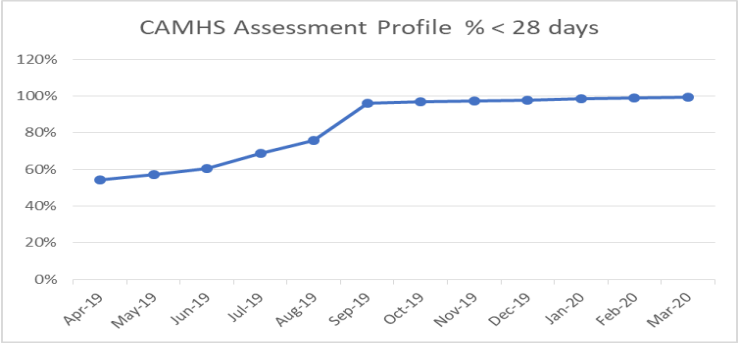
Actions:

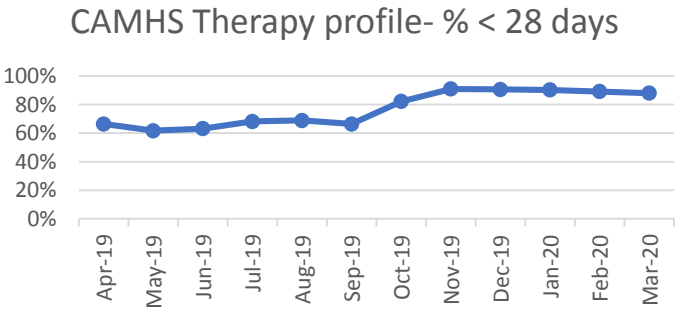
- Recruitment day undertaken in May for Central Area
- Further recruitment campaign being progressed
- Bid submitted to Welsh Government for Service Improvement funding identified for additional posts for core service and Early intervention service
- Bid includes for roll-out of GP cluster post in Denbighshire to East and West Areas which has been successful in management of demand to CAMHs
- Ongoing demand and capacity meetings across the teams resulting in an increase in capacity including additional hours and use of agency
- Use of groups to deliver interventions as appropriate

Outcomes:

- Increased activity for assessments resulting in an anticipated achievement of the Mental Health Measure targets from October 2019.
- Increased activity for interventions resulting in an anticipated achievement of the Mental Health Measure targets from December 2019.
- Reduction in demand overall to specialist CAMHS. Primary Care capacity under development and Early Intervention Service extended
- Appropriate support for Children, Young People and their families
- 6 trainee posts recruited which will need further support will be in post by end October 2019
- 3 Band 6 posts will be in post by end of September 2019
- Psychology posts will be in post by end of October 2019

Timelines:





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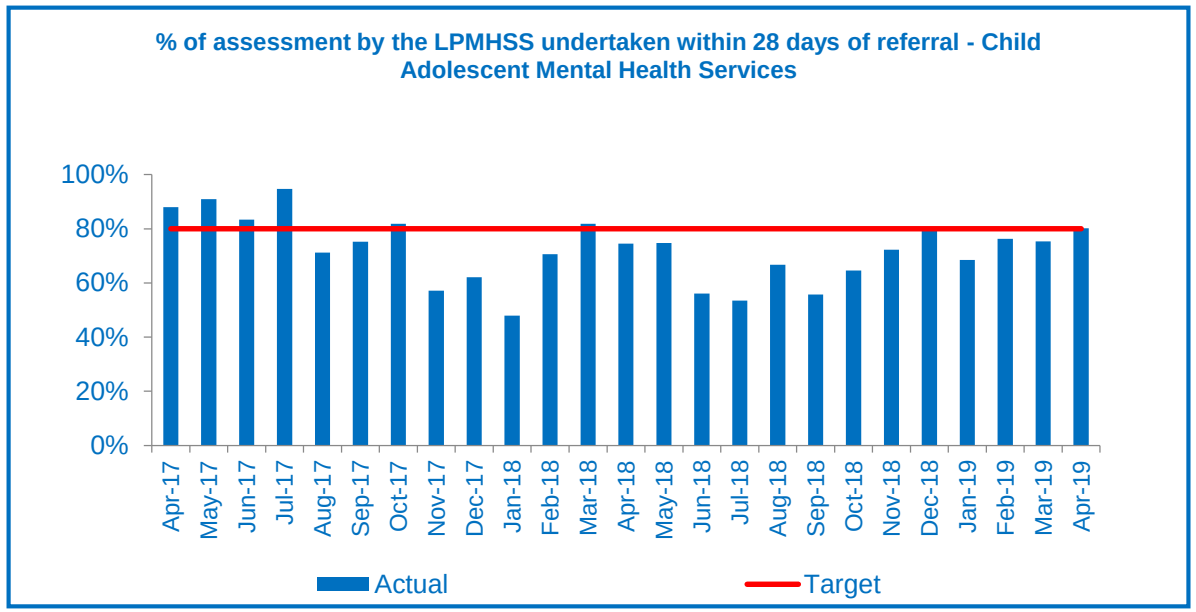
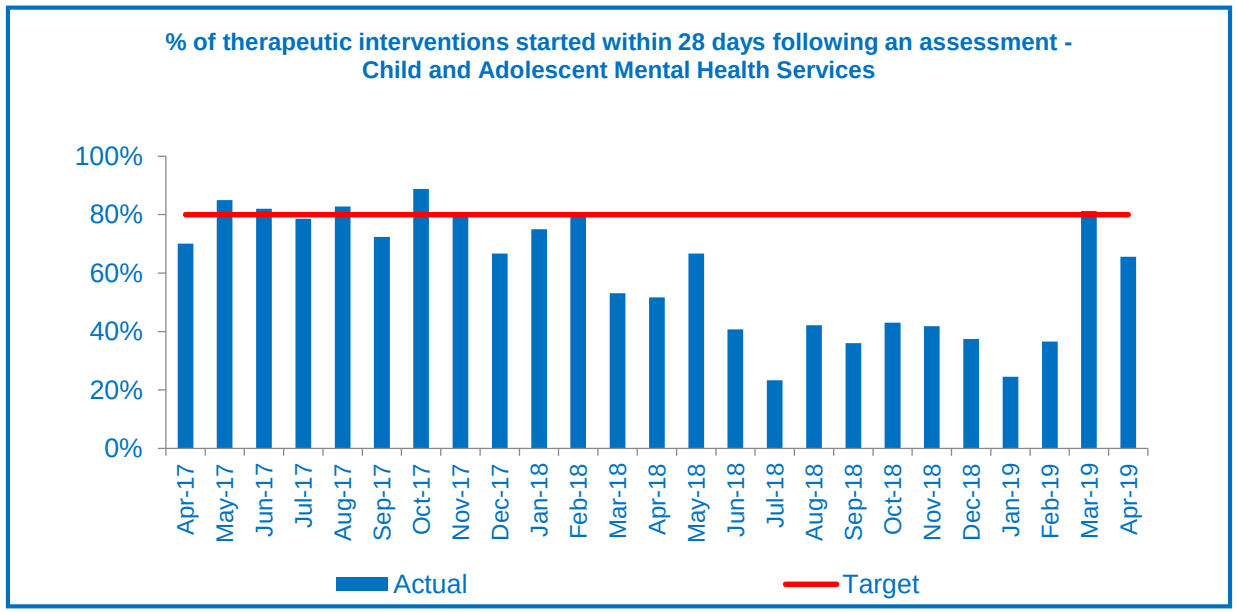
Quality, Safety & Experience Committee Version

July 2019

CAMHS Graphs





Appendix: Further Information

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

- performance reference tables
- tolerances for red, amber and green
- the Welsh benchmark information which we have presented

Further information on our performance can be found online at:

- Our website www.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb
http://www.facebook.com/bcuhealthboard

Quality, Safety & Experience (QSE) Committee

16.7.19

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

To improve health and provide excellent care

Report Title:	Annual Plan 2019-20 Progress Monitoring Report (APPMR)
Report Author:	Mr Ed Williams, Head of Performance Assurance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Public or In Committee	Public
Purpose of Report:	This report provides the committee with a summary of progress of the Actions within the Annual Plan for 2019/20
Approval / Scrutiny Route Prior to Presentation:	This paper has been scrutinised and approved by the Director of Performance.
Governance issues / risks:	Our report outlines the progress against Actions in the Annual Plan for 2019/20. Where any Action is scored as Red, a short explanation of why and what is being done to resolve the issue(s) is provided.
Financial Implications:	N/A
Recommendation:	The Quality, Safety & Experience Committee is asked to note the report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√

5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

This paper supports the revised governance arrangements at the Health Board and supports the Board Assurance Framework by presenting clear information on the quality and performance of the care the Health Board provides. It also addresses key indicators for mental health and primary care.

Equality Impact Assessment

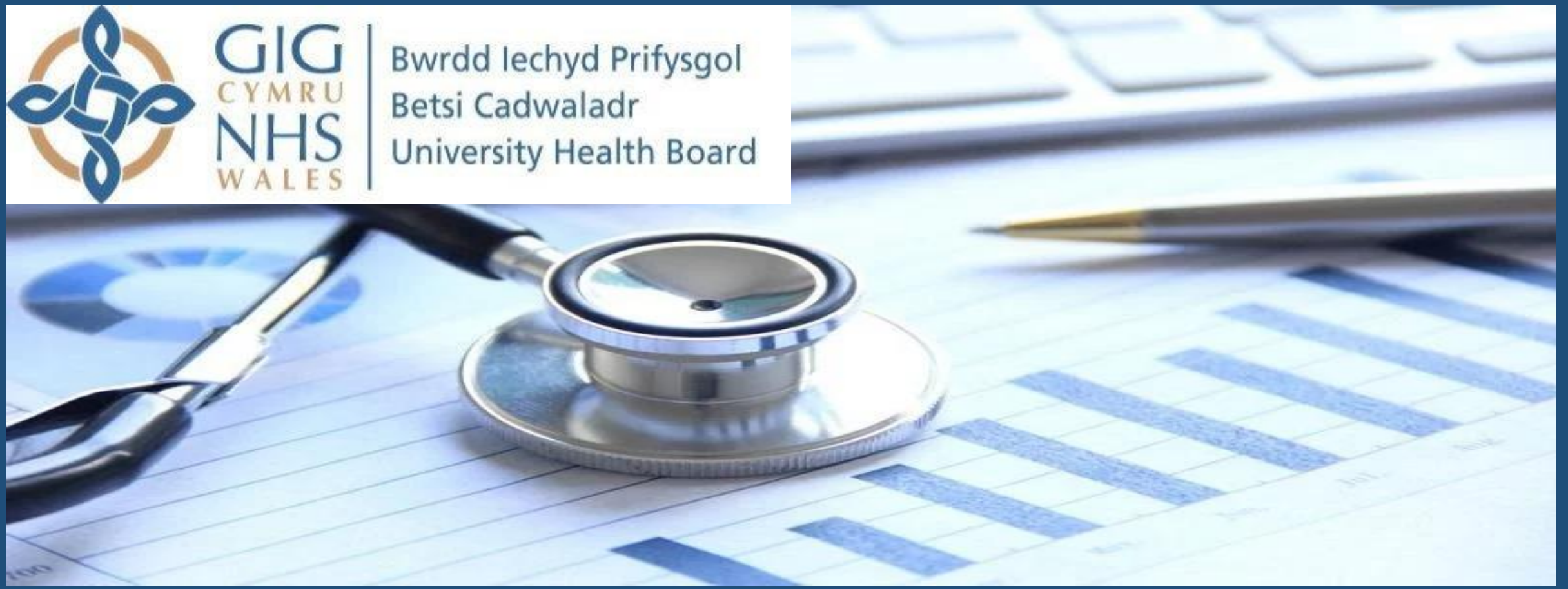
The Health Board's Performance Team are establishing a rolling programme to evaluate the impact of targets across the Equality & Diversity agenda.

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Three Year Outlook and 2019/20 Annual Plan: Monitoring of Progress against Actions

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



May 2019

About this Report

This report presents performance against the 2019/20 Annual Plan actions, and is presented in the same order as the plan i.e. health improvement and health inequalities, care closer to home, planned care, unscheduled care, workforce, digital and estates.

The ratings have been self assessed by the relevant lead executive director. All the ratings have been reviewed and approved by the executive team. Consideration will be given as to how assurance on progress can be provided on a periodic basis.

To interpret this report, it is necessary to note the basis of the rating which provides a succinct forecast of delivery, combined with an assessment of relative risk.

Feedback is welcomed on this report and how it can be strengthened. Please email Jill.Newman@Wales.NHS.UK.

RAG	Every Month End	By year end	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points expaining why, and what is being done to get back on track.
Amber	Achievement as forecast; work has commenced; some risks being actively managed	N/A	Where RAG is Amber: No additional information required
Green	On track for achievement, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

Three Year Outlook and 2019/20 Annual Plan
Monitoring of progress against Actions for Year One (2019/20)

May 2019

Programme Health Improvement & Health Inequalities

Actions	Exec Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Partnership plan for children progressed with a strong focus on Adverse Childhood Experiences	PH	*	R										Q4
Implement the Together for Children and Young People Change Programme	PC&C	A	A										Q4
Delivery of ICAN campaign promoting mental well-being across North Wales communities	MH&LD	G	G										Q4
Further develop strong internal and external partnerships with focus on tackling inequalities	PC&C	G	*										Q4
Healthy weight services increased	PH	G	G										Q4
Explore community pharmacy to deliver new lifestyle change opportunies	PH	G	G										Q4
Improve outcomes in first 1000 days programmes	PH	G	G										Q4
Further develop strong internal and external partnerships with focus on tackling inequalities	PH	G	G										Q4
Implement Year Three of Quality Improvement Strategy	N&M	G	G										

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

A meeting is scheduled for July 2019 to review the neurodevelopment pathway. An action plan will be produced following this meeting, and taken forward. This will complete the quarter one action in the plan.

Three Year Outlook and 2019/20 Annual Plan
Monitoring of progress against Actions for Year One (2019/20)

May 2019

Programme Care Closer to Home

Actions	Exec Leads	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Model for health & well-being centres created with partners, based around a 'home first' ethos	PC&C	*	A										Q4
Define and put in place Model for integrated Primary and Community Care Academy (PACCA) to support GP practices under greatest pressure	PC&C	A	A										Q4
Model for health & well-being centres created with partners, based around a 'home first' ethos	PC&C	A	A										Q4
Establish a local Gender Identity Team	PC&C	A	A							Q3			
Develop and implement plans to support Primary care sustainability	PC&C	*	G										Q4
Implementation of RPB Learning Disability strategy	PC&C	*	G										Q4
Establish framework for assessment for CHC and individual packages of care for people with mental health needs or learning disabilities	MH&LD	G	G										Q4
Put in place agreed model for integrated leadership of clusters in at least three clusters, evaluate and develop plan for scaling up	PC&C	G	G										Q4
Put in place Community Resource Team maturity matrix and support to progress each CRT	PC&C	G	G										Q4
Work through the RPB to deliver Transformational Fund bid	PC&C	G	G										Q4
Plan and deliver digitally enabled transformation of community care	PC&C	G	G										Q4
Develop and Implement a Social prescribing model for North Wales	PC&C	G	G										Q4

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

Three Year Outlook and 2019/20 Annual Plan

Monitoring of progress against Actions for Year One (2019/20)

May 2019

Implement the new Single cancer pathway across North Wales	T&HS	A	R	Q1									
Stroke Services	MD	A	R	Q1									
Develop Rehabilitation model for people with Mental Health or Learning Disability	MH&LD	*	G										Q4
Fully realise the benefits of the newly established SURNICC service	PH	*	G										Q4
Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists	MD	A	A										Q4
Systematic review and plans developed to address service sustainability for all planned care specialties. Implement year one plans for example Endoscopy, Rheumatology, Gynaecology	N&M, T&HS, MD	G	G										Q4
Rheumatology service review	PC&C	G	G				Q2						
Implement preferred service model for acute urology services	MD	G	G										Q4
Business case, implementation plan and commencement of enabling works for Orthopaedics (refer to estates section/ plan)	MD	G	G	Q1									
Centralisation of complex vascular surgery services supported by a new hybrid theatre on YGC site	MD	P	P	Q1									

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

A programme business case has been prepared to support the implementation of the **single cancer pathway** across North Wales. The programme business case is being presented to the SPPH committee, with the aim of submitting it to the July board for approval.

A **stroke** business case has been developed, supported by a detailed implementation plan. The intention is that this is presented to either the July board, or finance and performance committee.

Three Year Outlook and 2019/20 Annual Plan

Monitoring of progress against Actions for Year One (2019/20)

May 2019

Programme Unscheduled Care

Actions	Exec Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Demand Improved Crisis Intervention Services for Children	N&M PH	A	A										Q4
Dicharge Integrated health and social care	N&M	A	A										Q4
Stroke Services	MD	A	A	Q1									
Demand Improved Mental Health Crisis response	N&M,M H&LD	G	A										Q4
Flow SAFER implementation	N&M	G	A										Q4
Flow Ablett/ PICU for Mental Health (linked to Estates section/ plan)	N&M,M H&LD	G	A										Q4
Demand Improved Urgent Care Out of Hours/ 111 Services	N&M	G	G										Q4
Demand Enhanced Care Closer to Home Pathways	N&M	G	G										Q4
Demand Workforce shift to improve Care Closer to Home	N&M	G	G										Q4
Flow Emergency Medical Model	N&M	G	G	Q1									
Flow Early Pregnancy Service (emergency gynaecology)	PH	G	G										Q4

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

Three Year Outlook and 2019/20 Annual Plan
Monitoring of progress against Actions for Year One (2019/20)

May 2019

Deliver Year One Workforce Optimisation Objectives - reducing waste and avoidable variable/premium rate pay expenditure. Demonstrating value for money and responsible use of public funds	WOD	A	A										Q4
Provide 'one stop shop' enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services	WOD	A	A										Q4
Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture	WOD	G	A										Q4
Build on QI work to develop the BCU improvement system and delivery plan for efficient value based healthcare	WOD	G	G										Q4
Develop an integrated multi professional education and learning Improvement Programme in liaison with HEIW	WOD	A	G							Q3			
Deliver Year One Leadership Development programme to priority triumvirates	WOD	A	G										Q4
Provide 'one stop shop' enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services	WOD	A	G										Q4
Develop and Deliver Year one Communications Strategy to improve Communications and enhance BCUHB reputation	WOD	A	G										Q4
Establish an integrated workforce improvement infrastructure to ensure all our work is aligned	WOD	G	G				Q2						
Develop a Strategic Equality Plan for 2020-2024	WOD	G	G				Q2						
Develop an integrated workforce development model for key staff groups with health and social care partners	WOD	G	G										Q4
Develop and Deliver Year one Communications Strategy to improve Communications and enhance BCUHB reputation	WOD	G	G										Q4

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

Three Year Outlook and 2019./20 Annual Plan

Monitoring of progress against Actions for Year One (2019/20)

May 2019

Programme Estates Strategy

Actions	Exec Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Wrexham Maelor Infrastructure	PP&E	R	R	Q1									
Laundry Services	PP&E	A	A										Q4
North Denbighshire	PP&E	G	A										Q4
Statutory Compliance / Estate Maintenance	PP&E	G	G										Q4
Primary Care Project Pipeline	PP&E	G	G										Q4
Well-being Hubs	PP&E	G	G										Q4
Ruthin Hospital	PP&E	G	G										Q4
Vale of Clwyd	PP&E	G	G										Q4
Orthopaedic Services	PP&E	G	G										Q4
Ablett Mental Health Unit	PP&E	G	G										Q4
Hospital Redevelopments	PP&E	G	G										Q4
Central Medical Records	PP&E	G	G										Q4
Residencies	PP&E	G	G										Q4
Integrated Care Fund (ICF) Schemes	PP&E	G	G										Q4

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

Wrexham Maelor Infrastructure - the position is as reported last month. Work continues with our external advisors and we expect the Programme Business Case to be presented to the F&P Committee in July 2019.

Three Year Outlook and 2019/20 Annual Plan

Monitoring of progress against Actions for Year One (2019/20)

May 2019

Actions	Exec Lead	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	MD	A	A										Q4
Support the identification of storage solution for Central Library	MD	A	A				Q2						
Delivery of information content to support flow/efficiency	MD	A	A										Q4
Provision of infrastructure and access to support care closer to home	MD	A	A										Q4
Implement Tracker 7 cancer module in Central and East.	MD	A	A				Q2						
Phase three of Welsh Patient Administration Project (PAS) starts. It will replace the Commercial PAS system in the West and standardise processes relating to this system in other sites	MD	G	G										Q4
Reconstitute the Welsh Emergency Department System upgrading the Emergency Department System in the East (phase 1) and extending instances to Central and West (phase 2 and 3)	MD	G	G										Q4
Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	MD	G	G				Q2						
Transition program to review the management arrangements for ensuring good record keeping across all patient record types	MD	G	G										Q4
Rolling programmes of work to maintain / improve the digital infrastructure e.g. migration of telephone infrastructure from an end of life solution to one which is fully supported and capable of underpinning service change e.g. single call centre	MD	G	G										Q4
Support Eye Care Transformation	MD	G	G										Q4

RAG	Every Month End
Red	Off track, serious risk of, or will not be achieved
Amber	Achievement as forecast; work has commenced; some risks being actively managed
Green	On track for achievement, no real concerns
Purple	Achieved

Three Year Outlook and 2019./20 Annual Plan

Monitoring of progress against Actions for Year One (2019/20)

May 2019

Appendix A: Further Information

The Annual Plan is included on page 423 of the March 2019 Health Board papers.

The link to these papers is shown below:

http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Health%20Board%2028.3.19%20%20V2.0%20updated%2022.3.19-min.pdf

Quality, Safety & Experience (QSE) Committee

16.7.19

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

To improve health and provide excellent care

Report Title:	Quality & Safety in Primary Care
Report Author:	Mrs Clare Darlington, Assistant Director Primary Care (Central Area)
Responsible Director:	Dr Chris Stockport Executive Director Primary Care & Community Services
Public or In Committee	Public
Purpose of Report:	To provide a regular update, as directed by the QSE Committee, with specific detail and information as requested, including trend and themed reports in relation to concerns, incidents, contract breaches, patient stories and lessons learnt, as well as quality improvement initiatives. Feedback from the Committee is requested in order to develop the report further and best meet their requirements.
Approval / Scrutiny Route Prior to Presentation:	The development of the report has been progressed as a result of discussions at the North Wales Primary Care Quality & Safety (Q&S) Group, as well as Q&S meetings at an Area level. All such reports will be considered at the North Wales Primary Care Q&S and Area Q&S groups, that immediately follow the quarter for which information has been collated.
Governance issues / risks:	The Health Board is responsible for the commissioning and provision of primary care services in North Wales. The level and range of services required by the population as a whole is significant, with demand increasing, and the Health Board must ensure the provision best meets the needs of all residents, is safe and of an agreed quality.
Financial Implications:	There are no financial implications associated with this report.

Recommendation:	It is recommended that the QSE Committee: 1. Confirms the core indicators meet the requirements of the Committee 2. Notes the actions taken in terms of the core indicators 3. Notes the progress in relation to the health & safety of GP practices 4. Considers any 'focus on' topics that the Committee would find useful 5. Notes the example provided in relation to quality improvement

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Evidence of strengthened resilience and sustainability in primary care services

Equality Impact Assessment

As this is a retrospective report, with an overview of data and information in relation to services already being provided, an EqIA is not considered necessary. Equality is, however, an integral part of the Quality Improvement agenda and as such individual EqIA assessments will be required when undertaking an associated initiatives.

1. Purpose of report

In March 2019 the QSE Committee received a paper providing an overview of the arrangements in place in relation to the quality and safety of primary care services. It was noted in the paper that future reports would be developed under the direction of the QSE Committee to provide more specific detail and information as requested, including trend and themed reports in relation to concerns, incidents, contract breaches, patient stories and lessons learnt, as well as quality improvement initiatives.

The following paper provides a further report from the Assistant Directors for Primary Care and Dental Services, suggesting the key quality & safety indicators and related detail. Feedback from the Committee is requested in order to develop the report further and best meet their requirements.

2. Introduction

As commissioners and providers of primary care, the Health Board must ensure that these services are safe, whilst continually striving for quality improvement.

The three Area teams are responsible for primary care services. The Assistant Area Directors for Primary Care, Assistant Director Dental Services and Assistant Directors of Pharmacy & Medicines Management, work with the Assistant Director Primary Care Contracting, to provide and commission services, and coordinate the processes in order to address their quality and safety.

In line with the request of the QSE Committee, the following paper provides:

- Core Indicators and related data for 2018/19 and April-June 2019/20
- A 'Focus On' highlighted topic area
- An example of quality improvement achieved

3. Core Indicators

The following core indicators will be updated and detailed in each report presented to the Committee, and form the basis of the Primary Care Q&S Report.

3.1 Incidents

GP Practices are encouraged to regularly report incidents that are then reviewed, including liaising with other health board services where relevant; lessons learnt are then shared on a regular basis with all practices. They are able to use a paper based form and submit the detail to the Primary Care Clinical Governance teams, however the direct use of the online Datix platform is the preferred method.

Community pharmacies and dental practices do not currently have access to the Datix system and as such they are encouraged to report via the paper based process.

In 2018/19 1069 incidents were recorded by primary care providers. The table below provides an overview of the top two classifications of incidents reported in 2018/19.

Classification	Number	Main Subheadings	Number
Access, Appointment, Admission, Transfer, Discharge	412	• Notifications of temporary pharmacy closures. • Ambulance delays • Related to temporary resident patients	320 21 16
Medication	259	• Preparation of medicines / dispensing in pharmacy • Medication error during the prescription process	108 71

Between April-June 2019, 236 incidents were recorded by primary care providers.

The table below provides an overview of the main classifications.

Classification	Number	Main Subheadings	Number
Access, Appointment, Admission, Transfer, Discharge	80	• Notifications of temporary pharmacy closures. • Ambulance delays	73 4
Medication	64	• Preparation of medicines / dispensing in pharmacy • Medication error during the prescription process	29 15

In response to the incidents reported various actions have been taken, for example:

- Regular contact is made with the multiple community pharmacies in relation to temporary closures, to understand why there have been gaps in service and actions taken place to ensure future provision.
- All medication errors are investigated and any lessons learnt shared with other practices to reduce the likelihood of future errors.
- Specific ambulance delays are shared with the Welsh Ambulance Services Trust (WAST) for investigation, with comments recorded on the Datix system. Good communication links have been made with WAST colleagues in relation to incidents.

3.2 Concerns

Independent contractors across all primary care services are required to provide information to their patients on how to make a complaint. Complaints are dealt with directly by contractors in most circumstances.

Contractors are encouraged to inform the Health Board of concerns as they receive them and are able to seek advice from the primary care clinical governance teams. However, they are not obliged to inform the Health Board or provide a copy of a complaint response for every concern received.

Contractors are requested to complete an annual return detailing the number of concerns that they have received in the previous 12 months.

In addition, the Health Board does receive concerns relating to primary care services directly from patients, and the table below provides an overview of the numbers received. These include all concerns relating to managed practices which are known in total due to these practices being part of the health board structure.

Total number of complaints reported directly to the Health Board (2017/18 and 2018/19)

Contractor	Number of 'On the Spot' (OTS) 2017/2018	Number of 'On the Spot' 2018/2019	Number of Formal Concerns 2017/2018	Number of Formal Concerns 2018/2019	AM/MP Enquiry 2017/18	AM/MP Enquiry 2018/19
GP Practices	385	446	162	160	37	16
General Dental Practices	51	58	15	19	6	1
Community Pharmacies	4	16	3	4	1	0
Optician	3	3	0	0	0	0

The main areas of concern in 2018/19 related to consent, confidentiality and communication (237) and access, appointments, admission, transfer and discharges (212).

The increase in the number of OTS concerns between 2017/18 and 2018/19 is, in the main, due to the number of managed practices increasing, with OTS concerns consequently being reported through BCUHB systems.

The severity of the complaints received in 2018/19 are summarised in the table below:

Grade	Number
No Grade (Typically OTS)	537
Grade 1	1
Grade 2	119
Grade 3	50
Grade 4	12
Grade 5	4

The total number of complaints reported directly to the Health Board in Quarter 1 (April- June 2019/20) are outlined in the table below:

Contractor	Number of OTS Q1(2019/20)	Number of Formal Q1 (2019/20)	AM/MP Enquiry Q1 (2019/20)
GP Practices	107	50	2
General Dental Practices	8	3	1
Community Pharmacies	1	1	0
Optician	0	0	0

The main areas of concern in Quarter 1 related to consent, confidentiality and communication (48), often in relation to obtaining results or miscommunication with practice, and access, appointments, admission, transfer and discharges (48), mainly OTS complaints in relation to access to an appointment.

3.3 Contract Breaches

The majority of primary care services are provided by independent contractors and are commissioned under nationally negotiated contracts which meet the requirements of the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004, and the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006.

Where primary care providers do not comply with the requirements of the contracts remedial and/or breach notices can be issued by the Health Board. This only applies to GP practices and General Dental Services (GDS).

The number issued in 2017/18 and 2018/19 are detailed below:

Contractor	Number of Remedial Notices 2017/2018	Number of Remedial Notices 2018/2019	Number of Breaches 2017/2018	Number of Breaches 2018/2019
GP Practices	0	6	0	0
General Dental Practices	11	2	36	38

GP Practices

Of the 6 remedial notices issued in 2018/19, 3 related to failure to deal appropriately with temporary residents (2 to the same practice). Two notices were served due to failure to provide appropriate services within core hours and the final one related to inappropriate removal of patients from the practice list.

General Dental Services

A total of 38 contract breach notices were issued during 2018/19 relating to shortfall in the delivery of contracted activity during the year ending March 2018.

Two remedial notices were issued during the year, one for the re-establishment of routine dental services at a practice that had staffing issues, and one for the

provision of information requested by the Health Board in relation to management of the contract

The number of remedial notices and breaches issued in Quarter 1 2019/20 are detailed below:

Contractor	**Number of Remedial Notices Q1(2019/20)**	**Number of Breaches Q1(2019/20)**
GP Practices	0	0
General Dental Practices	1	0

For GDS, one remedial notice was issued to a contractor in West Area requiring reasonable estimates of the Net Pensionable Earnings of the associates at the practice to be provided to the Health Board in accordance with the Statement of Financial Entitlements (SFE).

No breach notices were issued during the first quarter. However, initial indications are that 33 GDS contractors have under delivered on their contracted activity during 2018/19 by more than 5%. These numbers will be confirmed in July at which time breach notices will be issued.

3.4 Performance Issues

There are strict regulations regarding the ability of an individual to practice as a GP or General Dental Practitioner. Performers are required to be on the Medical or Dental Performers' list as well as registered with the General Medical Council (GMC) or General Dental Council.

Concerns can be raised regarding the performance of an individual by anyone and in a number of ways – such as direct to the clinician themselves, to their Practice, to the Health Board or to their regulatory body. Where concerns raised about a practitioner are such that the Health Board is satisfied that it is necessary to do so for the protection of members of the public or is otherwise in the public interest, it may suspend a performer from the performers list in accordance with the provisions of the regulations.

As at 24th June 2019 the number of suspensions and GMC concerns notified to the Health Board were as follows:

Area	**Suspensions**		**GMC concerns**	**GDC concerns**	**Conditions**	
	GPs	Dentists	GPs	Dentists	GPs	Dentists
East	2	0	1	2	0	0
West	0	1	2	2	0	3
Central	0	0	2	0	0	1
Total	**2**	**1**	**5**	**4**	**0**	**4**

3.5 Quality Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced as part of the new GMS contract in 2004 and rewards practices for the provision of 'quality care' as well as helping to standardise improvements in the delivery of clinical care. Practice participation in QOF is voluntary, but most practices with General Medical Services (GMS) contracts do take part.

Over the past 2 years the majority of the QOF indicators have been made ‘inactive’ and performance/points from previous years rolled over. The only indicators active in 2018/19 were in relation to maintenance of disease registers, cluster working and Flu immunisation.

Summary of performance across North Wales practices in 2018/19 compared with 2017/18 is detailed below:

QOF	2017/18	2018/19
Total points available Average points achieved No of practices receiving total points	567 553 27	567 551 25
Cluster points available Average points achieved No of practices receiving total points	200.0 199.7 105	200 Information not currently available
Flu immunisation points available Average points achieved No of practices receiving total points	20.00 19.34 91	20 Information not currently available

3.6 Quality Assurance Visiting Programme

A Quality Assurance Visiting Programme (QAVP) is in place across GP Practices, Dental Practices and Community Pharmacies which serves to seek assurances that providers have adequate clinical governance frameworks in place. QAVP visits are also aimed at ensuring contractors and the Health Board have the opportunity to discuss and understand factors relevant to the delivery of a quality service in a safe clinical environment.

The focus in 2019/20 is that all GP practices have a QA visit in 2019/20. Should a practice be deemed to benefit from greater assistance, a further visit from a wider multi disciplinary team will be arranged.

Before commencing the QA visits, the process is being reviewed to ensure that any issues arising from HIW inspections, practice closures, and performance issues are included.

Quality Assurance visits to all General Dental Practices (91) were completed in August 2017 and the focus in 2018/19 was on the community pharmacy visiting programme.

Contractor	Number of Visits Q1 2019/20	Number of Visits 2018/19
GP Practices	0	0
General Dental Practices	0	0
Community Pharmacies	0	84 (20 West, 28 Centre, 36 East)

The focus in 2018/2019 was on community pharmacy visits and the resulting main actions are detailed below:

Action	Number of branches requiring action
Aware of BCUHB Safeguarding procedures and contact details	43
Putting Things Right (PTR) poster/leaflet	35
Pharmacy leaflet available	30
Twice daily fridge readings	27
Complaints system meets requirement of PTR	24

3.7 Health Inspectorate Wales (HIW) & General Pharmaceutical Council Visits (GPC)

HIW and the GPC liaise directly with independent contractors to undertake their inspections.

Some GP practices notify the LHB of the pending visit and seek support. HIW may also inform the Health Board directly at which time support to the practice will be offered. HIW publish the reports on their website.

GPC inspections that have taken place from April 2019 will be published on the regulators website from the summer of 2019.

The number of visits that have been undertaken are detailed below:

Contractor	Number of Visits 2018/19	Number of Visits Q1 2019/20
GP Practices	5	0
General Dental Practices	8	0

Details of GP Practices visits and report dates

The Stables Medical Centre, Flintshire	03/07/18	04/10/18
Overton Medical Practice	09/08/18	12/11/18
Clarence Medical Centre, Rhyl	31/08/18	03/12/18

Kinmel Bay Medical Centre	25/09/18	27/12/18
Porthmadog Health Centre	09/10/18	10/01/19

Details of Dental Practices visits and report dates

My Dentist, Rhyl	03/04/18	04/07/18
Ruthin Dental Practice	23/04/18	24/07/18
Springfield Dental Care, Wrexham	19/06/18	20/09/18
White Arcade Dental Practice	03/07/18	04/10/18
My Dentist, Queensferry	10/07/18	11/10/18
Deeside Medical Surgery	07/08/18	08/11/18
Bod Heulog Dental Care, Denbigh	23/10/18	24/01/19
Dentyddfa Deudraeth	10/01/19	11/04/19

3.8 Prescribing Indicators

Antimicrobial stewardship

Since 2014/15 there has been a steady decline in prescribing of antibiotic items per 1000 STAR-PU across primary care in North Wales. There have been reductions of prescribing in all 14 clusters, giving an overall reduction in total antibiotic usage of 14.1%. There remains a focus on the 10% of practices with the highest antibiotic prescribing rates to improve further.

Appendix 1 provides a diagrammatic representation with BCUHB performance in bold and ranked 3rd best in Wales.

Efficiency indicator – Proton pump indicator

Since 2014/15 there has been a significant reduction of prescribing of Proton Pump Inhibitors (PPI) Divided Daily Doses (DDD) per 1000 PU, with continued steady progress across North Wales . There have been reductions of prescribing in all 14 clusters, giving an overall reduction in total PPI usage of 8.15%. This has been supported by a combined strategy involving primary and secondary care pharmacy teams. Where PPIs have been initiated during an inpatient stay, the pharmacists ensure there is a clear management plan, or the medication is stopped prior to discharge. BCUHB has moved from being the worst, to being ranked 3rd best in Wales, which is detailed in the diagrammatic representation at Appendix 1.

Falls prevention

Pharmacy and Medicines Management is a member of the strategic falls group. The diagram in Appendix 1 demonstrates the continued steady progress across North Wales to reduce the use of hypnotics and anxiolytics, which are known to significantly increase the risk of falls. There have been reductions of prescribing in all 14 cluster areas, giving an overall reduction in total usage of 8.56%. We continue to focus plans on the 10% of practices with the highest prescribing rates to improve further, particularly in Gwynedd, Denbighshire and Wrexham. BCUHB is in bold and ranked 5th best in Wales.

The Primary Care Pharmacy and Medicines Management teams in each area work in collaboration with the Prescribed Medication Support Service referring patients to the service for review and ongoing support.

In addition, Pharmacist Independent Prescribers while reviewing patients during their medication clinics and will discuss hypnotics and anxiolytics as necessary and initiate a reduction where appropriate and possible.

3.9 General Dental Services

Quality indicators for GDS are extracted from the Dental Assurance Framework (DAF) report provide by NHS Business Services Authority (NHSBSA).

Quality indicators for individual contractors are monitored by the Dental Contracting Team. They are used at an operational level to identify and address quality issues in delivery of services.

There are currently no Welsh Government (WG) targets for the indicators with the exception of a 50% target for fluoride varnish for those contracts involved in the Contract Reform Programme

The DAF report is provided quarterly and is received during the month following the quarter end. Consequently, quality indicators for Q1 are not yet available.

Quality indicators for the last quarter of 2018/19 are set out below:

	Q4 2018/19	
Quality Indicators	**LHB**	**Wales**
Radiographs Rate per 100 FP17s *	22.6	20.8
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	43.6	42.9
Extractions Rate per 100 FP17s	5.9	6.0
Re-attending within 3 months - Child	5.6	6.0
Re-attending within 3 months - Adults	12.5	12.9
% satisfied with dentistry received	92.7	92.4
% satisfied with wait for an appointment	87.0	87.2

-* each FP17 represents a claim made by the contractor for a single course of treatment and records all the work delivered within that course of treatment. Hence 22.6 radiograph rates per 100 FP17s means that on average 22.6% of courses of treatment provided included the contractor taking one or more radiographs.

GDS quality indicators for most metrics reported are close to or better than the All Wales average during the fourth quarter of 2018/19. The exception to this is Patient satisfaction with wait for an appointment which is slightly worse and reflects the patient access issues currently being experienced, particularly in the West Area

4. Focus On: Health & Safety

The focus for this report is health and safety (H&S) in GP practices. It provides the latest position regarding the health and safety arrangements that are in place and that any measures identified following H&S Review visits are being effectively managed across the function.

The Management of Health and Safety at Work Regulations 1999 place a requirement on the Health Board to put in place arrangements to control health and safety risks.

As a minimum the following processes and procedures are required to meet the legal requirements:

a) A written health and safety policy
b) Assessments of risks to employees, patients, visitors, contractors, partners and any other people who could be affected by Health Board and/or Practice activities – and record the significant findings in writing. Any risk assessment should be suitable and sufficient
c) Arrangements for effective planning, organisation, control, monitoring and review of preventative and protective measures that come from risk assessment
d) Access to competent health and safety advice
e) Providing employees with information about the risks in the workplace and how they are protected
f) Instruction and training for employees in how to deal with the risks
g) Ensuring there is adequate and appropriate supervision in place
h) Consulting with employees about their risks at work and current preventative and protective measures

The legislation is enforced by the Health and Safety Executive (HSE) who have far reaching powers which include:

a) Access to work premises at any reasonable hour
b) Freedom to interview staff, visitors, contractors or patients
c) Confiscation of equipment and applicable documents
d) Take statements, photographs, measurements and samples
e) Issue notices (Improvement and Prohibition) requiring respectively improvements within a certain timeframe or stopping work until improvements are made also within a timeframe
f) Initiating criminal court proceedings for alleged breaches of Health and Safety

This report provides analysis of health and safety performance across Primary Care for the period 1st April 2018 to 31st March 2019.

The aim is to promote a continuing positive culture and to encourage ownership at every level and is reflected in the way that H&S in reviewed throughout Primary Care regardless of whether the Practice is managed or not. Through strong, visible and consistent leadership delivered in a timely, efficient, effective and affordable manner we ensure the Health Board Managed Practices and its Contracted Practices are supported to ensure it meets its legislative obligation to safeguard the health, safety and welfare of staff, patients and visitors.

It also enables every Practice to meet, and where possible, exceed, the statutory obligations placed upon it to safeguard everyone who might otherwise be affected by its actions and/or omissions.

Each Area has in place regular Quality and Safety meetings of which H&S forms an integral part of each agenda and is attended by the H&S Advisor for Primary Care. This forum is utilised to highlight, debate and escalate any identified H&S matter. During the reporting period the H&S advisor has attended the following Q&S meetings: East: 4, West: 3, Central 7.

The Corporate Health and Safety Team provide advice on all aspects of health and safety. Direct support is provided by the Primary Care H&S Advisor, the BCUHB's H&S team along with guidance and advice from the Clinical Governance teams.

Training

The following training was delivered in 2017/18 and 2018/19:

1 day Managing Safely for Practice Managers (and/or nominated deputies)					
	East	**West**	**Central**	**No of sessions**	**Number of attendees**
2017 - 2018	**2**	**3**	**2**	**7**	**78**
2018 - 2019	**2**	**1**	**2**	**5**	**39**
Total	**4**	**4**	**4**	**12**	**117**

The 1-day Managing Safely course is a bespoke certificated presentation specifically focused on the H&S subjects where Practices are required to demonstrate good management and control. These are held within specific venues that have large meeting room facilities with invites sent out to Practices within that Area catchment. The course includes a section on risk assessments including COSHH (Control of Substances Hazardous to Health) and is delivered in a relaxed and open environment.

To date approximately 71% of all Practices have had at least one member attend one of these courses with the highest attendee's coming from Ynys Mon and Gwynedd and the lowest from Flintshire and Wrexham.

Going forward ----

One further course will be arranged in each Area during 2019/20 to enable the small number of remaining managers, together with additional staff requests, to attend. It is envisaged that there will follow an on-going programme of half day refreshers programmed pan BCU areas.

Health & Safety Awareness for all Primary Care staff					
2018 - 2019	**East**	**West**	**Central**	**No of sessions**	**Number of attendees**
Total	**4**	**4**	**3**	**11**	**142**

This H&S Awareness presentation consists of a 45-minute face-to-face explanation of the roles and responsibilities under the current legislation of not just management requirements but also responsibilities of all employees, and is an ideal forum to provide open discussion on a variety of H&S subjects. This new presentation was introduced just this year and has been very well received by attendees from doctors to clerical and admin staff. On request, the presentation can include a section on Fire, including raising the alarm, the correct use of fire doors and a verbal demonstration of extinguishing media and operation.

Going forward ----

Further presentations have been booked in and will be offered throughout 2019/20.

In addition to the above training, the advisor provides and delivers one to one training and support to Practice Managers where challenges exist and statutory requirements have not been fully met.

Performance Monitoring

The Health and Safety Advisor, on behalf of Primary Care, continues to monitor performance by means of the following:

a) Periodic Health and Safety Review – conducted by the Corporate Health and Safety Advisor for Primary Care (GP's)
b) Review of DATIX Incident Reports
c) Shared learning from serious incident reviews

Health and Safety Review Visits

Health and Safety review visits are undertaken by the Corporate Health and Safety Adviser for Primary Care. Currently these have been carried out on an on-going basis and have this year included a number of Branch practices. Following each

review the Practice Manager (PM) is sent a copy of the review report together with an action plan identifying any issues, together with suggested actions.

	East	West	Central	Total
April 17 – March 18				
Reviews completed	**39**	**31**	**29**	**99**
April 18 – March 19				
Reviews completed	**30**	**28**	**29**	**87**

Going forward ----
In line with the Corporate H&S team, changes have been made to the review process. From 1st April, the review documentation will enable the review to become more streamlined, evidenced, as well as user friendly for the Practices. Prior to the review being carried out a 'review guidance document' will be sent to the PM, which clearly identifies what evidence will be need to be provided for the review. This new process will enable Practices, Primary Care and BCU to clearly evidence statutory requirements as well as demonstrate the level of management within each Practice. Primary Care will also be influenced positively by the latest BCUHB Corporate H&S 3 year plan that has recently been ratified.

Practice risk priorities

As in the previous year, following each Practice review a 'RAG' risk score assessment is recorded to identify the perceived level of assurance demonstrated at the time of the visit. The purpose of this assessment is to identify which Practices require a higher, more reactive, level of support during the following year and those that do not. The scoring is based on both the managerial attitude towards compliance; the actual physical evidence provided at the time of the review, or a combination of both, and is purely based on the advisors own view following their visit.

	Red	Amber	Green	Total
April 17 – March 18	**27**	**42**	**30**	**99**
April 18 – March 19	**9**	**36**	**42**	**87**

Red risk: These identified Practices will again require a specific focused re-visit / review with anticipated additional support to improve H&S compliance. A small number of these Practices still have such poor compliance and attitude to basic legislative H&S requirements that they could be at risk from HSE or Fire enforcement should a significant incident occur or if inspected / audited.

Yellow risk:: These Practices demonstrated an acceptable level of compliance and attitude and a high proportion purely need assistance with documentation and monitoring procedures.

Green risk: These Practices demonstrated a very high standard of both documented and procedural compliance and may be considered as requiring an extended period of time before their next review.

The above table clearly identifies the way that H&S is being enthusiastically addressed and adopted by some Practices within Primary Care and indicates the substantial improvements made by PMs across North Wales, especially in the number of Practices who were previously rated as red now reducing, by 18, to at least an amber. A number of practices, demonstrating such a change to compliance and management that their risk priority changed from red to green and this achievement should be acknowledged.

However, there remains a small number of Practices where concerns are still evident who will be supported in 2019/20 to improve their performance.

Subject risk priorities (based on current reviews)

In the previous annual report, a list of the questions that had the highest number of actions required were recorded and are listed below. This year (18/19) this database has been utilised again and will be used to identify any trends and weaknesses in relation to the various subject requirements.

As with the previous years report it is felt that any subject that was identified as requiring action in more than 50% of the Practices would form the main subject risk priorities for 2019/20.

	Subject risk priorities 18/19 (based on review)
Question	
16	Has the Practice Manager attended the 1 day Managing Safely course?
19	Are risk assessments reviewed on a regular basis?
32	Has a First Aid risk assessment been carried out?
36	Has a General (Environmental) risk assessment been carried out?
48	Have all COSHH products been identified?
49	Are all COSHH risk assessments & SDS's in place and reviewed?
56	Are oxygen and gas risk assessments in place?
59	Are safety devices used throughout or risk assessed if not?
62	Are Violence, Aggression & Security risk assessments in place?
67	Have DSE assessments been completed for identified 'main users'?

	Subject risk priorities 19/20 (based on review)
Question	
32	Has a First Aid risk assessment been carried out?
36	Has a General (Environmental) risk assessment been carried out?

Going forward ----

It is clear that the majority of the risk priorities listed in the previous year are being, or have been, addressed by a larger number of Practices and further identifies that the health and safety measures are being introduced and understood.

With the number of subjects reducing to such an extent provides us with the opportunity to identify additional subjects that need to be highlighted, assessed and supported within all practices. Our expectation is to focus on:

- Workplace Stress (all staff)
- Violence & Aggression (with on-site guidance and training on de-escalation)
- Security

RIDDOR Incident Reports

There are no RIDDOR's that have been reported to the H&S team during 2018/19

Health & Safety Executive (HSE)

The HSE do not routinely and have not visited GP Practices that the H&S team are aware of. They will generally only visit if they deem it necessary following a complaint from the general public/staff or a RIDDOR Reportable Incident. Any visit where a Practice is seen to be at fault or improvement needed is charged by the HSE at an hourly rate to cover their costs.

Health and Safety Alerts

There have been two Health and Safety Alerts issued to Primary Care for the reporting period 2018/2019**.**

Looking Forward - 2019/2020

Summary of objectives:-

a. Introduce the revised streamlined evidence based review process.
b. Formulate a 3 year review programme, based on previous RAG ratings.
c. Continue to assess that a General (Environmental) risk assessment is in place for every Practice.
d. Support Practices in completing suitable & sufficient specific risk assessments including COSHH.
e. Arrange one additional 1 day Managing Safely course for Practice Managers for each area.
f. Provide specific additional training to Practices when requested.
g. Provide or introduce guidance and support in relation to Stress in the workplace.
h. Support Practices to raise the profile of violence and agression concerns, including security.
i. Offer support visits to other primary care contractors and develop a visiting programme

This annual report provides Primary Care with an overview of the current status in regards to Health and Safety management within the BCUHB locality for both GMS and Managed Practices.

The report summarises the significant actions taken within the last 12 months to improve Health and Safety management, leadership & ownership. Every Practice visited will have a greater understanding of their objectives in compliance with the law, the benefits of strong H&S management requirements and culture which ultimately safeguards the health, safety and welfare of staff, patients and visitors.

5. Example of Quality Improvement

'The Sore Throat Test and Treat Service' is a successful project trialled in BCUHB over winter 2018/19.

In November 2018, a pilot service was launched in a number of areas in BCUHB and Cwm Taf Morgannwg UHB. This service provides assessment, advice and treatment for people over 6 years of age with a sore throat and included 33 pharmacies in BCU. The service involves a community pharmacist screening assessment using FeverPAIN or Centor score to assess likelihood of a bacterial (streptococcal) cause for the sore throat symptoms:

- FeverPAIN score of 0 or 1 / Centor score 0-2: Advice with/without simple analgesia
- FeverPAIN score of 2 or 3: Point of care test (RAT)
- FeverPAIN score of 4 or 5 / Centor score 3 or 4: Point of care test (RAT)

Where indicated, the pharmacist would then swab the patient's throat and undertake a rapid antigen test. Where negative, the patient is offered advice with/without simple analgesia. Where positive, the following antibiotics can be provided under a Patient Group Direction (PGD) (in addition to advice with/without simple analgesia):

1. Phenoxymethylpenicillin 500mg every six hours (dose reduced in children) for 10 days
2. Clarithromycin 500 mg twice daily (dose reduced in children) for 5 days– where phenoxymethylpenicillin is contraindicated
3. Erythromycin 500mg every six hours for 5 days – for pregnant women where phenoxymethylpenicillin is contraindicated

Any patients with symptoms indicating a serious illness, are at high risk of complications, or are systemically unwell are referred to GP, Out of Hours (OOH), or Emergency Department (ED) as appropriate.

Since the service was launched in North Wales, 1058 episodes of care have been logged on 'choose pharmacy', for patients ranging in age from 6 years old to 92 years old. Of the patients seen, 572 were given advice only, 12% were supplied with penicillin and a further 2% supplied with a macrolide antibiotic.

Treatment Given	Number of patients	Proportion of patients
Advice only	572	54%
Ibuprofen	468	44%
Paracetamol	97	9%
Clarithromycin	16	2%
Erythromycin	2	0.2%
Phenoxymethylpenicillin	122	12%

In addition, one pharmacist correctly identified a patient with epiglottitis and a potentially serious condition and was urgently referred to hospital.

6. Conclusion

The paper provides assurance to the Committee regarding the management of quality & safety in primary care, as well as monitoring core indicators in order that themes and resulting action is also outlined.

This paper provides a suggested format for future Primary Care reports for the Committee, and includes quality & safety indicators, a ‘focus on’ topic that provides detailed information on a specified topic, and an example of an area of quality improvement, which will also be refreshed for future papers.

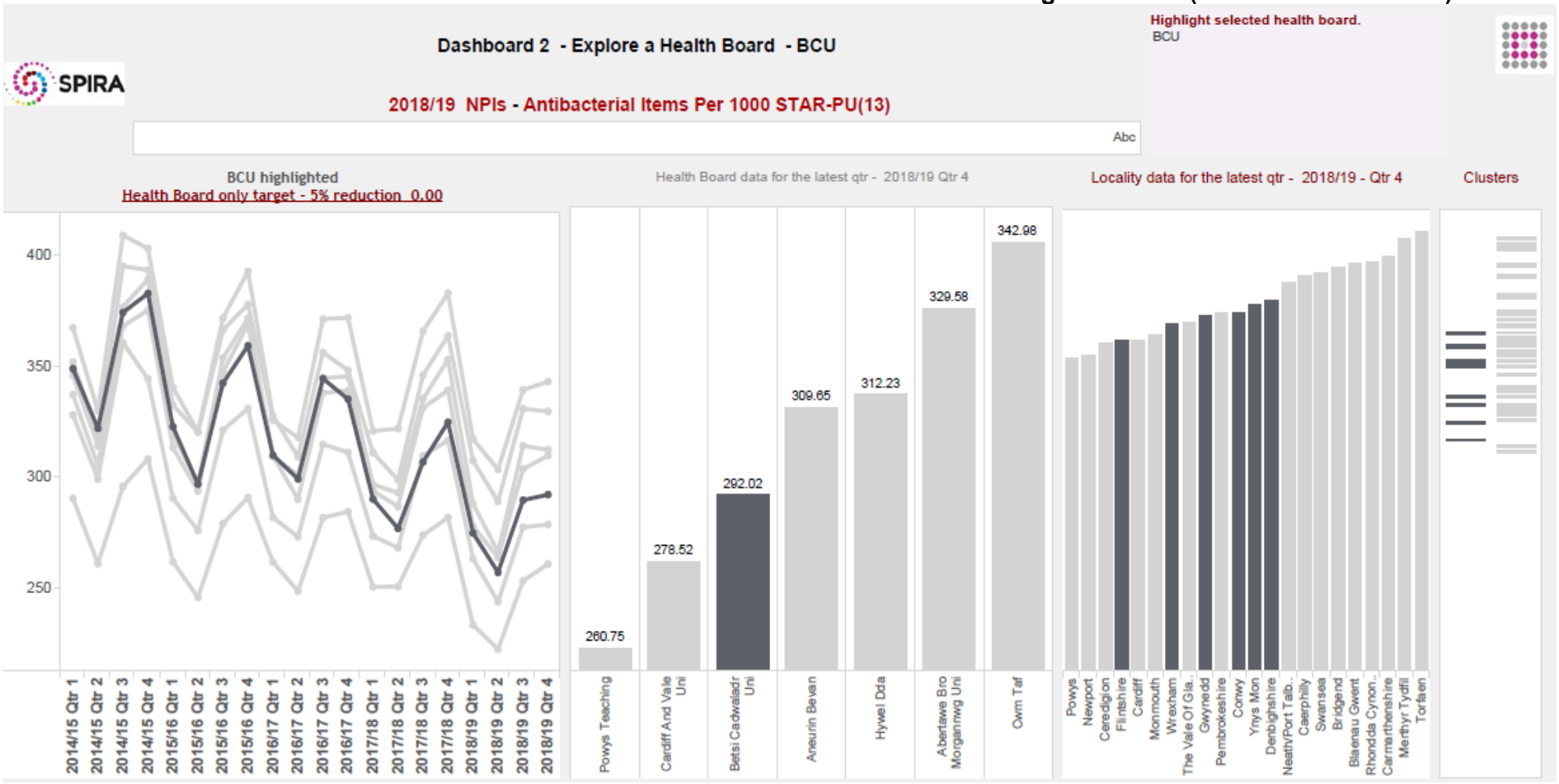
Feedback from the Committee is requested in order to develop the report further and best meet their requirements.

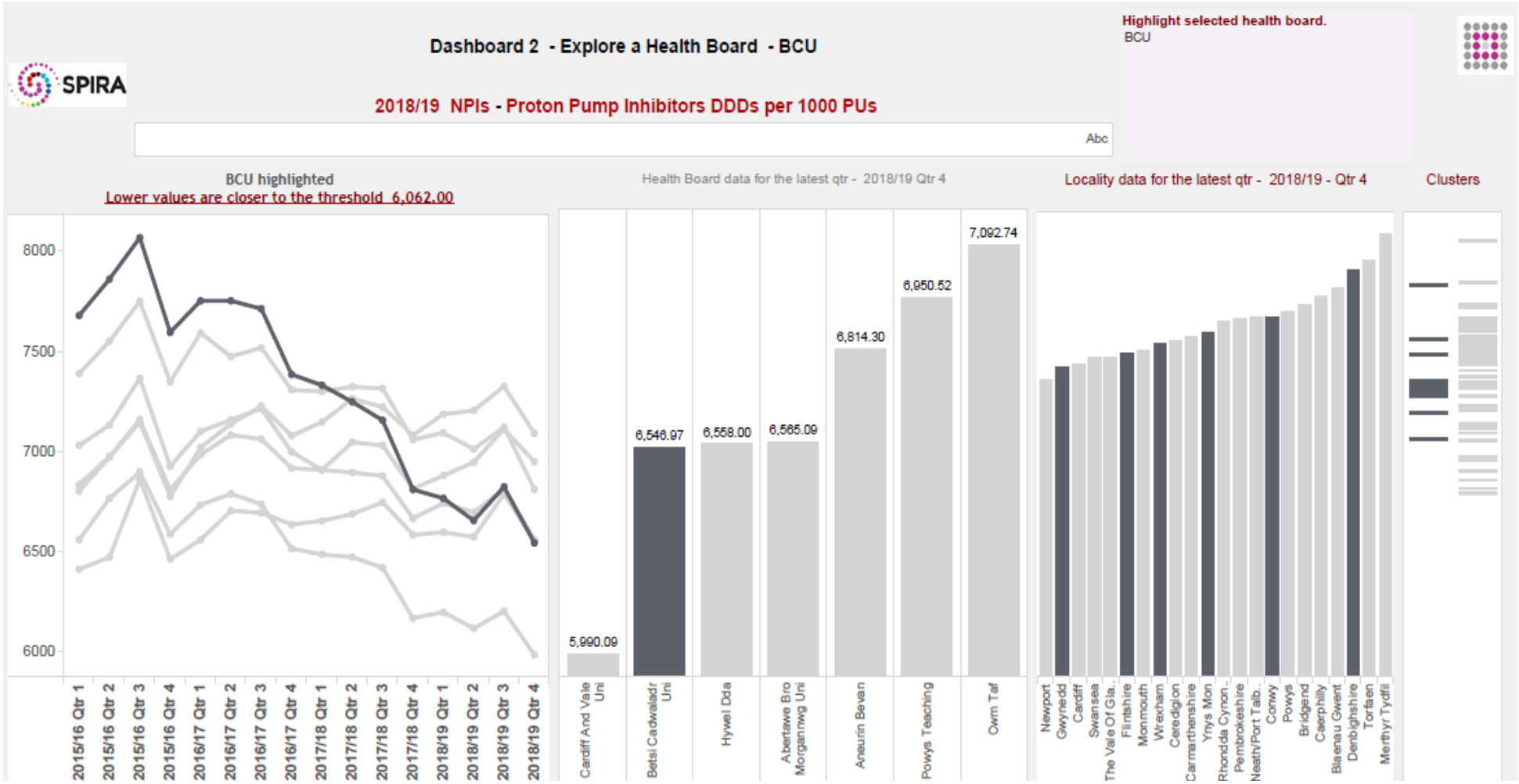
7. Recommendations

It is recommended that the QSE Committee:

1. Confirms the core indicators meet the requirements of the Committee
2. Notes the actions taken in terms of the core indicators
3. Notes the progress in relation to the health & safety of GP practices
4. Considers any ‘focus on’ topics that the Committee would find useful
5. Notes the example provided in relation to quality improvement

APPENDIX 1
Prescribing Indicators (BCUHB trend in bold)

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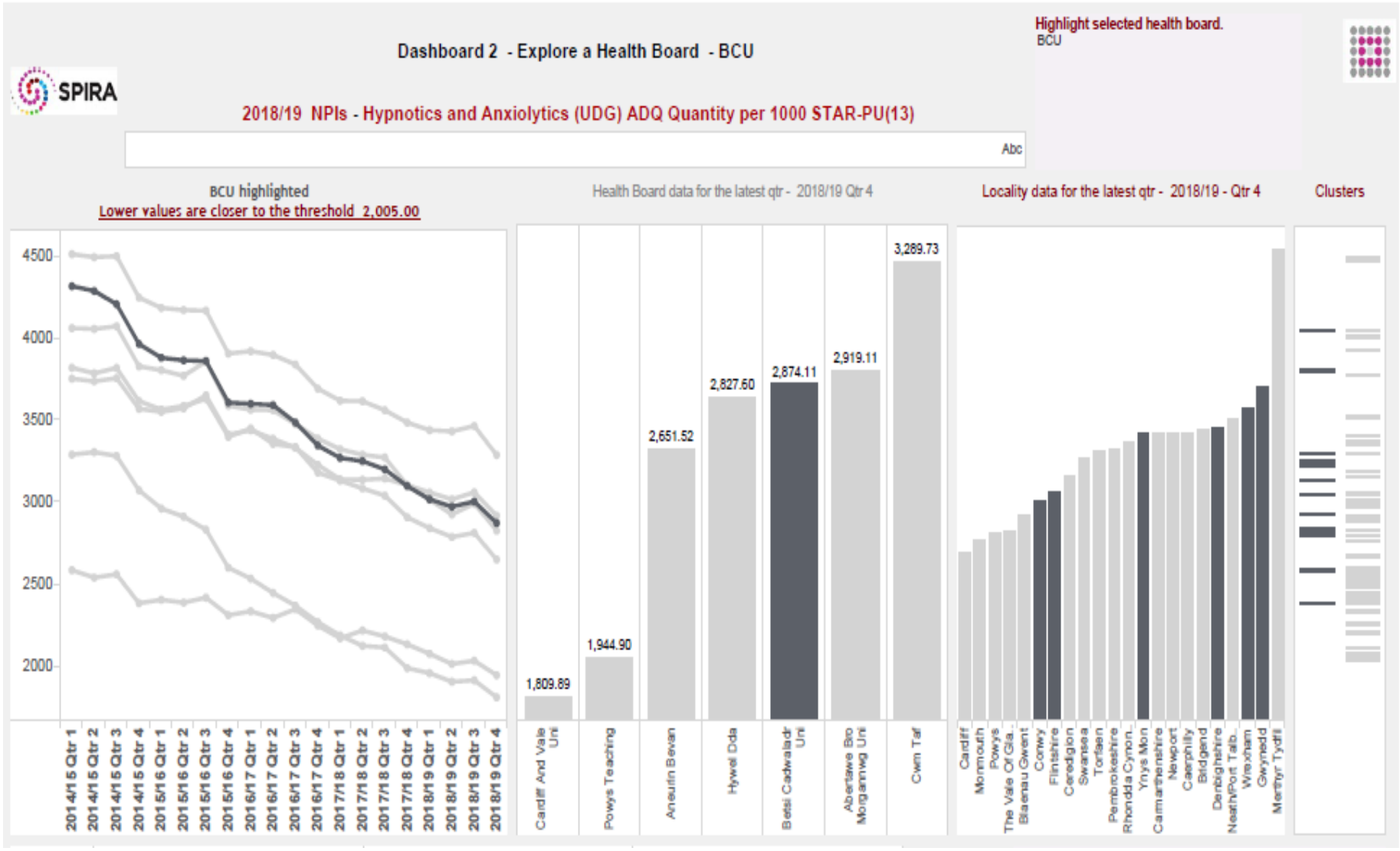
SPIRA
2018/19 NPIs - Proton Pump Inhibitors DDDs per 1000 PUs
Highlight selected health board.
BCU
Abc
BCU highlighted
Lower values are closer to the threshold 6,062.00
Health Board data for the latest qtr - 2018/19 Qtr 4
Locality data for the latest qtr - 2018/19 - Qtr 4
Clusters
8000
7500
7000
6500
6000
5,990.09
6,546.97
6,558.00
6,565.09
6,814.30
6,950.52
7,092.74
2015/16 Qtr 1
2015/16 Qtr 2
2015/16 Qtr 3
2015/16 Qtr 4
2016/17 Qtr 1
2016/17 Qtr 2
2016/17 Qtr 3
2016/17 Qtr 4
2017/18 Qtr 1
2017/18 Qtr 2
2017/18 Qtr 3
2017/18 Qtr 4
2018/19 Qtr 1
2018/19 Qtr 2
2018/19 Qtr 3
2018/19 Qtr 4
Cardiff And Vale Uni
Betsi Cadwaladr Uni
Hywel Dda
Abertawe Bro Morgannwg Uni
Aneurin Bevan
Powys Teaching
Cwm Taf
Newport
Gwynedd
Cardiff
Swansea
The Vale Of Gla..
Flintshire
Monmouth
Wrexham
Ceredigion
Carmarthenshire
Ynys Mon
Rhondda Cynon..
Pembrokeshire
Neath/Port Talb..
Conwy
Powys
Bridgend
Caerphilly
Blaenau Gwent
Denbighshire
Torfaen
Merthyr Tydfil


Highlight selected health board.
BCU
Dashboard 2 - Explore a Health Board - BCU
SPIRA
2018/19 NPIs - Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13)
Abc
BCU highlighted
Lower values are closer to the threshold 2,005.00
Health Board data for the latest qtr - 2018/19 Qtr 4
Locality data for the latest qtr - 2018/19 - Qtr 4
Clusters
4500
4000
3500
3000
2500
2000
1,809.89
1,944.90
2,651.52
2,827.60
2,874.11
2,919.11
3,289.73
2014/15 Qtr 1
2014/15 Qtr 2
2014/15 Qtr 3
2014/15 Qtr 4
2015/16 Qtr 1
2015/16 Qtr 2
2015/16 Qtr 3
2015/16 Qtr 4
2016/17 Qtr 1
2016/17 Qtr 2
2016/17 Qtr 3
2016/17 Qtr 4
2017/18 Qtr 1
2017/18 Qtr 2
2017/18 Qtr 3
2017/18 Qtr 4
2018/19 Qtr 1
2018/19 Qtr 2
2018/19 Qtr 3
2018/19 Qtr 4
Cardiff And Vale Uni
Powys Teaching
Aneurin Bevan
Hywel Dda
Betsi Cadwaladr Uni
Abertawe Bro Morgannwg Uni
Cwm Taf
Cardiff
Monmouth
Powys
The Vale Of Gla..
Blaenau Gwent
Conwy
Flintshire
Ceredigion
Swansea
Torfaen
Pembrokeshire
Rhondda Cynon..
Ynys Mon
Carmarthenshire
Newport
Caerphilly
Bridgend
Denbighshire
Neath/Port Talb..
Wrexham
Gwynedd
Merthyr Tydfil

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Infection Prevention (IP) Report Q4 (January to March 2019) Incorporating the IP Annual Report for 2018 -2019
Report Author:	Amanda Miskell – Assistant Director of Nursing (ADN) – Infection Prevention
Responsible Director:	Mrs Deborah Carter – Acting Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	This report provides an overview of IP activity, achievements, incidents and performance in relation to IP. The report should assure the Committee and relevant others of the innovative and quality work to prevent avoidable infection and incidence within the Health Board.
Approval / Scrutiny Route Prior to Presentation:	Via Infection Prevention Sub Group (IPSG) and Quality Safety Group (QSG)
Governance issues / risks:	Included within the report. There may be cost implications for failing to reduce or mitigate the risks associated with IP in terms of length of stay, avoidable harm, credibility and legal claims against the Board.
Financial Implications:	N/A for Q4
Recommendation:	The Committee is asked to: 1. Note the Infection Prevention Q4 report 2. Note the Annual Report for 2018/19

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Not required for update paper			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

1. Introduction

The IP quarter 4 (Q4) report will update the Health Board (HB) on the position of IP performance and any associated risks relating to IP, or those areas which support delivery of the IP agenda.

The quarterly and annual reports from the ADN for IP will report against the standards found within the Health Standards Framework (2015) published by Welsh Government. IP sits under Theme 2 “Safe Care” and has 12 criterion that should be met. These standards complement the guidance written within The Code of Practice for the Prevention and Control of Healthcare Associated Infections “The Code” (2014) published by Welsh Government and has 9 standards which must be adhered to in preventing Health Care Acquired Infections (HCAIs).

In addition any external scrutiny and evidenced based practice will be considered to give the Board assurance in relation to IP.

2. IP Team and Achievements

Quarter 4 saw significant changes within the IP service. Tracey Cooper (AND – IP) left the HB in the first week of 2019 to take up a new role in Worchester Trust. There were also sickness absences, maternity leave and vacancies. These were mitigated by the end of Q4, moving into the new 2019/20 year. Amanda Miskell joined the HB mid-January 2019 as Advanced Nurse Specialist – IP and covered both roles until the end of Q4. This should be considered in relation to the 2018/2019 IP annual report attached at Appendix 1. 2019/20 quarter reports will give the HB further assurance as we progress through the coming year.

Q4 enabled the service to take a fresh look at previous work programmes and priorities and commence the planning for 2019/20. This work has now been completed and will enable the service to work consistently supporting all HB colleagues in delivering safe, clean care.

New work plans were devised for the three localities to include area clinical provision, community hospitals and Outpatient Parenteral Antimicrobial Treatment (OPAT) services and areas for Mental Health, Learning Disabilities, and Drug & Alcohol services.

The HB Decontamination Advisor, Graham Yarlett, attended the National Central Sterilisation Event and returned with a plethora of knowledge to support the Decontamination visits expected from Welsh Government in Q1 and preparedness for the Vanguard initiative.

One of the IP nurses from the West locality, Louise Evans, presented at the National Infection Prevention Society (IPS) Mental Health special interest group on Injecting drug users and experiences in those admitted with Blood Stream Infections (BSIs) which are not Healthcare Acquired Infections (HCAIs). However there is innovative work to be done in providing harm reduction strategies going forward.

3. Incidents & Issues of Significance

The IP service has recommended that all Ice Machines are removed following an incident which found several organisms growing in the ice machines. These remain a risk and the Estates department are reviewing this provision.

There has been a positive legionella finding in the water supply at the Mental Health unit in West. The area was cleared and treated. The IP team in West continue to support colleagues in Estates and Facilities.

Ongoing issues with Pseudomonas growth in water supply on critical care at Wrexham Maelor Hospital (WMH). This is being addressed and is ongoing but there is an added complication due to the lack of isolation facilities in the area at WMH. There is money allocated for negative pressure suite in A&E. However, following discussions with planning and site leads, it is worth considering the use of this facility on critical care with other monies i.e. Safe Clean Care (SCC) to update and facilitate adequate isolation areas.

There has been an ongoing Tuberculosis (TB) outbreak in the East Area which Public Health Wales and the respiratory team in the East continue to manage well. However this is at the detriment of other specialist respiratory services and is noted on the corporate risk register in relation to dedicated TB provision. A further meeting has taken place with Secondary Care Nurse Director, Respiratory Consultant, IPC and a respiratory specialist nurse. IP will support an update of the TB brief and business case.

Welsh Government are revisiting the HB in June 2019 based on the decontamination report published in Autumn 2018. There are still risks associated with the decontamination of tunnelled scopes in use at Ysbyty Gwynedd and decontamination equipment throughout the Health Board. However, a review is taking place on the decontamination/sterile services and the resilience in relation to central processing and time line expectancies of equipment currently in place.

The IP service are still awaiting the trajectories from Welsh Government for HCAIs for 2019/20. These are likely to be reduced with the associated pressure on the HB to reduce even further. In view of this and HCAI performance, there needs to be further consideration of those HCAIs that are unavoidable and/or not HCAIs, for example antimicrobial treatment for high

dependent patients or those patients at the end of their life. Provisional trajectories have been discussed and communicated to performance and the Infection Prevention Sub Group with a suggested 10% reduction for clostridium difficile infections.

In relation to the ongoing work around adequate decant areas across the 3 acute sites to facilitate uninterrupted Hydrogen Peroxide Vapour (HPV) and deep cleaning to reduce the bioburden, WMH have now had a 6 bedded decant facility handed over to the IP team to facilitate and support an uninterrupted IP/HPV programme. This will ensure reduction in the environmental bioburden risk. This has already been seen at WMH with a significant reduction in clostridium difficile. Consideration for this facility should be considered for both Glan Clywd and Ysbyty Gwynned.

4. **Infection Prevention Sub Group (IPSG)**
   One IPSG took place during Q4 in February 2019. The terms of reference, business cycle, strategy and work programme will all be presented in June 2019 for approval, alongside this Q4 report.

5. **Outbreaks**
   YGC Ward 19 outbreak of Norovirus (one of the small round structured viruses (SRSV) we see associated with outbreaks)
   Ward 19 is a Care of the Elderly (COTE) ward located in an old style un-refurbished ward on the Glan Clwyd Site. It has limited side room capacity and no en-suite facilities. In relation to an outbreak of Norovirus in January 2019 affecting **14 patients and 8 staff with 19 bed days lost**. It is worth noting previous outbreaks June 2018 affecting **14 patients and with 89 bed days lost** and November 2017 affecting **7 patients with a loss of 11 bed days**.

   WMH
   January saw Gastro Illness considered to be a SRSV outbreak leading to closures on Evington and Mason ward.

   Partial closure took place on Bonney ward and this is considered to be related to medical patients being placed on Bonney (Gynaecology) whilst the hospital is under pressure for beds.

   One bay was also closed at Deeside Hospital.

   SAU was also closed with confirmed Flu cases.

   YG
   Also had an Influenza outbreak on Glyder Ward.

It should be noted that the IP teams kept in touch with the wards at least twice daily. A new communication has now been set up so the site is aware of issues/ward closures and can allocate staff and resources in a timely manner.

6. Performance and trajectories

Only one of the trajectories was achieved for Q4 and year end as included in the QSE previous reporting and attached IP annual report. The service is still awaiting new trajectories for 2019/20 from Welsh Government.

7. Safe Clean Care

Internal audit is currently taking place with a report expected May 2019. In addition Jan Stevens revisit has had to be postponed to May 2019 following unforeseen circumstances.

8. Recommendations

The Committee is asked to note the Infection Prevention Q4 report and the Annual Report for 2018/19

9. Appendices

(Appendix 1)

Appendix 1

<table>
<tr><td>Title:</td><td>Annual Report - Infection Prevention 2018/19</td></tr>
<tr><td>Author:</td><td>Amanda Miskell, Assistant Director of Nursing – Infection Prevention</td></tr>
<tr><td>Responsible Director:</td><td>Deborah Carter, Interim Executive Director of Nursing & Midwifery</td></tr>
<tr><td>Public or In Committee</td><td>Public</td></tr>
<tr><td>Strategic Goals</td><td>
<table>
<tr><td>1. Improve health and wellbeing for all and reduce health inequalities</td><td>X</td></tr>
<tr><td>2. Work in partnership to design and deliver more care closer to home</td><td>X</td></tr>
<tr><td>3. Improve the safety and outcomes of care to match the NHS’ best</td><td>X</td></tr>
<tr><td>4. Respect individuals and maintain dignity in care</td><td>X</td></tr>
<tr><td>5. Listen to and learn from the experiences of individuals</td><td>X</td></tr>
<tr><td>6. Use resources wisely, transforming services through innovation and research</td><td>X</td></tr>
<tr><td>7. Support, train and develop our staff to excel.</td><td>x</td></tr>
</table>
</td></tr>
<tr><td>Approval / Scrutiny Route</td><td>The issues presented in this paper have received scrutiny on various dates at the Quality, Safety and Experience Committee (QSE), and at the Infection Prevention Sub-Group (IPSG), which is chaired by the Executive Director of Nursing & Midwifery or the Assistant Director of Nursing – Infection Prevention.</td></tr>
<tr><td>Purpose:</td><td>Regular updates on healthcare-associated infection and infection prevention have been provided to QSE and Board throughout 2018/19.

The need for the Health Board to reduce avoidable infections remains a high priority across Wales. QSE continues with close scrutiny of this important quality and safety issue.

The report provides a reflective annual report for the year 2018/19, including detail on performance in relation Health Care Acquired Infections (HCAIs), progress on Jan Stevens review and the Safe Clean Care Campaign.</td></tr>
<tr><td>Significant issues and risks</td><td><u>Key issues highlighted in this report include:</u>

• Summary of the key recommendations and progress from the Steven’s report.</td></tr>
</table>

	• An update on progress with the Board-endorsed Safe Clean Care Programme following findings in the Stevens report, and the positive impact of the programme to date. • An annual report for 2018-19, which includes a summary of infection performance data for *Clostridium difficile* infection, *Staphylococcus aureus* bacteraemia and *Escherichia coli* bacteraemia. • Within the report an update is included on key elements of the work programme, and other risks and issues of significance, including Norovirus and Influenza, water safety, food safety, the current position with critical ventilation systems, and decontamination of medical devices. Healthcare-associated infection, incorporating decontamination, cleanliness and antimicrobial resistance, remains on the corporate risk register, with a combined risk score of 20. (Likelihood = 4, Impact = 5). A range of mitigating actions and control measures are in place, including the actions described in this report, and measures described in previous reports to QSE and Board.
Special Measures Improvement Framework Theme/ Expectation addressed by this paper	Leadership and governance, to improve patient safety

Executive Summary

Whilst progress has been made in recent years within Infection Prevention, the level of infections overall have remained high across BCUHB putting patients at continued risk of harm. During 2018/19 there was a decrease in Clostridium Difficile Infections (CDI) and Meticillin Resistant Staphylococcus Aureus (MRSA), however the number and rates of other key infections increased across BCUHB.

1. Purpose of report

This update provides the Committee with:

- An update on recent progress with the Safe Clean Care programme which the Board has continued to actively support, and the positive impact to date.
- An overarching annual report that summarises all the reports previously authored and tabled at IPSG, QSG and QSE.
- An update on infection rates.

2. Introduction/Context

Regular updates on healthcare-associated infection and infection prevention have been provided to QSE and Board throughout 2018/19.

The need for the Health Board to reduce **avoidable** infections remains a high priority across Wales. QSE continues with close scrutiny of this important quality and safety issue.

The report provides a reflective annual report for the year 2018/19, including detail on performance in relation HCAIs, progress on Jan Stevens review and the Safe Clean Care Campaign.

3. Main body of the report

Stevens Report and the Safe Clean Care Campaign 2018/19
In August 2017 the Board commissioned the Stevens review in response to concerns that infection rates were not reducing at the rate of comparable organisations. A key message from the report was that *'While progress has been made at BCUHB over the past few years, the level of infections is still unacceptably high, and presents a continuing risk of harm to patients'.*

Jan Stevens previously highlighted the evidence from the many organisations that have achieved and sustained low levels of infection. She emphasised that the Board, clinicians and ward teams need to recognise that the position at the time of her report was not acceptable, real improvement is possible and emphasised that everyone has a role to play.

The report recommended a wide range of actions, including a campaign to improve staff engagement and drive a change in culture focussed on 5 elements:

- Good hand hygiene (including bare below the elbows)
- Taking blood cultures, inserting lines and catheters aseptically and managing them according to guidelines
- Following standard precautions consistently, prompt isolation, keeping doors closed to single rooms, wearing personal protective equipment
- Prescribing antimicrobials prudently
- Ensuring environment and equipment is cleaned correctly.

The report concluded:

"Whilst progress has been made, your levels of infection remain a significant risk to the organisation, to patients and to the reputation of the Health Board. The improvements you need to make are achievable with real commitment from all and with a relentless attention to detail. The amount of work required will need some dedicated support and adoption of good practice used around the UK."

In response and with the active support of The Board, the Executive Director of Nursing and Midwifery has overseen development of the Safe, Clean Care Campaign. Additional resources and support has been identified to ensure the campaign can be delivered at pace, through a series of 90-day improvement cycles.

The plan reframes the key standards as advised by Janice Stevens and focuses on:

- Clean hands
- Bare below the elbows
- Rapid isolation
- Device care, and care bundles
- Clean and clutter free environments
- Antimicrobial prescribing

Between April 2018 and March 2019 a wide range of activities has taken place including presentations at Grand Rounds, ward-walks and trolley dashes, regular communications to staff, work to improve accountability, and site-based celebration events.

A workshop held on 5th June 2018 to develop the 90-day planning cycle, with a focus on community hospitals with acute sites will be continuing with the 90-day improvement cycles. This includes an increase in focussed work on antimicrobial stewardship (AMS) with a HB wide AMS group driving forward on improvements across Community, Acute and Primary care.

Focussed work on prescribing of proton pump inhibitors (PPI) in 2018/19 has led to a reduction of over 11% in prescribing across North Wales. PPI are a significant risk factor for *Clostridium difficile* infection.

A celebratory event is planned for May 2019 but initial indications are that the campaign is engaging staff, with all areas celebrating successful bids, work that has progressed and overall positivity in relation to the campaign and IP.

Janice was due to revisit the HB in March 2019 but unfortunately this has had to be postponed until May 2019.

Overall Performance 2018/19

The Health Board did not achieve year 2018/19 trajectories for all alert organisms, however we may still come under trajectory for Clostridium difficile. It should be noted that although the Health Board is not yet fully achieving the Public Health Wales (PHW) trajectories, BCUHB has seen significant improvements in its infection rates and continues to have the best cumulative monthly rate per 100,000 population of all Health Boards in Wales for *St. aureus* bacteraemia, *Klebsiella sp* bacteraemia and *Pseudomonas aeruginosa* bacteraemia.

BCUHB also has the third best rate per 100,000 population for *E. coli* bacteraemia and C. difficile.

Since February 2019 the IPC team have commenced Post Infection Review (PIR) on all *C difficile Toxin Positive Infections* including community cases. This coincides with a follow up of all *C difficile Toxin Positive Infections* for a period of 4 weeks after completion of treatment or discharge. This will enable the team to review patients, trends, prevent relapses and consider if these infections were avoidable or not. In patient PIRs to date have indicated learning which may be transferable to community health care provision where applicable.

- Inappropriate antimicrobial prescribing
- Rapid detection and treatment
- Delayed isolation and advice for patients with diarrhoea
- Poor compliance with bare below the elbows
- Sustainability of environmental and cleanliness standards

Actions in the IPC and Safe Clean Care (SCC) improvement plans are continuing to focus on these issues and have made significant impact which has meant that these features are reduced and along with them the reduction in overall infection rates.

However further focus is required to reduce the number of these infections. Themes from PIRs of MSSA Blood Stream Infections (BSIs) include skin and soft tissue infections in the community leading to bacteraemia, and in hospital poor cannula care and contaminated blood cultures. The programme of work to reduce these includes improving cannula care and blood culture technique through the use of aseptic non-touch technique (ANTT) by medical and nursing staff. Actions continue in the Safe Clean Care Programme to improve practice on these issues.

From March 2019 there will be an increased effort as part of SCC and the IPC team to review all invasive devices on a daily basis with emphasis on vascular lines and intravenous antibiotics using the Start Smart Then Focus methodology, and for urinary catheters, the HOUDINI approach whereby nurses can make the decision to review and remove urinary catheters (not supra pubic).

***Escherichia coli* (E coli) Bacteraemia**

The prevalence of origin for these infections alongside other gram negative infections is across the whole health economy with more community cases than inpatient, although it is likely that some of the diagnosed inpatient infections were in fact community cases. The E coli collaborative work continues, with work in place to further increase focus on key drivers of these infections (primary care urinary tract infections and their management, urinary catheters and hydration). This will require a multi-faceted approach across all sectors of the health economy working collaboratively with Public Health Wales et al.

Deaths related to *Clostridium difficile* infection

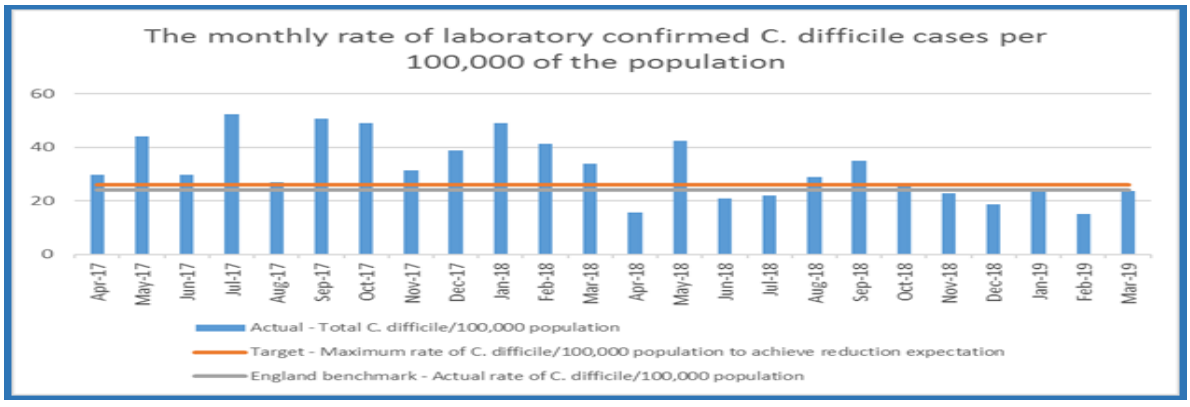
The number of deaths in patients who have *Clostridium difficile* infection (CDI) continues to be very closely monitored. Deaths related to *Clostridium difficile* infection are recorded on either part 1 of the certificate (a direct cause), or on part 2 of the certificate (a contributory cause). All cases are reported as serious incidents and post-infection review performed, with lessons learned shared.

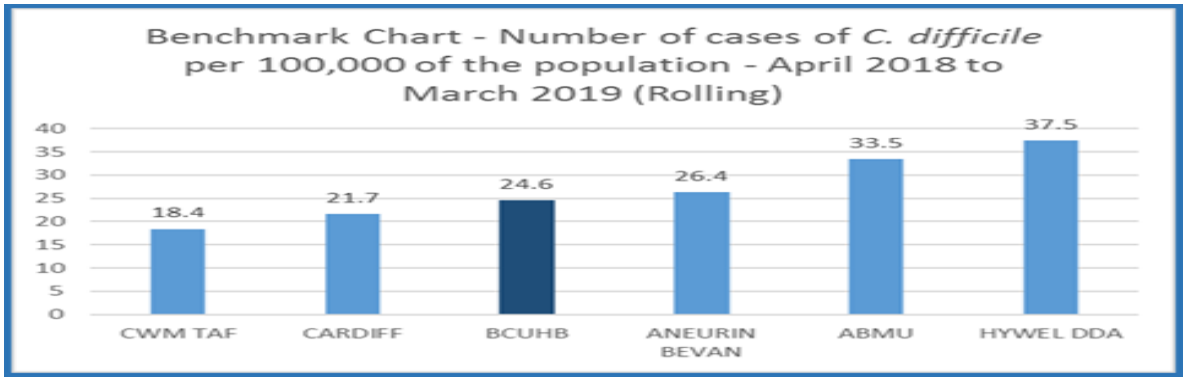
MRSA Screening

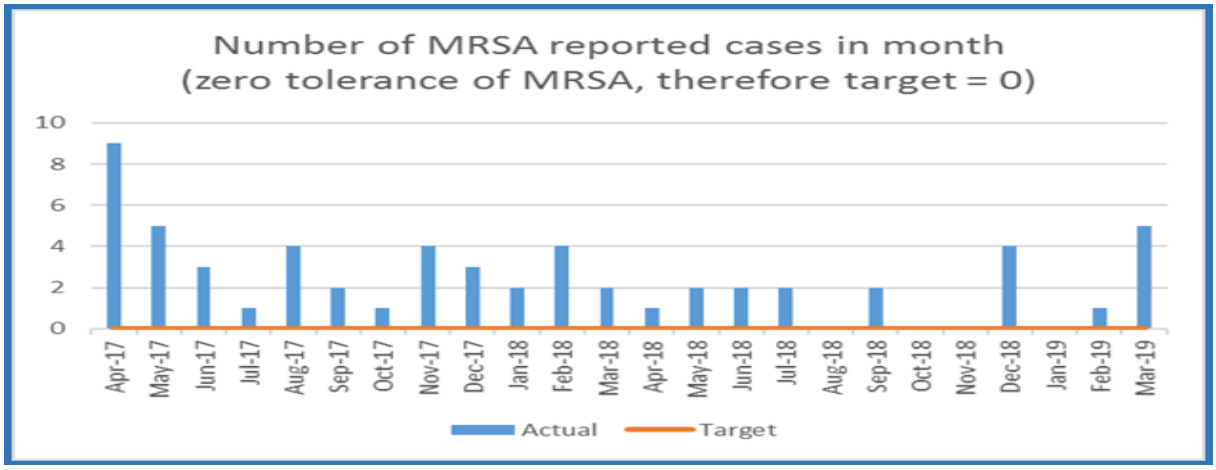
MRSA screening of certain groups of patients on admission is required in line with the evidence-base, national requirements and BCUHB protocol. This includes universal screening of 100% patients in key risk groups including intensive care and orthopaedics. From reviews the IPC team have recognised that although compliance around screening is high, screening of other sites and devices is sometimes missed. February's monthly IPC learning focused on this and support for screening patients at risk will continue with a review of the MRSA policy.

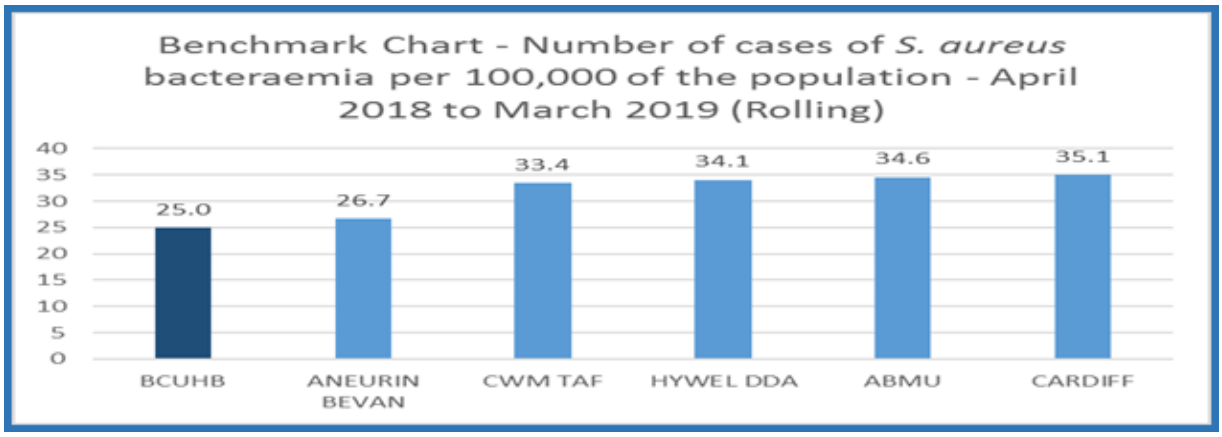
In 2018/19 the Health Board did see a reduction in two key infections, CDI and MRSA although MRSA is not significantly significant seeing an increase in December and March 2019. However there was an increase in gram negative infections and MSSA. Seen nationally.

From April 2019, ALL infections will be reviewed with key themes and risks identified. This will assist the HB in concentrating our efforts on those infections that are avoidable and/or HCAIs. The preventative work for others is related to antimicrobial stewardship, whole health economy approach and collaborative working.









Going forward into 2019/20, key actions are as below to support further collaberative working:

• Infection Prevention & Control (IPC) Team monitor all Health Care Acquired Infection (HCAI) groups via ICnet on a daily (M-F) basis.
• Typing takes place for any infections considered to be cross infection or outbreaks.
• Post infection reviews are carried out for all CDI and MRSA blood stream infections (BSI).
• All C. difficle infections (CDI) are followed up for 4/52 following completion of treatment or discharge.
• All antimicrobial prescribing is monitored by the pharmacy team with an emphasis on Start Smart then Focus (SSTF) related to stepping down intravenous to oral treatment.

• Monitor population sizes and demographics in relation to infection rates and trajectories.
• Dedicated IPC resource for community and Mental health services.

This should support the 2019/20 work programme by:
• Increased awareness of trends and prevalence of infection rates in Primary, Secondary & Community Care.
• Sharing of knowledge across the health economy.
• Patients remain on a seamless follow up for CDI.
• Reduction in unnecessary antibiotic prescribing and related resistance.
• A more robust outcome in relation to avoidable and unavoidable infections.
• Focus on those infections or harm which is deemed avoidable.
• Reduction in the use of invasive devices and risk of infection.
• Scrutiny and learning from focused HCAI executive review.

Infection Prevention and Microbiology Team Capacity
An increased Consultant Microbiologist capacity has been achieved by Public Health Wales through use of temporary staff, and PHW continues to work with BCUHB to identify sustainable long-term staffing solutions. Despite this mitigation, this remains a risk for the Health Board and discussions for a sustainable solution are on-going with PHW.

Influenza – Staff Vaccination
A completed corporate flu plan with key actions was completed identifying key actions for our divisional board members, occupational health, local flu co-ordinators, communications colleagues, flu leads and managers. To accompany this, a staff flu programme logic model was designed to clearly outline the programme, its activities, operations and outcomes, which was shared to all flu leads across BCUHB. Our aim for the programme was to increase staff engagement, target areas of high-risk and support a vaccination uptake of 60% for BCUHB (75% in high-risk areas). Unfortunately, BCUHB fell short of the targets set out in this action plan for the 2018 / 19 staff flu campaign. On evaluation of the 2018 / 19 staff flu vaccination campaign, we have identified recommendations that should be included for the 2019 / 20 staff flu vaccination campaign.

Engineering Ventilation Systems
Guidance for the operational management and performance verification of ventilation systems installed within the healthcare estate is provided within Health Technical Memorandum (HTM) 03-01: Specialised ventilation for healthcare premises Part B.

Ventilation is used extensively in all types of healthcare premises to provide a safe and comfortable environment for patients and staff. More specialised ventilation is provided in areas such as operating departments, critical care areas and isolation facilities for primary patient treatment.

Ventilation is also installed:

- To ensure compliance with the quality assurance requirements of items processed in pharmacies and sterile service departments;
- To protect staff from harmful organisms and toxic substances (for example in laboratories)

HTM03-01 defines a critical ventilation system as a system providing ventilation to one of the following areas:

- Operating theatres of any type, including rooms used for interventional investigations (e.g. catheter laboratories);
- Patient isolation of any type;
- Critical care, intensive treatment or high dependency unit;
- Neonatal unit;
- Category 3 or 4 laboratory or room;
- Pharmacy aseptic unit;
- Inspection and packing room in a sterile services department;
- MRI, CAT and other types of emerging imaging technologies that require particularly stable environmental conditions to remain within calibration;
- Any system classified as a “Local Exhaust Ventilation” (LEV) system under the COSHH Regulations;
- Any other system that clearly meets the definition

The loss of such a system would seriously degrade the ability of the premises to deliver optimal healthcare.

The guidance provided within HTM03-01 requires all critical ventilation systems in addition to quarterly inspection and maintenance, to be subject to a system verification which should be carried out at least annually. The purpose of the annual verification of the critical ventilation systems is to:

- Ensure the system achieves the minimum standards specific to the application;
- To ensure the fire compartmentation has not been breached;
- To ensure the general condition of the system is adequate for purpose
- To ensure the system is operating to an acceptable performance level – this requires:

1. A full measure of the supply and extract flow rates;
2. The calculation of room air change rates if applicable;
3. The measurement of room differential pressures if applicable
4. The measurement of room noise levels;
5. Air quality checks if appropriate;
6. A check of the control functions for the system

To ensure the system remains fit for purpose.

The Estates department hold a copy of the annual verification check list taken from HTM03-01.

The service for the provision of critical ventilation system verifications has been tendered via NHS Wales – Shared Services Partnership. RJ Urmson Commissioning Engineers Ltd were the successful bidder and they have been appointed under contract to provide the service for a three year period commencing in the 2018 – 2019 financial year on a pan BCU basis.

The service provider has been provided with a schedule of critical care ventilation systems and are now attending site to undertake the verifications as they fall due. Verification reports are uploaded to the BCUHB – Operational Estates SharePoint site and can be shared by other means upon request. Operational Estates have also developed an action plan which contains all recommendations made within the individual verification reports which is being updated on an ongoing basis with details of actions carried out.

Operational Estates will produce a schedule of critical ventilation systems that are deemed to have reached the end of their working life and as such require replacement.

Water Safety
IP are part of the strategic water safety group (WSG). There is still an ongoing lack of assurance (evidence) from Facilities that cleaning standards are being adhered to in relation to water outlets and the required running of water outlets in accordance with ES02 is being achieved in Augmented Care areas. There is also a concern about the lack of representation of Facilities at the WSG.

There is also concern about the lack of representation of Community Dental Service at the WSG although there is representation at the SDG.

Update on the Emergency Department (ED) Project at Ysbyty Gwynedd (YG) - improvements to delivery and system temperatures within the DHWS is dependent upon the completion of a system mapping exercise now being undertaken by Mott Macdonald engineering consultants. The system mapping exercise has now been completed and the consultant engineers have submitted their report. This now requires review prior to determining what actions are now to be carried out.

Issue of significance and concern relating to water safety compliance within the East area due to a lack of resource. There are serious staffing resource issues which are being addressed in the short term by supporting the East area with staff from the Central area. Good progress has been made in the last two months and progress is continuing.

Ongoing issues on Critical Care re: Pseudomonas contamination issues at Wrexham Maelor Hospital. A number of high level failures have occurred within these locations and a range of works and actions are being undertaken to improve the situation and return the routine sampling levels to normal. POU filters are in use and we are in receipt of advice and guidance for the Authorising Engineer - water

Agreed objective to remove ice making machines from within BCU. A joint approach is to be taken between Operational Estates and Infection Prevention with regard to

consulting with the various departments where ice machines still exist with the overall objective being to remove the remaining machines from use.

4. Assessment of risk

Healthcare-associated infection, including antimicrobial resistance and decontamination are included in the overall review of risks at IPSG. Significant work took place during Q4 in relation to reviewing all risks and prioritising in terms of Severity and likelihood with 20 being the top priorities.

5. Equality Impact Assessment

Reducing avoidable infections helps minimise inequalities that arise as a result of those infections. There are no other specific equality issues contained within this paper.

6. Conclusions / Next Steps

BCUHB saw an increase in some key infections in 2018/19, and did not meet ALL the HCAI reduction targets. In response the IP teams have actively supported the launch of the Safe Clean Care Programme.

The annual IP work programme will be approved and scrutinised by the Infection Prevention Sub-Group in June 2019, with monthly reports on position and performance to QSE.

Focus will continue on;

- Clean hands
- Bare below the elbows
- Rapid isolation
- Device care, and care bundles
- Clean and clutter free environments
- Antimicrobial prescribing

Board Members will need to continue to actively and consistently support the key actions in the Safe Clean Care programme, and hold staff to account to ensure the programme continues to be delivered at pace to achieve the improvement needed.

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Occupational Health and Safety (OHS) Annual Report 1st April 2018 - 31st March 2019
Report Author:	Mr Peter Bohan Associate Director of Health, Safety and Equality
Responsible Director:	Mrs Sue Green, Executive Director of Workforce and Organisational Development
Public or In Committee	Public
Purpose of Report:	This report provides an overview of incidents, accidents, occupational health, safety activity and training covering the period 1st April 2018 to 31st March 2019. The report requires additional evaluation of themes and actions to ensure lessons are learned and evidence of action plans are being implemented across all services areas.
Approval / Scrutiny Route Prior to Presentation:	The report has been discussed at the Strategic Occupational Health and Safety Group on the 28th June 2019.
Governance issues / risks:	A full review of legislative compliance is currently being undertaken to identify if the current safety management systems within the Board are appropriate. The Strategic Occupational Health and Safety Group will monitor the activities of Occupational Health and Safety Team and provide assurance to the Board that reporting procedures and OHS structures can clearly evidence compliance in all service areas.
Financial Implications:	There may be cost implications for failing to reduce or mitigate risks associated with Occupational Health and Safety in terms of fines prosecutions, lost time injuries and claims against the Board.
Recommendation:	The Quality, Safety and Experience Committee is asked to: 1. Note the position outlined in the Annual Report. 2. Support the proposed improvement plan and full review of OHS systems through a gap analysis of legislative compliance and subsequent proposed 3 year strategy. 3. Train Senior Leaders and develop further competence in the workforce at all levels.

Health Board's Well-being Objectives *(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Engagement Leadership and governance			
Equality Impact Assessment Update paper – Gap analysis review with project timeline.			

1. Executive Summary

The Annual Occupational Health, Safety (OHS) and Wellbeing report aims to give an overview of the key areas of concern and progress made in compliance with OHS legislation across the Betsi Cadwaladr University Health Board during the period 1st April 2018 to the 31st March 2019. In addition the report includes the Fire Safety Annual Report (Appendix 1), Sustainability Report (Appendix 2) and a 3 year Occupational Health and Safety improvement strategy (Appendix 3) to ensure the Board is better informed about legal compliance, setting clear goals, risk identification/management and further developing a pro-active occupational health and safety culture. The report outlines where future developments and opportunities for improvement can be identified in line with ensuring and maintaining the occupational health, safety and wellbeing of its employees, the public, visitors, patients, contractors and volunteers who use our services.

2. Introduction

This report is produced to inform the Betsi Cadwaladr University Health Board of the previous year's progress and development made towards meeting the Health Boards statutory obligations for OHS. It has limited information that provides assurance on safety management systems that pro-actively control all risks identified; however work on a three year improvement strategy is evidenced in (Appendix 3) along with an appraisal of achievements to date and future priorities.

3. Background

All organisations have statutory duties to ensure suitable arrangements are put in place to manage OHS and wellbeing effectively which should form an integral part of workplace behaviours and attitudes. This report identifies additional work and evaluation required to ensure the planning, organising and monitoring of the organisation's compliance with statutory health and safety obligations and duties can be clearly evidenced.

4. Key issues to note:

- The Health & Safety team has undertaken 269 reviews in service areas including 83 in West, 49 in East, 50 in central and 87 in GP practices. Following each review the H&S Advisor RAG (red, amber, green) rates each premise based on managerial attitude towards compliance and the physical evidence providing feedback on findings to Directorate Service Leads. The self-assessments reviews of Health and Safety have been undertaken by 173 Departments with the average score achieving 93% compliance. It is likely that this level of compliance will be significantly lower when assessed against the legislative compliance framework and the gap analysis currently being undertaken by the OHS Safety Team.

- The total number of accidents and incidents reported in the annual report are 5,601 the most significant areas relating to slips trips and falls with a total of 4,709. There were 1,457 incidents affecting staff, with sharps accounting for 373 incidents and slip trip fall accounting for 317 incidents. There is limited evidence of correlation between sickness absence with 25.7% of staff being recognised in the system being off work with

stress/anxiety and depression and 10.5% presenting with musculoskeletal disorders. Further work on correlation of incidents sickness absence and claims is required to target hotspot areas.

- The numbers of violence and aggression incidents was 3,752. This is an increase of 157 incidents from the previous 12 month total. This year there were 2,175 incidents classed as “affecting staff” this is a significant increase from the previous year of 399 with the total figures of 1,776. Of these, 992 resulted in a personal injury (942 previous year). This figure indicates the importance of the review of all security measures currently being undertaken by the Health and Safety Team which includes lone working, CCTV, lock down procedures, conflict resolution and restraint training for staff.

- A total of 97 RIDDOR reportable incidents the most significant relate to large number of slips, trips and falls, 38 reported through RIDDOR which correlate with the number of reported incidents of 317. The number of sharps incidents reported on all incidents was 373, the 2 RIDDOR sharps incidents occurred when staff where exposed to HIV, Hep B or Hep C. One exposure occurred during a post mortem on a hepatitis C positive patient where the tooth of the forceps nicked the staff member’s glove and scratched her thumb. 13 RIDDOR incidents relate to abuse by patient on staff attributable to a major injury or staff member being off work for over 7 days. The findings of the report have identified that significant work has been undertaken; however further work on the distribution of information concerned with lessons learned and the numbers of RIDDOR incidents will increase as a more mature safety culture is developed across the Health Board.

- Occupational Health (OH) Department has achieved the platinum level award for the service which includes a strong commitment to Corporate Social Responsibility; the organisation evidenced support in key activities such as transport, capital build, procurement, community engagement, employment skills, and facilities management. The award recognises the organisation has gone beyond legislation and demonstrates an exemplar commitment to the wellbeing agenda. There has been a significant amount of work undertaken to support staff regarding their mental health and wellbeing through a number of interventions, seminars and workshops across the 3 main sites. These have included the delivery of bespoke team interventions following requests, for example mindfulness workshop to the community team. The OH Team has developed 200 wellbeing champions and had contact with over 19,000 employee contacts in the period of this annual report and supported 8,147 sickness absence reviews.

5. Health and Safety at Work etc. Act 1974

The foundation of the UK health and safety system in Great Britain was established by the Health and Safety at Work etc. Act 1974 (HASWA) which remains the UK’s principal health and safety legislation. Under the main provisions of the Act, employers have legal responsibilities in respect of the health and safety of their employees and other people who may be affected by their undertaking and exposed to risks as a result. Employees are required to take reasonable care for the health and safety of themselves and others who may be affected by their acts or omissions. In promoting, stimulating and encouraging high standards of health

and safety at work, the Act requires the governing bodies of all employing organisations to ensure:

- Safe operation and maintenance of the working environment, plant and systems
- Maintenance of safe access and egress to the workplace
- Safe use, handling and storage of dangerous substances
- Adequate training of staff to ensure health and safety
- Adequate welfare provisions for staff at work

Essentially, the HASWA law is based upon the principle that those who create risks to employees or others in the course of carrying out work activities are responsible for controlling those risks. These particular regulations govern the management of health and safety in the workplace.

6. Management of Health and Safety at Work Regulations 1999

These regulations place a duty on employers to assess and manage risks to their employees and others arising from work activities. Under the Regulations, employers must also make arrangements to ensure the health and safety of the workplace, including having in place plans for responding to emergency situations, and providing adequate information and training for employees, and for health surveillance, where appropriate. Similarly, a responsibility is placed upon employees to work safely in accordance with the training and instructions given to them. Employees must also notify their employer of any serious or immediate danger to health and safety, or any shortcomings in health and safety arrangements.

7. Gap Analysis of legislation

The improvement plan (Appendix 3 Occupational Health and Safety Strategy 2019-2022) is linked to a complete review of the UK Occupational Health and Safety legislative framework. The gap analysis using 33 pieces of legislation and over 180 questions will be undertaken from the 17th June for 4 weeks and will evaluate 50 plus premises for compliance. The focus will be on evidence identified on site of key pieces of legislation which include asbestos, legionella, Control of Substance Hazardous to Health (COSHH), stress, sharps, work at height, RIDDOR and workplace regulations. It is anticipated that the self-evaluation scores of 93% will be significantly lower when we consider the whole framework that requires evidence of compliance with the law. A project plan based of the findings will be built into the 3 year strategy.

8. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

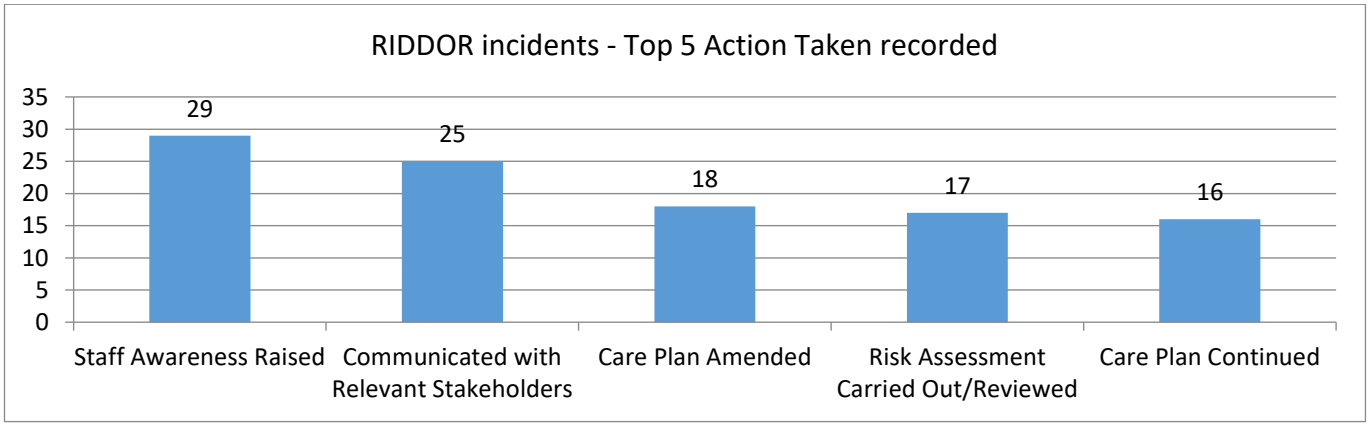
This set of regulations commonly referred to as the RIDDOR regulations require employers and other people in charge of work premises to report and keep records of: work-related accidents which cause deaths, work-related accidents which cause certain serious injuries (major injuries), work related accidents resulting in over seven day absences, diagnosed cases of certain industrial diseases and certain ‘dangerous occurrences’ (incidents with the potential to cause harm).

The information provided below is a summary of the range of incidents reported; this has included a large number of slips, trips and falls 38 reported through RIDDOR which correlate with the number of reported incidents of 317. The number of sharps incidents reported on all incidents was 373 the 2 RIDDOR sharps incidents occurred when staff where exposed to HIV,

Hep B or Hep C. One exposure occurred during a post mortem on a hepatitis C positive patient where the tooth of the forceps nicked the staff member's glove and scratched her thumb. 13 RIDDOR incidents relate to abuse by patient and was attributable to a major injury or staff member being off work for over 7 days. A root cause analysis will be undertaken to identify the range and type of RIDDOR incidents to ensure lessons are learned across the Board.

Annual RIDDOR Information April 1st 2018- March 31st 2019

RIDDOR incidents by Detail and Region	BCUHB Central	BCUHB East	BCUHB West	No value	Total
Abuse - other	1	1	0	0	2
Abuse etc. of Staff by patients	3	3	7	0	13
Accident caused by some other means	5	9	5	0	19
Appointment	0	0	1	0	1
Discharge	0	1	0	0	1
Environmental matters	0	2	0	0	2
Exposure to electricity, hazardous substance, infection etc.	0	3	0	0	3
Fracture	0	1	0	0	1
Infrastructure or resources - other	0	0	1	0	1
Injury caused by physical or mental strain	6	1	2	0	9
Lifting accidents	2	1	1	0	4
Needle stick injury or other incident connected with Sharps	1	1	0	0	2
Slips, trips, falls and collisions	16	14	8	0	38
No value	0	0	1	0	1
Total	34	37	26	0	97



The top 5 actions taken to control the risks associated with RIDDOR incidents, include staff awareness raised (29) and communication with relevant stakeholders (25) further work on root cause analysis will be required as the organisation learns lessons and effectively tracks actions completed.

8. Risk Register relating to Occupational Health and Safety

Currently the strategic Datix risk register module doesn't contain a specific Health and Safety category, so Health and Safety risks appear under a variety of risk types. This process doesn't allow a coherent overview of the current major organisational risks per se.

9. Claims 1st April 2018- 31st March 2019

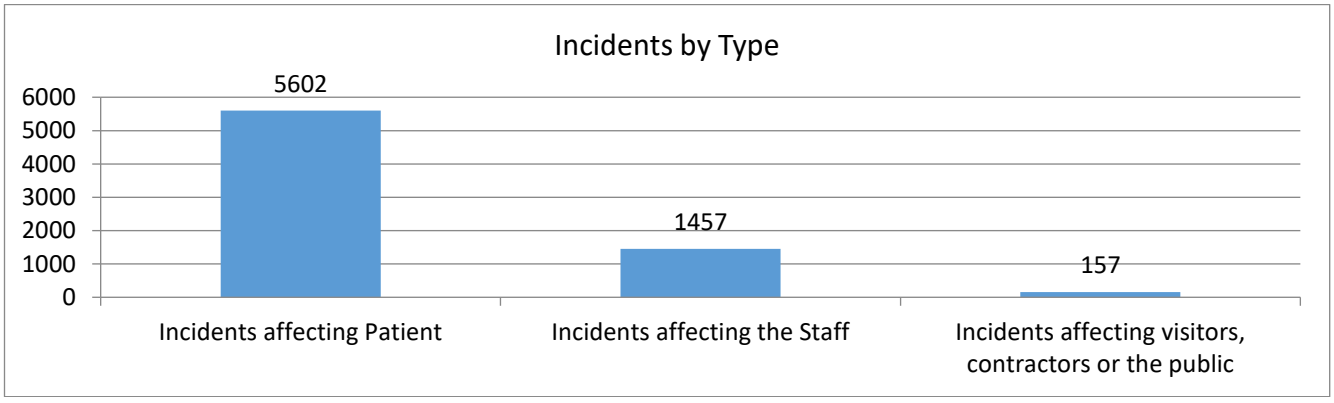
The Claims information has been provided to the Strategic Occupational Health and Safety Group; the data below indicates the numbers of claims but no specific detail. Further work will be required to correlate the information in the future with accidents incidents and sickness rates.

Claims Opened	2017/18	2018/19	Total
Clinical Negligence	235	221	456
Personal Injury	54	62	116
Total	289	283	572

Clinical Negligence Claims Opened by Region	2017/18	2018/19	Total
BCUHB Central	95	84	179
BCUHB East	70	74	144
BCUHB West	70	62	132
No value	0	1	1
Total	235	221	456

10. All accident Incidents 2018-2019

The Health board utilises the DATIX system to record all incidents and near misses. An analysis of the data reported from April 1st 2018 -31st March 2019 indicates that the main Health and Safety related incidents are as follows.



Contributory Factors (Top 5) identified against Slip, trip or falls incidents	Accident of some other type or cause	Collision with an object	Fall down Steps	Fall from a height, bed or chair	Fall from a Trolley	Fall on level ground	Fall over raised bed rails	Suspected fall	Tripped over an object	Total
Mobility Issues	33	21	0	532	2	593	2	138	12	1333
Medical Condition Contributory Factor	31	14	2	377	3	391	4	96	5	923
Dementia - Contributory Factor	22	33	0	318	3	378	0	111	14	879
Behaviour - Patient Uncooperative	21	11	0	312	3	320	1	89	7	764
Impaired Cognition	15	6	1	274	0	241	4	79	8	628
Total	122	85	3	1813	11	1923	11	513	46	4527

Slips Trips Falls Incidents.	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	60	51	66	177
Collision with an object	24	26	43	93
Fall down Steps	4	4	4	12
Fall from a height, bed or chair	662	546	591	1799
Fall from a Trolley	14	2	2	18
Fall on level ground	804	680	594	2078
Fall over raised bed rails	6	2	7	15
Suspected fall	169	104	198	471
Tripped over an object	26	9	11	46
Total	1769	1424	1516	4709

Incidents by Detail and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident caused by some other means	157	137	132	426
Exposure to electricity, hazardous substance, infection etc.	35	34	28	97
Injury caused by physical or mental strain	84	58	32	174

Lifting accidents	31	25	14	70
Needle stick injury or other incident connected with Sharps	139	114	120	373
Slips, trips, falls and collisions	124	108	85	317
Total	570	476	411	1457

The largest numbers of incidents affecting staff is sharps 373 incidents. In June 2018 a self-audit assessment tool was provided to staff to assess compliance with the Sharps legislation. All service areas completed the self-audit tool. In addition key site visits were undertaken in the Emergency Departments (EDs) and Theatres. The key outcome of the audit concluded that not all the specialist safety devices procured were in use; support and advice has been provided and further work is planned for 2018-2019. In October 2018 The OH Department commenced an awareness campaign to look to reduce sharps incidents which involved distribution of a pack to managers and local dialogue with key service leads.

12. Violence & Aggression Annual Report

12.1 Assurance

The Violence & Aggression management program is being supported and developed through the following procedures and forums:-

- The “Procedure & Guidance Protecting Employees from Violence & Aggression” – Procedure HS02 document and support.
- Representation at the All Wales Violence & Aggression Case Managers/Security Managers Group.
- Representation at the All Wales Violence Advisory Group.
- Mental Health & Learning Disabilities (MHLD) Division specific policies- Proactive reduction & therapeutic management of behaviours which challenge, MHLD 0049 & Physical Restraint Guidelines,MHLD0047

12.2 Violence & Aggression Training Provision across BCUHB

Violence and Aggression training is provided by specialist teams including Workforce and Organisational Development, Mental Health and Learning Disabilities Division. The Training is delivered by classroom-based training and e-Learning which is available for specific modules.

12.3 Mental Health Training Compliance Data (Jan-Dec 2018)

Training Compliance for Physical Restraint courses can only be accessed January to December this requires addressing for the next annual report.

Training Compliance for Physical Restraint Courses	
Service	Compliance
Acute	90%
Older persons mental health	76%
Rehabilitation	86%
Forensic	97%
LD Total	80%
Mental Health Total	86%

WOD Training Compliance figures 2018-2019	
Module A [Level 1]	Module B/C [level2]
95% Compliant (94% previous year)	64% Compliant (67% previous year)

13. Reported incidents of Violence/Aggression (V&A)

During the period 1st April 2018 - 31st March 2019 there were 3,752 incidents of violence and aggression recorded incidents on the Datix system, this is a separate category to accidents and incidents. This is an increase of 157 incidents from the previous 12 months when there were 3,595 incidents in total. Out of the 3,752 incidents this year there were 2,175 incidents classed as “affecting staff” this is a significant increase from the previous year of 399 with the total figures of 1776. Of these, 992 resulted in a personal injury (942 previous year) with 655 injuries affecting staff (480 previous year) and 18 RIDDORs were reported compared to 17 in the previous year. This is a significant concern for the safety and security of staff with the Health Board.

Total V&A incidents: All Areas=3,752: *Note 2,175 incidents effecting staff.	Data
Division of Mental Health and Learning Disabilities	2,502
Specialist Medicine (secondary)	425
Primary and Community Services (Area)	323
Surgery (Secondary)	157
Children and Young People (Area)	126
Therapies (Area)	37
Women's and Maternal Care (Secondary)	32
Anaesthetics, Critical Care and Pain Management (Secondary)	25
Primary Care (Area)	24
Radiology (Secondary)	24

Estates and Facilities (PandP)	20
Office of the Nurse Director (Corporate)	13
Cancer Services (Secondary)	12
North Wales Community Dental Service (Area)	10
Pathology (Secondary)	5
Pharmacy and Medicines Management (Area)	4
Strategy (PandP)	4
Office of the Medical Director (Corporate)	3
Public Health (Corporate)	3
Chief Executive Office (Corporate)	1
North Wales Managed Clinical Services	1
Therapies and Health Science (Corporate)	1

Datix incidents by outcome						
Personal Injury	No Injury, Harm or Adverse Outcome	Near Miss	Near miss-No intervention	Damage to property or equipment	Disruption to services	Death *See note below
992	1985	567	112	57	1	38

*Note: 38 Deaths are recorded on the Datix system by Mental Health Services. This is recorded when they are informed of a death of patient including circumstances where patient is not receiving in-patient care.

Datix Incidents by Category				
Verbal Abuse	Aggressive Behaviour	Assault	Threatening behaviour	Other & unreported
244	1630	890	223	765

Criminal Justice Interventions, reported to V&A Case Manager (staff were victims 01/04/18-31/03/19)			
Successful Prosecutions		Unsuccessful/ discontinued Prosecutions	Ongoing police investigations/awaiting court result
Including Assault & Public order offences and malicious Communications	11 Offenders 18 Offences (3 Offenders)	2 (1)	3 (1)
Previous year in brackets			

BCUHB internal sanctions	
Letters to patients	Alternative arrangements (e.g. appointment changes such as location time/security/police presence etc.)
11	6

14. Partnership Engagement

The Police Inspector seconded to BCUHB is now permanent following North Wales police internal recruitment process (April 2018) and now covers all BCUHB areas. The V&A Case Manager maintains links with other Health Boards and Trusts in Wales, Welsh Government, Police and Crown Prosecution Service (CPS) through membership and attendance of the All Wales Case Managers Group. The group reports to the All Wales Health and Safety Managers group and will continue to have direct link with the NHS Anti Violence Collaborative.

Training providers have maintained links with the All Wales Violence Advisory Group and are active in influencing All Wales Training & Information Scheme (passport) for Violence & Aggression review. Mental Health division attends the Proactive Reduction of Restrictive Interventions Clinical Effectiveness Group (PRRICE). Regular communication between the Witness Care Units within the Courts system has been maintained.

14.1 Welsh Emergency Department Frequent Attenders Network

BCUHB is a key member of the Welsh Emergency Department Frequent Attenders Network (WEDFAN), which is a network of multi-agency teams that link all Welsh Emergency Departments. The purpose of WEDFAN is take a multi-agency problem solving approach to explore any gaps in service provision which can be offered to those persons who attend on a frequent basis with the intention to reduce demand for Emergency Departments and provide improved outcomes. BCUHB meets locally and also share good practice nationally. V&A Case Management has been required on some occasions due to frequent attender abusive behaviours.

14.2 Workplace Safety Group.

The Workplace Safety Group has reformed following a period of reorganisation within Safeguarding department in order to provide advice/support and governance to line managers/supervisors whose staff are subject to (or perpetrators) of domestic abuse.

15. Looking Forward- Obligatory Responses to Violence in Healthcare.

The Memorandum of Understanding between Police, CPS and NHS (Wales) has now been replaced by the Obligatory Responses to Violence in Healthcare agreement. This agreement, signed by BCUHB Chief Executive Officer focuses on incidents addressed within the criminal justice system by,

- Improving effective communication between NHS, Police & Crown Prosecution Service
- Encouraging reporting of incidents

- Strengthening the investigation and prosecution process, by improving the quality and timeliness of shared information
- The agreement seeks to assist police when investigating incidents that occur on in-patient Mental Health premises in respect to exploring in-patient's intention to commit a crime.
- Requires each NHS body to gather and provide timely evidence to be scrutinised by the NHS Anti-Violence Collaborative.

The Obligatory Responses to Violence in Healthcare agreement will be endorsed by the issue of a Welsh Health Circular during 2019.

16. All Wales Assurance Changes.

The All Wales Violence & Aggression Case Managers/Security Managers Group has been renamed The All Wales Case Management Group to better reflect its evolving membership- which now includes, Police, Crown Prosecution Service and Welsh Government representation. The All Wales Violence Advisory Group has now been dissolved and representation from this group have joined the All Wales Violence & Aggression Case Management Group.

17. Personal Safety Markers

The Personal Safety Marker (for Violence/Aggression) is yet to be adopted largely due infrastructure and compatibility issues surrounding the electronic patient note system. Work in this area has remained static due to the compatibility issues experienced by electronic note system.

18. Security

BCUHB no longer employs a dedicated Security Manger, but security has been placed with the Corporate Occupational Health & Safety Team. This area will be subject to a major review as part of the gap analysis taking place in June and July 2019.

	2017	2018	Total
Fires, fire alarms and fire risks	32	22	54
Public order, Protests, Bomb scares, Riot, Disorder	9	9	18
Security - other	596	922	1518
Security incident related to Personal property	145	136	281
Security incident related to Premises, Land or Real Estate	72	70	142
Security issue related to Equipment	63	69	132
Security issue related to Vehicles	12	10	22
Staff records or information	97	113	210
Total	1026	1351	2377

19. Changes in Legislation.

The Welsh Government is currently reviewing section 119 & 120 of the Criminal Justice and Immigration Act 2008, which makes causing a nuisance or disturbance on NHS property an offence and gives powers of removal to NHS employees. This may have training implications for BCUHB staff. The Welsh Government continues to review this is and further updates will be

provided once received. Assaults on Emergency Workers (Offences) Bill 2017-19 has now received Royal Assent .This has effectively doubled the maximum sentencing length for common assault from 6 months to 12 months if perpetrated against Emergency Workers. This is a positive step in supporting our front line services.

20. Reviews

The BCUHB procedure HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is currently under review and will take into account possible links to the security function which has now been placed within the corporate Health & safety portfolio. The CCTV procedure is currently being developed-supported by Corporate Occupational Health & Safety Team.

21. Progress of Divisions and Corporate Functions

The Safety Leads group continues to meet throughout the year. This group has been well attended and has proved to be an essential way of communicating messages as well as identifying where improvements have or need to be made across the Occupational Health and Safety system.

22. Health & Safety Reviews.

The Health and Safety reviews are currently undertaken by the Corporate Health and Safety Advisers. The purpose is to work with the Directorates/Areas and Corporate Functions to help them identify risks in relation to Occupational Health and Safety.

The West has seen a significant number of reviews undertaken during the time period 1st April – 2018 to the 31st March 2019 with 83 visits. All reviews were provided to the responsible Directors of the services, with improvements being made in communication with teams in relation to the control of substances hazardous to health, first aid and working at height. Trends within the West area identify that the most compliant services are Women's services, Mental Health and Learning Disabilities Shared services. These services have a dedicated risk/health and safety governance lead. Secondary care is the least compliant which is evidenced in the reviews. Secondary care however, has taken recent action to try and resolve this by a new improved health and safety assurance group and reporting/escalation process.

26 reviews of the Ward Environmental Risk Assessments were carried out at the request of the Hospital Management Team, following an unannounced Health and Safety Executive (HSE) visit to Ysbyty Gwynedd in March 2018, where hazard identification on the wards and appropriate risk rating was questioned by the Inspector. Directly, following this intervention and the H&S Advisors reviews, £60,000 has been spent on ward hazard improvements including swipe cards to manage access to storage and cleaning areas. Further improvement work will be evidenced in 2019/2020's programme of reviews, which will continue to monitor H&S compliance.

The East area H&S Advisor has undertaken 49 reviews with themes being identified such as poor ratings for emergency evacuation exercises, first aid, and COSHH compliance including medical gasses. Poor rates of Violence and Aggression Risk Assessment, work at height and Display screen equipment. The best compliance rates are strongly linked to those functions which have a well-defined H&S governance structure and maintaining close relationship with

H&S Advisors for reviews and guidance. The Medical Directorate and Community Dental are consistent between departments, with higher overall compliance than other functions. The Area Team now has designated accountable persons and a much more robust reporting and monitoring system than previous years. A large number of staff have also received training through the Managing Safely course.

The early Corporate H&S Reviews in 2018 for the newly appointed H&S Advisor for Central identified a lack of understanding from department and ward managers of what was required for H&S compliance. The focus therefore for the Central H&S Advisor in this year was to complete a partial review of the questions already in place and a guidance document giving details of evidence required for each of the questions on the Corporate H&S Review. In addition to this, templates relating to the Corporate H&S review have been collated or written and formatted to ensure consistency with a document control system. The team's webpages have been extended to include the Corporate H&S Review with support from the Team Secretary.

A total of 50 Corporate H&S reviews were then undertaken within the Central area and each of these identified a large number of recommendations, some of which have led to further templates being written such as a H&S folder contents sheet. A number of departments, particularly in Dental, MH&LD and Women's and Children's, have worked hard to complete their recommendations and full support with this has been provided. The guidance has been well received and has now been extended to the newly formatted Self-Assessment Tool which was released in April 2019. The Corporate H&S Review questions have been amended further to start from April 2019 and questions reduced to 50. These will be scored going forward which will ensure the team can identify areas across BCU of non-compliance where further training or support may be required. We can also identify departments who have high scores for H&S compliance so that their work can be recognised. The focus for 2019 in YGC will be on the compliance from all of the wards. This was delayed in 2018/19 due to the completion of the asbestos removal in YGC. This project saw many wards being relocated and therefore inconsistency with their reports. The project has now completed and it is anticipated that wards will remain in their current location.

The H&S Advisor for GP Practices has undertaken a total of 87 reviews across BCU. Following each review the H&S Advisor RAG rates each practice with the rating based on managerial attitude towards compliance and the physical evidence. The number of practices rated Red have fallen from 27 down to 9, Amber ratings have fallen from 42 to 36 and Green ratings have risen from 30 up to 42 from the previous year. This improvement is expected to continue in this current financial year. Each 'negative' response to a question in the review is recorded on a database and the report highlights clearly that the areas identified for priority during the review has decreased substantially. 117 managers deputy's or identified staff have attended the one day Managing Safely course. This was specifically presented to Practice Managers based on a GP Practice environment. Additionally the advisor now offers direct H&S & Fire training during sessions to practice staff with 11 sessions being delivered last year and over 140 staff members attended. The number of sessions is expected to increase throughout the coming year.

23. The Corporate H&S Self-Assessment Feedback

The self-assessment should be completed by all department managers and then the Corporate H&S team should check the returns and visit areas to ensure that the compliance recorded is accurate. The tool for this period had 177 questions which each Department required recording their evidence of compliance or an action plan. The uptake for this was not good and feedback

was that it was time consuming and difficult to work with. There were 173 returns from the H&S self-assessment forms, with radiation, noise and vibration being the most frequently identified as not applicable. The results therefore are calculated on where these apply e.g. Radiation ranging from 99%-100%. The majority of scores under 60% were mostly seen in staff health and wellbeing and first aid. The overall rating of compliance is 93% across all service areas.

Corporate H&S Self-Assessment Feedback Data		
1	Health and Safety Procedure	91%
2	CPG/Corporate Function	96%
3	Health, Safety and Emergency Planning	84%
4	Consultation, Communication and Control	94%
5	Information, Instruction and Training	86%
6	Risk Assessment	85%
7	Monitoring	91%
8	Incident Reporting and Investigation	98%
9	Fire and Emergencies	82%
10	First Aid	82%
11	The Workplace	96%
12	Work Equipment	92%
13	Hazardous Substances, biological agents	85%
14	Sharps	94%
15	Patient and Object Handling, WRULDs	94%
16	Violence and Aggression	76%
17	Display Screen Equipment (DSE)	89%
18	Radiation	99%
19	Noise	99%
20	Vibration	100%
21	Staff Health and Well-being	77%
22	Work at Height	87%
Total Self-Assessment Compliance		93.3%

The Self-Assessment Tool has been re-written in April 2019 to ensure that it is in line with the Corporate H&S Review. The new format, with just 50 questions, has received positive feedback and with the associated guidance all Managers should be in a position now to complete this. It is anticipated that the compliance for returns will improve and will ensure that there will be consistency between the self-audit review and corporate review audit process.

24. Wellbeing/ Attendance management

Data obtained from Occupational Health from 1st April 2018 to 31st March 2019 indicate that percentages of absence from work was:-

Anxiety/stress/depression/other psychiatric illnesses	25.7%
Other musculoskeletal problems	10.5%
Back Problems	5.2%
Injury, fracture	5.2%

To reduce sickness absence in the workplace the all Wales attendance management training program was introduced to BCU in partnership with staff side representatives. The attendance management policy has set a clear focus on wellbeing and compassionate management. To support this the OH Department has provided 11 training sessions during this quarter with 413 (22.6%) of managers trained to date.

24.1 The Gold Corporate Health Standard Award

On the 28th June 2018 the Health Board renewed its gold level Corporate Health Standard award. The gold level award recognises a strong commitment to health, safety and wellbeing for the organisation's employees. The assessor highlighted that 'the Gold Action Plan 2018 was comprehensive, clear and well-presented. The Gold assessment has been in place since 2016. The assessor was extremely positive about the work about maintaining the Gold level standard and how it had embedded health and wellbeing into the organisation by creating an 'engaged culture' ensuring that staff 'owned' the health and wellbeing agenda and contributed significantly to its success. Staff health and wellbeing was part of the organisation's ten-year strategy 'Living Healthier Staying Well'. It formed an integral part of the approach to health and wellbeing. The Steering Group continues to engage with a wide range of representation including Trade Unions and reports to the Finance & Reporting Committee and the Board. Senior Level Commitment was clearly evident.'

24.2 The Platinum Corporate Health Standard Award

The platinum level award which includes a strong commitment to Corporate Social Responsibility has also been obtained this year and required the organisation to evidence support in key activities such as transport, capital build, procurement, community engagement, employment skills, and facilities management. The award recognises the organisation has gone beyond legislation and demonstrates an exemplar commitment to the wellbeing agenda. This is the first time the Health Board has been awarded the Platinum level standard. The assessors were very impressed by the active engagement both internally and externally of the Wellbeing Group and had increased community engagement with strong evidence that BCUHB had adopted a sustainable approach to their work.

24.3 The Staff Health & Wellbeing tools

In collaboration with the all Wales Staff Health & Wellbeing group, the OH Department has designed guidance which signposts staff to information and resources to enable them to make better choices with regards to their own health and wellbeing. This includes guidance such as the 'Mind' and '5 Ways to Wellbeing'. The initiatives to further develop the wellbeing agenda include messages on physical activity through various media platforms across the organisation.

Linking in with National calendar events to support such initiatives as national walking month, cycle to work day, on your feet Britain and national fitness day. Collaborative partnerships have been established with local authority leisure centres and heads of leisure to support staff in accessing leisure centres within the local areas across BCUHB. Corporate memberships and discounts have been agreed to help encourage staff to change health behaviours and become more active by using local centres.

Work on the Health Trail is ongoing on the Ysbyty Gwynedd site. The 2km health trail is currently being discussed and planning for the development of this trail continues. The aim of this health trail is for staff, patients and the public to use as part of the 'get active' message and will encourage people to be active on the Ysbyty Gwynedd site. Access to this trail will be for all and can be used for walking, running or cycling purposes. A health and wellbeing hub has been started in John Spalding library, Wrexham which will look at supporting staff to manage their wellbeing in work. A pilot project has been established to review the benefits of such a hub on the Wrexham site. The room includes space to do yoga and mindfulness as well activities to engage mental wellbeing. If successful the hub will be considered for the other two library sites across North Wales.

24.4 Tobacco Awareness

Changes to the smoking legislation across Wales was discussed and a tobacco control-working group was established to discuss the impact of the future legislation on BCUHB staff. We are currently waiting for confirmation of the new legislation implementation date and the policy has been drafted. Support for staff continues to support staff through the smoking cessation program.

24.5 Alcohol Support

There has been collaborative working with our alcohol liaison colleagues resulting in 3 alcohol awareness events delivered across the 3 main sites in BCUHB. The awareness stands focused on providing updated information on the dangers of excessive drinking and updating staff on the new alcohol guidelines. Messages around alcohol awareness were also promoted via our health matters newsletter and social media platforms. The drug and alcohol substance misuse policy was reviewed to support referral pathways for staff into support services across North Wales.

24.6 Staff Flu Campaign 2018/2019

BCUHB administered the highest number of flu vaccinations across Wales more than 522 compared to the next highest performing health board in Wales. Overall uptake for the eight staff groups (which includes non-patient contact) was 51.25% (9,112 staff) which is a decrease of 2.82% (324 doses) on the previous year. All eight occupational groups have shown a decrease in their flu vaccination uptake this year when compared to the previous year with no groups achieving the 60% target set by the Chief Medical Officer. The number of 'cold, cough, flu' absence recorded on Electronic Staff Record (ESR) was less in staff who received the jab by 259 occurrences (3,317 total occurrences in total).

24.7 The Counselling Advice Line

In January 2019, the OH Service introduced a revised programme that enabled counsellors to engage with staff earlier if they had any issues they may like to discuss. This has meant that

initial telephone support is made within 24-48 hours. Rapid access pathways to mental health support and psychology are being further developed.

24.8 Occupational Health Activity

The support advisers' activity for sickness absence early intervention support totalled 19,670

Advisors activity 2018-2019			
Support Adviser - 1st review			88
Support Adviser - < 10 day review			287
Support Adviser - 2nd review			41
Support Adviser - 3rd review			7
Support Adviser - 4th review			3
Support Adviser - Advisory follow up			11
Support Adviser - Appointment by Phone			1
Support Adviser - Contact client attempt 2			3,972
Support Adviser - Contact Client Initial			11,131
Support Adviser - Contact Client Other Attempt			21
Support Adviser - Day 10 review			1,244
Support Adviser - Day 21 review			491
Support Adviser - returning call from letter			413
Support Adviser - returning call from phone call			1,960
Total			**19,670**

24.9 Activity for Clinical Practitioners

The activity for sickness absence/self-referral support was 8,147.

Sickness absence referral data 2018-2019.	
Self-Referral (in person)	218
Self-Referral (phone)	101
Sickness Absence - case review plan (by phone)	5
Sickness Absence - case review plan (in person)	19
Sickness Absence - first (by phone)	2,271
Sickness Absence - first (in person)	413
Sickness Absence - first with medic (by phone)	20
Sickness Absence - first with medic (in person)	311
Sickness Absence - first with OT / PT (by phone)	414
Sickness Absence - From CARE by Phone	928
Sickness Absence - From CARE in Person	4
Sickness Absence - review (by phone)	2,454
Sickness Absence - review (in person)	989
Grand Total	**8,147**

25. Staff Mental Health and Wellbeing support April 1st 2018- March 31st 2019.

There has been a significant amount of work undertaken to support staff regarding their mental health and wellbeing through a number of interventions, seminars and workshops across the 3 main sites. These have included the delivery of bespoke team interventions following requests for example mindfulness workshop to the community team.

In March the OH Department launched a program called 'How to create wellbeing in the workplace' training sessions for managers. This focuses on drawing together key elements of the wellbeing model including leadership behaviours, leadership improvement, measuring wellbeing, how to run focus groups and wellbeing planning. Following 3 awareness sessions at which 53 managers attended, it was identified that managers felt the sessions improved their awareness of wellbeing issues in the workplace. There are 21 sessions planned for 2019/20 with a 3 month post training session evaluation process to determine outcomes. Two bespoke sessions have been organised with Workforce & Organisational Development (W&OD) to support key areas which include hotspots (such as theatres & ED at Glan Clwyd). This has taken into account workforce data which has included sickness absence, Performance Appraisal Development Review (PADR), mandatory training which has been triangulated with staff data e.g. staff survey results or 'Be Proud' which will produce local action plans to support improvements.

To support the sickness absence policy and provide staff support the OH Department has provided 5 mindful movement sessions in February and March 2019 to a variety of workgroups identified as sedentary workers. The post evaluation findings have identified that staff reported improvements in both emotional and physical wellbeing scoring as a result of the intervention.

The OH Department has led an initiative to enrol 200 staff as mental wellbeing champions as part of our mental wellbeing Time to Change program they also have a twitter account to communicate effectively and a newsletter has been produced to support the program. The evaluation report identified that 20 wellbeing champions surveyed felt more empowered to challenge stigma around Mental Health in the workplace and felt more confident in having individual conversations with their colleagues about mental health issues.

Wellbeing Intervention31st March 2018 to 1st April 2019	**Numbers of Staff Attended**
Managing stress, anxiety, low mood, managing change, 5 ways to wellbeing workshops, improving sleep	129
Bespoke interventions to teams and group support including mindfulness and staff debriefs	413
Other teaching e.g. managers A Step into Management	141
staff mental wellbeing champions development meetings and wellbeing training	32

Creating Wellbeing in the Workplace	171
Mental Health & Being LGBT	40
Counselling 1st Appointment by Phone/ triage by phone/ phone advisory	1,568
Counselling 1st Appointment in Person	1,088
Counselling Discharge Session	4
Counselling EMDR	4
Counselling Review by Phone	192
Counselling Review in Person	2,662
Grand Total	5,518

Debriefs have taken place to support staff following incidents along with managing change and uncertainty sessions. There is also training for staff in managing anxiety/sleep/low mood and delivery of the 5 ways to wellbeing. There has been a number films produced including a Short Film for Mental Health awareness week with 'Today I Can' and 'Ted' type talks to be filmed with champions to share good practice and techniques around creating wellbeing and developing emotional resilience. The intranet has been further developed with a link with the Staff App and Mental Wellbeing Portal. There has also been significant work from the counselling advisory service and mediation support.

26. Health & Safety Training

The Corporate Health and Safety Team undertake a variety of internal training. Within the last year the following courses ran and attendance has been as follows:-

Training April 2018-March 2019	**East**	**Central**	**West**	**Number of Sessions**	**Number of Attendees**
Managing Safely					
No of Sessions	5	5	6	16	
No of attendees	50	69	54		173
Combined Risk Assessment & COSHH					
No of Sessions	1	2	6	9	
No of attendees	3	17	71		91
RIDDOR Awareness					
No of Sessions	2	3	1	**6**	
No of attendees	9	19	3		**31**
			Total	31	295

Course Subject	Number of sessions	Number of staff trained	Number of Cancelled Sessions	Did Not Attend
Managing Safely 2 Day Course	16	173	1	58 (25%)
Risk Assessment & COSHH ½ Day	9	91	7	19 (19%)
RIDDOR Awareness Training 1 ½ hrs	6	31	4	7 (18%)
Total	31	295	12	83 (22%)

It has become evident that registration numbers are often low and sessions are cancelled when there are 8 delegates or less. When sessions were facilitated for specified areas, the attendance has been 100%. The data does not capture people who registered and then withdrew and this will form part of an evaluation of training through the gap analysis process.

27. Manual Handling/ Violence and Aggression Training Team Annual Report.

27.1 Introduction

This is the first Annual Report that the revised BCUHB Manual Handling Team has produced and it provides information on the service, the team and details some of the achievements made over the last 12 months, between April 1st 2018 and March 31st 2019. Within BCUHB there remains a constant pressure for improvement to services and within the Manual Handling Training team who aim to contribute wherever possible to these improvements.

27.2 The Service

The Manual Handling Training team's overarching responsibility is the delivery of Manual handling and Violence and Aggression training, both of these core subjects are delivered to the All Wales passport standard. The All Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) was developed by the All Wales NHS Manual Handling Group. It was originally launched in 2003 with endorsement from the Welsh Government, NHS Wales and the Health and Safety Executive. After several minor reviews in the intervening years a comprehensive review was undertaking in 2014 to take into account changes to the structure of the NHS in Wales. The Passport Scheme is acknowledged as being a key guidance document in the UK as evidenced by reference in publications such as:

- Ergonomics – manual handling of people in the healthcare sector. British Standards Institution PD ISO/TR 12296: 2012
- Welsh Local Government Association (WLGA) Manual Handling Passport Scheme (2005 and 2011)

- NHS Scotland Manual Handling Passport & Information Scheme (2010)
- Smith, et al., (2005) The Guide to the Handling of People (5th edition)
- Smith, et al., (2011) The Guide to the Handling of People (6th edition)
- UK Skills for Health Training Framework (2013).

Additionally, the modules contained within the Passport Scheme are accredited units within the Qualification and Credit Framework for Wales. All Wales NHS Manual Handling Passport & Information Scheme 2014. The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides also a framework for the delivery of violence and aggression training within the NHS in Wales. It provides guidance on the development of documentation to ensure the effective assessment and management of violence and aggression. The overall aim of the Scheme is to ensure consistent standards of documentation and training within the NHS. At the time of this report work is underway to review the passport scheme related to Violence and Aggression training. (All Wales NHS Violence and Aggression Training Passport and Information Scheme)

27.3 Policies

It is evident to note that the Passport Scheme predominately focuses on training provision, it also acknowledges that training alone is not sufficient to ensure safe handling practices within an organisation. An organisational Manual Handling Policy will provide a framework for implementation of a strategy that outlines roles and responsibilities, risk management processes and training arrangements.

Within BCUHB we have two supporting procedures in place to support Manual Handling within the organisation.

- WP 55 - Procedure & Guidance Document for Manual Handling, due for review in February 2020
- WP56 – Procedure for the management of the Larger Person, due for review in February 2020

The Mandatory training department intranet page along with offering training dates it also illustrates descriptions of all available courses and relevant resources, course and product information, contact details along with current news.

27.4 The Team

At the time of this report the team consist of:

- *Manual Handling Manager* - Predominately responsible for WP56, WP55 and current Risk Register. Manages the Manual Handling Advisor along with the Manual Handling/Violence & Aggression Trainers. Subject matter expert pertaining to Manual Handling for the Health Board, advising on issues that arise. PADR and HR issues within the team. Lesson planning and updating relevant course contents. Working alongside other Subject Matter Experts planning mandatory training and delivery of Orientation. Plan the out-sourcing of training with local Universities and other agencies. Assisting the Manual Handling Advisor with complex assessments. Supporting Champions and

Trainers to deliver a High Standard of training in manual handling. Annual Risk Assessment Audit.

- *Manual Handling Adviser* – Predominately responsible for completing complex back to work assessments, ergonomic risk assessments that include Display Screen Equipment (DSE) or manual handling issues. Health promotion and Subject matter expert advice in relation to the Occupational Health fitness to work mandatory training days.
- *Manual Handling/Violence & Aggression Trainers* – Delivery of Manual Handling and Violence & Aggression training. Competency assessments. Assist Manual Handling Manager with Risk Assessment audit. Sling Audit. Support Champions in their workplace.

27.5 Training figures

During April 2018 until March 2019 the compliance levels for training provided by the team were as follows:-

Manual Handling [level 1] remained the same end of year figure of 78%.
Manual Handling [level 2] increased by 7% with an overall compliance at the end of the year of 74%
Violence & Aggression [level 1] increased by 1% with an overall compliance at the end of the year of 95%. Violence & Aggression [level 2] decreased by 3% with an overall compliance at the end of the year of 64%.

During 2018 the following training courses were delivered by the Manual Handling Team: Orientation - The all Wales Manual Handling Passport & Information Scheme, Violence & Aggression refresher training. This is provided to BCUHB staff that have been risk assessed as needing training to include breakaway practical techniques. Mandatory training days [MTD]**,** Bank nurse training, 2 yearly workplace competencies/refresher, back to nursing students and University Students 1st and 3rd Year students

27.6 Income Generation

The Mandatory training department continues to deliver training through income generation to all student nurses attending Bangor University Student Nurse/Midwives/Occupational Therapy programmes. Income generation figure is usually around the 30k figure.

27.7 Specialist report:

Manual Handling Adviser - ergonomic assessments:

Approximately 71% of the assessments requested were related to back pain usually caused by poor posture, lack of movement and ineffective Display Screen Equipment / Work Station set up. In most cases there were alterations to the set-up of the workstation and recommended an ergonomic chair, advised on good posture and frequent movement and mobility where possible. In some more complex cases the Advisor recommended an ergonomic sit to stand desk and other ergonomic equipment, including document holders, monitor arms, speech recognition programme, foot rest and keyboards. It appears that the majority of work related back pain could be avoided if the sedentary worker was more aware of good posture and the need to get up and be active more often, an information leaflet was created and sent out via the Communications Team to all BCU employees. Consideration of the introduction of a sit to stand

desk in every office, especially for employees required to ‘Hot Desk/Agile work’ is essential and would help to prevent long term back pain and sickness absence.

Other assessments have been carried out in the workplace for more practical ‘hands on’ workers. These assessments usually affect multiple staff members normally carrying out repetitive tasks where concerns have been raised in relation to manual handling. All of these assessments have concluded in a solution being found and recommended. In some cases equipment has been sourced and purchased and in other cases a risk assessment has been put in place and the manual handling Procedure WP55 adhered to.

There have been a number of individual Return to Work/Work Place Assessments carried out which have resulted in personal reports and recommendations being made. There has been 3 staff members who have been advised that redeployment would be beneficial via Occupational Health since the risk assessment was completed. A small amount of risk assessments have been carried out in relation to manual handling of patients, mostly in their own homes and a few as inpatients. All have resulted in recommendations being made and acted upon in the best interest of patient and staff.

28. Manual Handling Manager Report

There is a Patient Handling Champions intense two day training programme to assist the ongoing improvements of Manual Handling in the workplace. On completion of the programme, the Champions gained a certificate to identify they have achieved the skills required to carry out Manual Handling Competencies for the staff in their own departments and to be a Lead in their area in manual handling. To date we have a total of 189 Champions within BCUHB. These sessions continue monthly rotating on the 3 main sites within BCUHB throughout 2018 and towards the end of 2018 a waiting list was set-up to ensure classes were maximized to the full capacity of 12 per session. Champions are also offered an annual refresher, with support offered via email, phone call or in person during planned and spontaneous visits to the hospital. Feedback from the Champions has been positive and mostly the champions have begun to make a difference within their individual departments/wards. Some have fed back that new equipment has been purchased and others a change of attitude towards better manual handling practice has been achieved.

28.1 Manual Handling Risk Assessment Audit

During the latter part of 2018 an audit of the Manual Handling Risk Assessment document took place, where a random sample of 5 patients risk assessments were assessed over different wards in the 3 main sites and included the community hospitals. A total of 47 ward areas were audited within BCUHB and only 2 areas passed without any concerns.
Summary of the findings are as follows:

- Most areas it was noted that the risk assessment forms were incorrectly completed with the essential criteria missing for example, height and weight of the patient and no narrative information on individual patient profile was documented.
- The manual handling patient care plan was not completed or updated and many areas found to have them missing from the records completely.
- During the audit, it was noted that mainly in the community hospitals they place the care plan with other documents at the end of a Patient’s bed, which is more beneficial for employees to view how to assist patients with their manual handling needs.

- Also noted, some areas are reviewing the whole risk assessment instead of just the actual review sheet and then updating the care plan if changes are made.
- Patient Specific Equipment is being issued without Patient details being added to them, along with the date of issue.
- Many areas have not completed an Environmental Risk Assessment.
- Re-auditing of these areas will take place in the first trimester of 2019 and areas that haven't shown to improve will be discussed along with the Health & Safety Teams and the Quality & Safety Committee to create an action plan.

28.2 Planning for 2019

The Manual Handling Team aim to develop further as follows:

- *Manual Handling Manager:* Maintain audit of Manual Handling including roll out of the new 'All Wales' electronic documentation that includes the Manual Handling Risk Assessment documentation.
- *Manual Handling Manager* : Develop and implement specific training following Hasscas report in relation to delivering training based upon 'PCBSP -Patient Centred Behavioural Support Plan' with the Positive Interventions Clinical Support Service, along with the continuation of The All Wales Violence & Aggression training.
- *Manual Handling Manager:* Monitor training figures of total number of staff trained by the department and the compliance for Manual Handling Level 1 & 2 and Violence & Aggression Level 1 & 2 with the roll out of the Mandatory Training implementation plan and an overarching aim of reaching the 85% national target for Mandatory Training.
- *Manual Handling Manager:* Review training presentations offered in both Level 1 & 2 Manual Handling and Violence & Aggression training.
- *Manual Handling Manager along with the Manual Handling/Violence & Aggression Training Team:* Update the Champions programme and continue with support to existing Champions throughout BCUHB.
- *Manual Handling Manager & Manual Handling Advisor:* Review ergonomic procedure and guidelines in collaboration with Occupational Health and target high risk DSE areas to reduce sickness in this area.
- *Manual Handling/Violence & Aggression Training Team:* Continue with the production and implementation of guides and documentation for all areas on safe Manual Handling practice.
- *Manual Handling/Violence & Aggression Training Team:* Continue to provide high standard training in Manual Handling and Violence & Aggression to all areas.
- *Manual Handling/Violence & Aggression Training Team:* Maintain Sling Register, Annual Risk Assessment audit.

29. Previous HSE regulatory input April 1st 2018- 31st March 2019

A visit by an HSE inspector in March 2019 identified minor contraventions with the law after a breach of COSHH regulations, this invoked a Fee for Intervention charge. An investigation was undertaken and action plan implemented. There have been no formal notices served by the HSE in the year 2018/2019.

30. Conclusion

There is a need for a systematic review of the safety management system across the Health Board. The good work previously undertaken requires consolidating and an effective management system implementing based on the HSE framework plan, do, check, act. The report does not give assurance of compliance with the law, significant gaps exist in all service areas. The cost to the organisation of not effectively managing work related violence and stress is significant in terms of human cost and sickness absence pay. It is anticipated the gap analysis being undertaken will provide a baseline to work from as the organisation further develops a positive OHS culture.

31. Recommendations

The Committee is asked to:

1. Note the position outlined in the Annual Report.
2. Support the proposed improvement plan and full review of OHS systems through a gap analysis of legislative compliance and subsequent proposed 3 year strategy.
3. Train Senior Leaders and develop further competence in the workforce at all levels.

Appendix 1. Annual Fire Safety Report

Strategic Occupational Health and Safety Group 28th June 2019	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***
Report Title:	2018/19 Annual Fire Safety Report
Report Author:	Rod Taylor – Director of Estates and Facilities
Responsible Director:	Mark Wilkinson - Executive Director of Planning and Performance
In Committee	In Committee
Purpose of Report:	The 2018/19 Annual Fire Safety Report presents the Health Board's current and proposed fire safety management arrangements including performance statistics and details of Fire Incidents. Attached to the report are copies of the current Fire Safety Policy, which was updated in January 2019, and a copy of the annual online Fire Safety Audit return to Specialist Estates Services (SESN) 19/05 for 2018-19.
Approval / Scrutiny Route Prior to Presentation:	The report has been considered at the Fire Safety Management Group and following submission to the Strategic Occupational Health and Safety Group and Executive Management Group will be included within the 2018-19 Annual Health and Safety, which will be presented to the Quality and Safety Committee.
Governance issues / risks:	There is a need to keep a clear focus on fire safety, this includes investigating the causes of fire and how they might be prevented including appropriate action to prevent reoccurrence. The more fires that occur the greater chance of a serious incident. Fires will always have the attendant disruption to health service delivery and possible legal action from the Fire and Rescue Service if it is seen that there were weaknesses in policies and procedures. Hospital evacuation strategies are developed on the principle of Progressive Horizontal Evacuation, this concept relies on compartmentation, reliable fire alarm systems and competent staff to manage the response to incidents. It is vital that processes are in place to ensure appropriate Pre Planned Maintenance (PPM) of our passive and active systems and robust training for staff. Reliability of fire alarm systems is key to provide early warning to staff, frequent UWFS can lead to disruption to service delivery. Action to reduce calls should be considered including, improved control of contractors, covering manual call points to reduce accidental and

	deliberate activations and measures to reduce activations through cooking. For the first time in over two years the department is up to full complement of staff, this will allow a re-focus of activity to ensure core business including the completion of Fire Risk Assessments is prioritised. Competency is one of the key lines of enquiry within the Hackitt review; therefore, at a local level having competent staff is a vital element of our fire safety strategy and ensuring that all staff receive the appropriate training and development commensurate with their role. It is proposed to improve the collation and analysis of statistics to allow effective performance management to ensure improved targeting of resources.
Financial Implications:	The Annual Fire Safety Report has identified both revenue and capital financial requirements to improve the current fire management and maintenance systems. These funding requirements will be taken forward for consideration as part of annual corporate budget setting process and capital planning programme for the Health Board.
Recommendation:	The Strategic Occupational Health and Safety Group is asked to note :- • The contents of the 2018/19 Annual Fire Safety Report. • To note the submission of the online Fire Safety Audit return to Specialist Estates Services (SESN) 19/05 for 2018-19. • Note the updated Policy For The Management of Fire Safety – ES04 • Note the requirements for additional resources that will be quantified and risk based through the revenue and capital planning budget-setting process. • Note the 2019/20 action plan to reduce Unwanted Fire Signals in Health Care Premises.

Health Board's Well-being Objectives *(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*		**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√

1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	**x**
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Engagement			
Equality Impact Assessment - Not Required			

BETSI CADWALADR UNIVERSITY HEALTH BOARD

2018/19 Annual Fire Safety Report

1. Introduction

Fire safety remains topical within the national media, with the Grenfell enquiry on going and the publishing of Dame Judith Hackett's report: Building a Safer Future – Independent Review of Building Regulations and Fire Safety, which suggests extending the recommendations beyond high rise to institutional buildings such as hospitals and care homes.

As Building Regulations are devolved in Wales, a Building Safety Expert Group was set up in October 2018 to discuss the key issues highlighted by her report. They published their response: A road map to safer buildings in Wales in March 2019. The report broadly supported the findings of the Hackett review with an additional recommendation to reduce the existing threshold from 18 meters to 11 meters. The Government in Wales is also supportive of the installation of sprinklers therefore it would be prudent to monitor progress on this issue.

Hospitals are not immune from fire as was demonstrated in dramatic fashion in Tamworth in February this year where a Mental Health Unit suffered severe damage from a fire started by a patient. All three of our MHU's across North Wales have experienced small fires ignited by patients over the last 12 months.

This annual report summarises the Betsi Cadwaladr University Health Board's (BCUHB's) current and proposed fire safety management arrangements.

2. Management Arrangements

The management arrangements for Fire Safety within BCUHB are contained within ES04 Policy for the management of Fire Safety. It was reviewed in January 2019 with only minor changes to include amendments to the Organisation's structure and reference to changes to relevant guidance documents. The main change to the structure is that the Executive Director of Planning and Performance is now the board level director with responsibility for fire safety.

Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 05-01) Firecode, Managing Healthcare Fire Safety. This document was amended in February 2019.

This guidance supersedes the previous edition published in 2006, the main changes include:

- Greater emphasis for keeping Fire Risk Assessments up to date.
- Although the management structures remain the same more prominence is given to local/departmental management responsibilities.
- New guidance refers to two levels of management. Enhanced and adequate which follow the principles of BS9999:2017 Fire safety in the design, management and use of buildings.
- Additional guidance on establishing 'Fire Safety Protocols' to achieve a consistent approach to fire safety aspects.
- Enhanced information for developing Training Needs Analysis.

The effectiveness and compliance to BCUHB's fire safety policy is reported to Health Board through the BCUHB's corporate governance structure, namely;

- Local area fire safety teams, East, Central and West
- Fire Safety Management Group
- Strategic Occupational Health and Safety Group
- Quality Safety and Experience Committee
- Health Board

3. NHS Wales Shared Services Partnership, - Web-based Annual Fire Audits

The SSPFS monitors the fire safety activities of all Local Health Boards in Wales through the electronic fire safety audit reporting system. LHBs are required to submit annual returns in May/June of each year.
Data submitted by BCUHB is analysed by the SSPFS and is thereafter used as the basis of their annual report to Welsh Assembly Government.

General matters raised in this 2018/19 audit report are as follow:-

- Requirement to ensure that Responsible Person and Deputy Responsible Persons are aware of, accept, and fulfil their duties and responsibilities in terms of fire safety management.

- Continue to ensure that all risk assessments are maintained up-to-date and significant findings are prioritised and addressed accordingly.

- Requirement in place to ensure accurate fire drawings are developed for all BCUHB Premises.

- Reviews their maintenance regimes for compliance with the relevant standards for fire detection, escape lighting, ventilation systems, fire dampers, fire doors and lightening conductors.

- Reducing smoking on Health Board premises.

Actions identified above are being addressed through the Hospital Management Teams, Designated Responsible Persons for fire or directly with the managers concerned. Operational Estates discretionary capital programme and statutory compliance reserve funding is being utilised to address estates related actions.

4. **NHS Wales Shared Services Partnership - Web-based Fire Safety Risk Assessments.**

Undertaking fire safety risk assessments is the primary role of the Fire Safety Advisor, each is responsible for completion and review of assessments of premises within their area. Pressure to provide support to Capital Development on new schemes over recent years especially in YGC and the department being understaffed for over 12 months due to retirements, have resulted in slippage in the completion of the risk based re-inspection programme within the requisite timeframe.

Within the reporting period, of the seven hundred and twenty three (723) assessment areas within one hundred and thirty one (131) premises contained within the system, ninety nine (99) are outside their identified review date which equates to approximately 13% of the assessments. Priority is given to ensuring clinical areas providing overnight care are completed on schedule.

Over the next twelve months an audit of the on-line system will be undertaken to cleanse the data and to remove any assessments that are no longer valid and to introduce further assessments which may be required as a result of relocation of staff or taking over the management responsibility of premises. This will then feed into a re-inspection programme which will aim to complete all outstanding assessments over the next twelve to eighteen months.

The system acts as a property asset register from a fire safety perspective which once each FRA is completed and action plan generated will together with the fire safety audits feed into the discretionary capital programme and the higher risks will be captured within a fire specific risk register which will be developed through the Datix platform.

5. **NHS Wales Shared Services Partnership – Independent Review of Fire Precautions.**

During December 2018, on behalf of the Welsh Government, NWSSP – Specialist Estates Services (NWSSP-SES) commenced an independent review of the fire precautions at Colwyn Bay Community Hospital, in accordance with the monitoring procedures outlined in Facilities Services Notification FSN12/102.

Overall the report recognised the Board’s proactive approach to fire safety management on the site. A number of recommendations were made, including:

- Enhancing the fire alarm system to support fire response procedures.

- Refine the maintenance regime in line with current British Standards.

- Means of escape provisions to be improved, especially procedures to ensure external stairways are usable in inclement weather.

- Update the ‘as installed’ fire drawings.

6. Staff Training Arrangements and Statistics

Fire safety training (provision & recording) is a statutory requirement and forms part of Mandatory Training.
The existing fire training sessions are;

- Corporate Induction/orientation.

- Workplace Fire Safety - Set dates for the year. Open to all.

- Workplace Fire Safety – On request only, delivered specifically tailored for individual directorates/ wards/departments etc. Seminars are arranged for consultants, project managers and contractors

- E - Learning – This compulsory test underpins the learning modules, and has been introduced as an E-learning module in 2014.

Fire Safety training compliance reports as at 31st March 2019 indicated that 18521 staff were eligible for training and 14941 (80%) were trained. This shows a 1% decrease in compliance over the last twelve months.

7. Fire-code Compliance Work

The primary source of funding is the Operational Estates discretionary capital and statutory compliance reserve, based on a five year investment programme. Fire safety improvements are included within major capital schemes and refurbish projects.

Following the tragic fire in Grenfell Tower, Welsh Government issued guidance to public sector bodies to undertake fire safety checks in premises within their portfolio which were either above 18 meters high or provided overnight accommodation on two stories or more.

A project to install a new fire alarm system in Llandudno Community Hospital involved conducting a void survey which has highlighted deficiencies relating to the current compartmentation within the hospital which will need to be rectified.

During the redevelopment of the Emergency Department of Ysbyty Gwynedd a deficiency with the existing compartmentation has been identified. The findings raise the question as to the adequacy of the compartmentation across the rest of the building, a survey is required as a priority to ascertain the current condition and any actions required against current WHTM standards. NWSSP-SES have indicated that Ysbyty Gwynedd will be the subject of next year’s independent review of fire safety.

Wrexham Maelor Hospital has been subject to an ongoing programme of upgrading work to the fire detection system using discretionary capital. This work has been undertaken following a letter from the Fire and Rescue Service some years ago highlighting concerns with the fire

alarm following an incident. The site currently consists of a number of different systems some of which are obsolete and replacement parts proving difficult to source. The rate which the programme is progressing is a concern as the current funding available to allocate to the scheme is limited.

Work has also taken place in community hospitals and clinics to upgrade the fire alarm systems and emergency escape lighting. This work will continue in 2019/20. Further projects are planned for community hospitals and clinics and other key sites. (Elements of firecode work within Ysbyty Glan Clwyd were captured within the redevelopment project which is nearing completion).

8. Fire and Rescue Service Audits

Enforcement of fire safety within healthcare premises is the responsibility of the Fire and Rescue Authority, within this area this undertaken by North Wales Fire and Rescue Service. In order to develop a consistent working relationship with the Fire & Rescue Services the 'Working Together in Partnership' Concordat between the Welsh Government's Department for Health and Social Services and the Chief Fire Officers' Association Wales was developed. Audits are normally undertaken based on a risk based re-inspection programme, following a fire or due to the number of Unwanted Fire Signals received.

Within the reporting period Fire Safety Enforcement Officers undertook audits at the following premises none resulting in enforcement action.

Bryn Hesketh EMI Colwyn Bay.
Holywell Community Hospital.
Deeside Hospital.
Ty Llywelyn MSU Llanfairfechan.
Llandudno Community Hospital.
Ffordd Las Health Centre, Rhyl.
Bodfan, Caernarfon.

9. Fire Service Liaison and Site Visits

The North Wales Fire & Rescue Services (NWF&RS) officers continue to visit the three district general hospitals and to a lesser extent the community hospitals, across BCUHB on familiarisation visits.

10. Fire Incidents

There have been a total of seven (7) fire incidents reported to the fire safety team over the reporting period 2018/2019. The majority of incidents involved the attendance of the North Wales Fire and Rescue Service. This figure is significantly less than 2017/2018 during which we had a total of nineteen (19) fire incidents. (63% reduction)

Four (4) of the fires were attributed to electrical defects, although PPM's had been undertaken on applicable items within the appropriate timeframes. The three (3) other fires were caused through deliberate ignition by patients within Mental Health Units.

Electrical defects accounted for the largest number of recorded fires (57%) followed by deliberate ignition (43%), this is consistent with the two top identified causes of fires in healthcare premises across Wales according to the Annual Fire Statistics Report 2018 for the NHS Estate in Wales.

Table detailing Recorded Fire Incidents in 2018/19

Date	Location	Cause
24/04/2018	Fforddlas Health Centre, Rhyl	Small fire in cupboard confined to telecommunications cables.
15/06/2018	Plant room between Pediatrics and Tŷ Croeso. Ysbyty Glan Clwyd.	**The fire was confined to an electrical fan within the ducting located within the plant room.**
11/08/2018	Ablett Unit, Ysbyty Glan Clwyd	A small fire occurred in a bedroom on Dinas Ward, a patient ignited a pillow using a cigarette lighter. The fire was spotted quickly by a member of staff who used a fire extinguisher to tackle the fire which was confined to the pillow.
22/11/2018	Plant room 5.9 located on roof of Ysbyty Gwynedd	Fire confined to an electric motor within the plant room which was part of an extraction system for a cutting table in the Pathology lab. The fire was tackled by a member of the estates staff using a fire extinguisher.
27/11/2018	Ablett Unit, Ysbyty Glan Clwyd.	A fire occurred in a bedroom on Dinas Ward, the fire was discovered by the fire alarm system, and the fire was confined to bedding and the mattress. A member of staff tackled the fire with a fire extinguisher. There was no patient in the room at the time. The cause of the fire was determined as deliberate ignition.
21/01/2019	Hergest Unit, Ysbyty Gwynedd	A small fire occurred in the local kitchen on Cynan Ward, it was discovered by a member of staff who noticed that a number of polystyrene bowls left on the worktop were smoldering. They were quickly extinguished using a bowl of water. A patient admitted to igniting the fire with a cigarette lighter.
28/02/2019	Ysbyty Glan Clwyd	A small fire occurred in a wall mounted fan unit located within the Theatres area. Damage was confined to the unit and the theatre was not in use at the time of the fire.

11. Unwanted Fire Signals

The total number of unwanted fire signals reported during 2018/2019 was three hundred and eighty three (383) compared to four hundred and eighteen (418) in 2017/18 a decrease of thirty five (35). (8% decrease). However it is slightly over the five year average of three hundered and seventy one (371)

The decrease in the number of fire alarm activations in 2018/2019 have occured across a number of sites, including a decrease of twenty seven (27) at Ysbyty Maelor Wrexham a 24% reduction, 15 (15) less within the staff residences at Ysbyty Glan Clwyd a 22% decrease.

Staff residences account for 37% of all unwanted fire signals recieved across BCUHB sites with the vast majority of these can be attributed to cooking fumes.

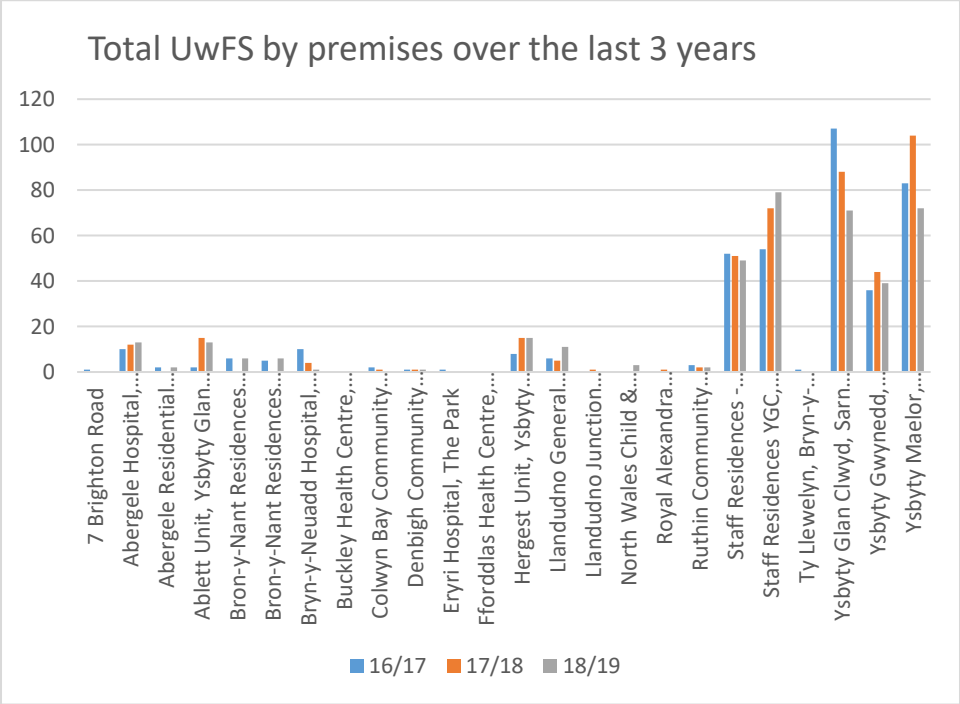
Cooking accounted for the largest number fire alarm activations (34%) followed by system faults (19%) and other environmental effect (12%), this is consistent with the top three (3) identified causes of UwFS according to the Annual Fire Statistics Report 2018 for the NHS Estate in Wales although other environmental effect is the top cause in healthcare premises across Wales (19%) followed by cooking (18%) and system fault (16%).

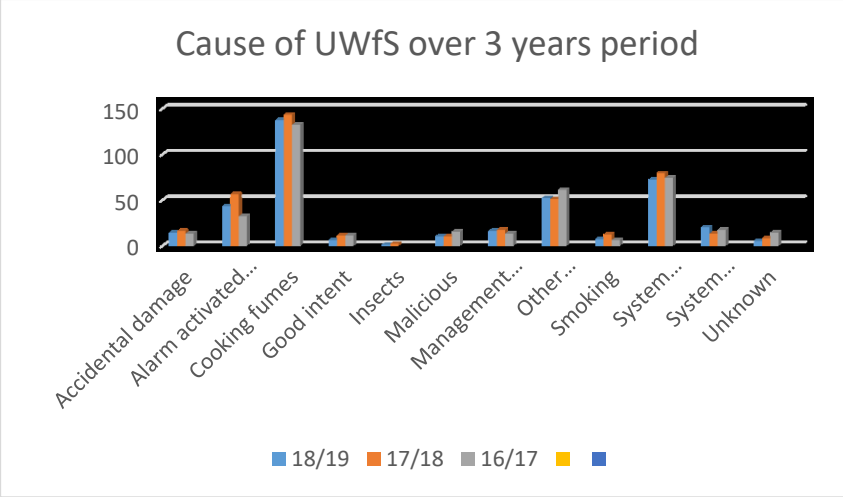
UwFS by premises over the last three years

	18/19	**17/18**	**16/17**
Abergele Hospital	13	12	10
Abergele Residential Homes	2		2
Ablett Unit	15	15	2
Bron-y-Nant Residences 1 - 30	6		6
Bron-y-Nant Residences 31 +	6		5
Bryn-y-Neuadd Hospital	1	4	10
Hergest Unit	16	15	8
Llandudno CH	11	5	6
Ruthin Community Hospital	2	2	3
Staff Residences - Ysbyty Gwynedd	49	51	52
Staff Residences YGC	79	72	54
Ysbyty Glan Clwyd	73	88	107
Ysbyty Gwynedd	40	44	36
Ysbyty Maelor	72	104	83
Others	3	5	4
Totals	**383**	**418**	**388**

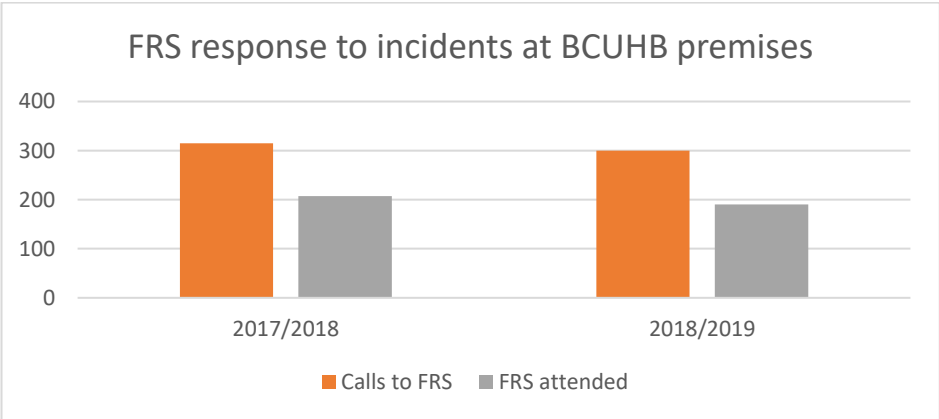
UwFS by cause over the last three years.

	18/19	17/18	16/17
Accidental damage	14	16	13
Alarm activated by patient or public	43	56	32
Cooking fumes	137	143	132
Good intent	6	11	11
Insects	1	2	
Malicious	10	10	15
Management procedures not complied with	16	17	13
Other environmental effect	52	51	61
Smoking	7	12	6
System fault/design	72	79	74
System procedures not complied with	20	13	17
Unknown	5	8	14
Totals	**383**	**418**	**388**





North Wales Fire & Rescue Service share data on a regular basis, according to their data that they received three hundred (300) calls and attended one hundred and ninety incidents (190) at BCUHB sites over this reporting period compared to three hundred and fifteen (315) calls and attending one hundred and seventy eight (108) incidents across the BCUHB during 2017/18. The difference between the call numbers and attendance is due to our switchboard operators informing them that the fire alarm signal has been investigated and FRS assistance is not required.



The FRS have raised concerns over the number of Unwanted Fire Signals they attend in Healthcare premises. In South Wales they have amended their attendance at such premises due to the perceived excessive levels of calls, therefore we will need to evidence how we intend to reduce the calls in the future. The Annual Fire Statistics Report 2018 for the NHS Estate in Wales also supports the reduction of calls in accordance with WHTM 05-03 Part H: Reducing false alarms in healthcare premises.

Target premises identified in the report:

Ysbyty Maelor Wrexham	40% reduction
Ysbyty Glan Clwyd	40% reduction
Hergest Unit	40% reduction
Ysbyty Gwynedd	10% reduction
Ruthin Hospital	10% reduction

12. Conclusion

There is a need to keep a clear focus on fire safety, this includes investigating the causes of fire and how they might be prevented including appropriate action to prevent reoccurrence. The more fires that occur the greater chance of a serious incident. Fires will always have the attendant disruption to health service delivery and possible legal action from the FRS if it is seen that there were weaknesses in policies and procedures.

Hospital evacuation strategies are developed on the principle of Progressive Horizontal Evacuation, this concept relies on compartmentation, reliable fire alarm systems and competent staff to manage the response to incidents. It is vital that processes are in place to ensure appropriate Pre Planned Maintenance (PPM) of our passive and active systems and robust training for staff.

Reliability of fire alarm systems is key to provide early warning to staff, frequent UWFS can lead to disruption to service delivery. Action to reduce calls should be considered including, improved control of contractors, covering manual call points to reduce accidental and deliberate activations and measures to reduce activations through cooking.

For the first time in over two years the department is up to full complement of staff, this will allow a re-focus of activity to ensure core business, including the completion of Fire Risk Assessments is prioritised. Competency is one of the key lines of enquiry within the Hackitt review, therefore at a local level having competent staff is a vital element of our fire safety strategy and ensuring that all staff receive the appropriate training and development commensurate with their role. It is proposed to improve the collation and analysis of statistics to allow effective performance management to ensure improved targeting of resources.

Appendix 2: Sustainability Report

Sustainability Report 2018-19

BCUHB provides a range of high quality services both in primary and secondary care. The Health Board is the largest LHB in Wales, covering almost a third of the country's landmass. The services are delivered in a variety of campus' ranging from acute district general hospitals to community clinics and home visits by clinicians. By the nature of the services we provide it means we have an environmental impact which must be carefully managed to avoid significant financial and environmental consequence.

BCUHB is an integral part of the NHS Wales family and as the population of Wales grows, challenges like carbon reduction, waste reduction and securing products and resources from a sustainable source all impact on the day to day service delivery; however we strive to ensure that impact is reduced to as far as reasonably practicable.

The BCUHB portfolio across North Wales consists of 3 main acute general hospitals located at Bangor, Glan Clwyd - St Asaph and Wrexham. Complimenting this there are 18 community hospitals and over 70+ community clinics and other small (owned or leased) satellite buildings or rooms giving the total property portfolio in excess of 90+ properties.

East Community Hosp = 5
West Community Hosp = 8
Central Community Hosp = 5

East Other properties = 24+
West Other Properties = 20
Central Other Properties = 19

As part of our corporate commitment towards reducing these effects we maintain a formal Environmental Management System (EMS) designed to achieve the following:

- Sustainable development;
- Compliance with relevant legal and government requirements;
- Prevention of pollution;
- Mitigation against the impact of climate change;
- A culture of continuous improvement.

Effective environmental management is achieved through:

- Promotion of the environmental policy to all relevant stakeholders;
- Identification of all significant environmental aspects and associated legal requirements, including those resulting from service change and new legislation;
- Establishing and monitoring objectives and targets aimed at reducing environmental and financial impacts, in line with those issued by the Welsh Government;
- Provision of appropriate training to all relevant personnel;
- Regular internal and external audits;
- Regular review of the effectiveness of the EMS by the Environmental Steering Group;
- Working with local, regional and national partners to achieve a consistent public sector approach to environmental management and ensure best practice procedures are identified and implemented.

Our performance is measured using a number of tools and through our involvement with a number of partnership bodies:

- BS EN ISO 14001 2015 Environmental Management System;
- Carbon Reduction Commitment Annual Reporting;
- Annual Energy and Facilities Performance Monitoring System;
- Welsh Health Estates Environmental Forum;
- NHS Wales Shared Services Partnership-Facilities Services;
- In-house, real-time utility consumption monitoring systems.

These arrangements ensure that effective environmental management is conducted to current best practice standards and that continuous improvement is embedded in the culture of the organisation.

The current Corporate Carbon Reduction Performance Target is a 3% year on year reduction in CO_2 emissions as required by the Welsh Government's Climate Change Strategy Delivery Plan for Emissions Reduction.

BCUHB Environmental Commitment

The Health Board has a number of environmental aspects, which if not carefully managed and controlled would have significant financial and environmental impacts. As part of a corporate commitment to reducing these impacts, the Health Board has implemented and maintains a formal Environmental Management System (EMS), which is designed to achieve the following key principles:

- Sustainable Development
- Protection of the Environment
- Fulfilment of Compliance Obligations
- Prevention of Pollution
- Continual improvement of the EMS to enhance environmental performance

Effective environmental management will be achieved through the following processes:

- Promotion of the environmental policy to all relevant stake holders and interested parties
- Identification of all significant environmental aspects and associated compliance obligations, including those resulting from legislation changes.
- Implementation of suitable and sufficient control procedures, covering normal, abnormal and emergency operating conditions.
- Establishing and monitoring key corporate objectives and targets, aimed at reducing environmental and financial impacts, in line with those specified by the Welsh Government.
- Provision of appropriate training to all relevant staff
- Regular planned internal audits
- Regular review of the effectiveness of the EMS by an Environmental Steering Group, chaired by a member of the Board.

BCUHB ISO14001 Environmental Management System

The ISO 14001:2015 standard has now been implemented and embedded throughout BCUHB certification was achieved April 2018. The ISO14001 EMS has proven to make BCUHB more aware of their environmental responsibilities that have a significant impact on the environment, including legal and regulatory accountabilities, and enables associated risks to be managed more efficiently.

The Environment Officers have successfully completed Lead Auditor transitions training, and are now certified to IRCA/CQI.
Members of the Environmental Management Steering Group have engaged in implementing the 2015 version of the standard by highlighting:-

- The key changes, the changes service providers need to make
- Top Management's commitment and involvement in the EMS
- Compliance with the Environmental Policy
- Needs and Expectations of interested parties
- External and Internal Issues, compliance obligations and significant aspects
- What each section of the standard means to their service/department
- Performance, evaluation and monitoring

ISO14001:2015 Environmental Management System

ISO14001:2015 provides a framework to protect the environment and respond to changing environmental conditions in balance with socio-economic needs. ISO14001:2015 helps to achieve the intended outcomes of its EMS, which provide value for the environment, BCUHB itself and interested parties. Consistent with BCUHB's Environmental Policy, the intended outcomes of the EMS includes:-

- Enhancement of environmental performance
- Fulfilment of compliance obligations
- Achievement of environmental objectives

The assessment evidenced the cornerstones of the system are in place, i.e. Corporate and site specific Aspects and Impacts, Objectives & Targets Environmental Programmes in place across the sites. The Internal Audit Programme is on target and internal audits are being carried out effectively. Non –conformance process is effective and works efficiently.
One minor non-conformity is still outstanding from the previous assessment see below:-

Outstanding Minor Non Conformity 27th & 28th November 2017

Site	Minor Non Conformity	Root Course	Corrective Action	To Be Completed By	Target Date	Status
Corporate	The organisation does not ensure all parties working for it or on its behalf are fully aware of the environmental policy, aspects and impacts	Environmental Training is not mandatory.	Environmental Training to be mandatory and a new bespoke e-learning is being designed	Environmental Officers	April 1st 2019	Approved awaiting from WOD

The Following table shows the schedule of ISO14001 audits that took place in 2018:-

COMMUNITY SITES – 5 SITES OVER 3 DAYS		
Address	**Date**	**Duration of Visit**
Cefni Hospital	11 June 2018	0.5 days
Eryri Hospital	11 June 2018	0.5 days
Holywell Hospital	28 June 2018	0.5 days
Denbigh Hospital	28 June 2018	0.5 days
Penley Hospital	29 June 2018	0.5 days
Report Write up	29 June 2018	0.5 days

CLINICS – 4 SITES OVER 2 DAYS		
Address	**Date**	**Duration of Visit**
New Flint Health and Wellbeing Clinic	03 October 2018	0.5 days
Rhosllanerchrugog Clinic	03 October 2018	0.5 days
Corwen Clinic	04 October 2018	0.5 days
Blaenau Day Hospital – whole building	04 October 2018	0.5 days

Corporate Day		
Health Board Corporate Day (Iso 14001) Wrexham Maelor Hospital	19 November 2018	1 day

There were no new minor non conformities were raised during the surveillance audits April 2018 -March 2019.

Corporate Environmental Objectives Programme

Objectives and Targets are part of a 3 year programme in line with the EMS, they are agreed with the Environmental Steering Group , reported and updated every meeting then at the end of the 3 year programme they are concluded and reported on.

The three year Environmental Objectives programme is now concluded and progress and results detailed below:-

- Minimise waste associated with activities and influence supply chain to reduce waste to landfill

  100% of blue bin confidential waste is recycled, steps have been taken to introduce more environmental friendly cardboard and clinical waste boxes.

- Natural Resources - to operate and procure in an environmentally responsible manner

  A Sustainability Risk Assessment (SRA) is completed on any procurements above £25,000

- Ethical and corporate social responsibility - to use products certified as ethically sourced

  NWSSP has appointed an Anti-Slavery and Ethical Employment Champion, a Sustainability Risk Assessment (SRA) is completed on any procurement above £25,000

- Reduce CO2 emissions by upgrading boilers, controls and building fabric.

  Capital investment needs to be secured to fund projects moving forward.

- Raise Energy Awareness

  Non to date other general awareness given by Estates

- Prohibit the disposal of food waste to sewer by end of 2017

  All DGH's and some community sites are recycling their food with either the Local Authority or a private contractor, regulations have been deferred.

- Raise awareness of environmental & waste information and topics

  Environmental & Waste Training & Awareness ongoing

- Identify and create a biodiversity area

  3 Beehives have been sponsored for the Health Board, Habitat areas identified in YGC

- Introduce segregation of Gypsum waste for incineration

  Steriycle new contract 1st April 2017 gypsum waste is now being segregated and collected by Stericycle.

- Keep air borne asbestos fibres at safe levels

  Asbestos Management Plan in place.

- Monitor transport related CO2 emissions

  Monitoring data entire fleet – staff, grey and pool cars.

- Reduce the risk of oil pollution by upgrading tanks and bunds by local controls and procedures

  Central – All oil storage areas maintained, Corwen Clinic oil tank removed.

  East – All oil storage and bunds are maintained by Operational Estates Officers

  West – All 23 oil storage tanks and bunds are categorised as red, amber or green. They are monitored and maintained by Estates and replaced as and when funding becomes available.

- Protect staff and patients from Radon, maintaining levels below 400Bq/m2 for work places and 200Bq/m2 in staff residences

  Radon monitoring was undertaken December 2017, results have now been received and a report written by RPA, winter 2018 monitoring commenced Results expected spring 2019.

- Eliminate the risk of ozone depleting and other damaging greenhouse gases

  Central – F Gas Register on going due to YGC Redevelopment

East – F Gas Register is managed by Engineering Estates Officers, maintenance is carried out by external contractor.

West – F Gas Register maintained by nominated Estates Officers. All R22 units have been replaced. R404a is now in process of being replaced for a more energy efficient gas as and when required.

- Water Safety Management - Reduce the risk of contaminated aerosols

  Central, East & West reducing the risk of contaminated aerosols by assessments and annual review.

Waste

The Health Board continues to work in partnership with Seven Ways Environmental Services as its recyclable/domestic (clear Bag) waste contractor to improve waste management within the Health Board and reduce its impacts on the environment, by diverting as much waste as possible from landfill.

Recycling rate for the Health Board is approximately 97%, it is anticipated that recycling will continue to increase following measures that have been implemented to improve waste segregation.

In conjunction with Safe Clean Care Campaign to continually improve patient safety and reduce infections; Spring Clean Events and Autumn Cleans took place April 2018, October 2018 , during which furniture, electrical and metal waste were collected from 45 sites across the Health Board.

The All Wales Clinical Waste Contract for the collection, transportation and disposal of Clinical Waste commenced on 1st April 2017. The Health Board now benefits as Stericycle have developed a commercially viable use for the end product of orange bag clinical waste treatment processes (flock) which is used as a fuel sources and is shipped to Norway/Sweden and used as an additive to bind cement. This means that the Health Boards' alternative heat treated clinical waste is 100% recycled. Incinerated clinical waste is also 100% recycled into energy which will result in further improvements to our waste reuse/recycling figures.

However the All Wales Clinical Waste Contract collection service has been problematic with nil or missed collections from various sites across North Wales, BCUHB is working with Stericycle to improve collections and contingency plans.

In addition the Health Board recycles cardboard, scrap metal, electrical equipment, furniture, plastics, batteries, confidential waste, food waste, toner cartridges and fluorescent lamps. For the financial year April 2018-March 2019 landfill across the Health Board has reduced by 46%, incineration waste is 100% recyclable and recycling has increased by an additional 5%.

Plastic Free Discussion Group

The Health Board recycles more than 90% of general waste through a Materials Recovery Facility but more can be done to reduce the amount of plastic waste that is being produced. The Environment Team has set up a "Plastic Free Discussion Group" to generate ideas and look at ways in which plastic can be reduced across the board. Initial ideas include alternatives to:

- Plastic cups at water dispensers
- Plastic straws
- Wipes that contain plastic
- Disposable plastic catering cups and food containers
- Plastic tablet/medication cups

White Goods Guide

In an effort to reduce the amount of electrical waste being moved around the hospital sites and deposited in the waste yards, the Environment Officers have worked closely with Procurement colleagues to redevelop the White Goods Guide, the guide now instructs staff placing an order for a new fridge that they also have to include the removal of the old appliance by the supplier, if this is process is not followed the order will not be processed.

Public Service Boards

BCUHB has representatives on all Public Service Boards in North Wales:-
Conwy & Denbighshire PSB – supporting environmental resilience, working in partnership to develop environmental resilience in our communities, preparing for adapting to local climate changes in the future e.g. flooding and reducing our carbon and ecological footprint.
Flintshire PSB – main priority are developing greater access opportunities to green infrastructure, protecting and enhancing the environment, improving flood protection and reducing the impacts of climate change.
Gwynedd and Anglesey PSB – working together locally to mitigate the effects of climate change in our communities,
Wrexham PSB – Committed to focus on cross-cutting issues of poverty, equality, Welsh language and climate change. Programme groups and partners will be responsible for embedding climate change within their work.

Environmental & Waste Training

The Environment team has reviewed and revised the All Wales e-training package for waste and environmental management. ISO 14001:2015 Standard places more emphasis on training and competency of any persons that can have an impact on the Environmental Management System. A bespoke mandatory training module will demonstrate the Health Board's commitment to Environmental Management as well as the Standard's training, awareness and competency requirements. The Health Board has approved the bespoke E-Learning package and will become mandatory for all BCUHB staff.
The Environment Officers have attended ISO14001:2015 Transition Training and are certified CQI and IRCA Lead Auditors.

Biodiversity and Natural Environment

Health Board sites cover a huge area of land which impacts on biodiversity. Any site development has a detrimental effect on wildlife and its habitat. Consequently our impact on biodiversity is identified as one of our environmental aspects. BCUHB decided to focus on this as an improvement objective to identify and create biodiversity areas.
Three beehives continue to be sponsored on behalf of the Health Board by Seven Ways Environmental Services BCUHB principle waste contractor through the National Beekeeping Centre, Wales. The Beehives are homed at the National Beekeeping Centre Wales, Conwy.

Ysbyty Glan Clwyd site has two Great Crested Newt ponds, a lagoon, two additional ponds, meadow spaces and an abundance of natural habitat for various species of living organisms creating a whole ecosystem and natural pollination, but all very overgrown and not managed. Therefore Ysbyty Glan Clwyd has developed a Biodiversity Plan for the Newt Ponds and lagoons and meadow spaces on site to:-

- Protect the environment and fulfil compliance obligations and relevant legislation
- Responsibly maintain and restore the Great Crested Newt ponds without destroying their natural habitat and surrounding area
- Not increase the number of people, traffic or pollutants in the area
- Avoid harming the great crested newts, damaging or blocking access to their habitats
- Allow more pollinators by managing and developing the natural habitat better

Year 1 of the Biodiversity Plan has been incorporated into the Grounds Contract. The photographs show designated biodiversity areas, before in July 2018 and after, in September 2018

BEFORE **AFTER**

Aims of BCUHB

- To protect the Great Crested Newts and their habitats in line with legislation
- Biodiversity areas to be managed for the benefit of wildlife and compliant with legislation
- Helping conserve the biodiversity at Ysbyty Glan Clwyd Hospital and surrounding area.
- Contribute to the biodiversity conservation in Wales and the UK.
- To promote biodiversity through simple and practical actions and solutions.
- Grassland areas to be managed as a ‘meadow’ allowing grass to grow long in the spring and summer, then cut after the flowers have set seed in late summer.

Energy & Carbon management

2018-19 Energy & carbon management
The Health Board has achieved Corporate Health Standard Platinum award, and evidence of the incorporation of sustainable technology within our estates projects has been part of the submission.

The Health Board is currently undertaking various feasibility studies for Energy and Carbon Management incentives. It has worked with Colleagues at the Welsh Government and Energy Service and their partners the Carbon Trust to promote and encourage sustainable initiatives in the public sector in undertaking property surveys across North Wales for potential LED lighting savings both schemes as invest to save schemes and a quick wins via a “ready reckoner” conversion table.

A detailed specification has been written for the procurement of goods and services as part of the “invest to save” schemes for low-energy LED lighting.
This incorporates seventeen schemes in both community and acute hospitals, subject to tendering cost and approval of the funding application work is expected to commence in 2019.

Carbon reduction schemes are mainly dependent upon resource allocation from the annual Discretionary Capital Programme and Major Capital Development Schemes. Schemes that achieved carbon savings during 2018 were:

- At the Elms in Wrexham lights were replaced with LED fittings, 30year old boilers were replaced with new A rated ones, un-insulated brick walls were insulated, the roof has thermally insulation installed and all single glazed windows were replaced with double glazed hardwood frames to a total cost of £2.178M, expected completion is May 2019.
- Broughton clinic replacement oil boiler.
- Children’s Ward boiler replacement @Wrexham Maelor due to being obsolete
- BMS energy controller upgrade @Wrexham Maelor Children’s ward
- BMS energy controller upgrade @Chirk Hospital
- Pwll Glas @Mold Window replacement to increase energy efficiency
- Child Health centre @Wrexham Maelor – replacement of some single glazed windows to double glazed units.
- Partial roof cladding @Cath Glad House in Mancott to improve insulation.
- Boiler and hot water replacement at the Ablett unit @YGC
- Replacement boilers and pumps on Oncology unit @YGC
- Street lighting upgrade to LED lights @Ruthin, Denbigh and YGC Hospitals.
- Upgrade of some heating systems @Colwyn Bay Hospital
- Upgrade of Hot water Boiler in Glan Traeth Ward @RAH
- CHP Investment and upgrade @YGC in order to increase running hours and plant reliability.
- Replacement hot well tanks @YG with addition better insulation.
- Replacement of catering equipment @Penrhos Stanley and Eryri and Llandudno Hospital for better efficiency and reliability.

The refurbishment of Glan Clwyd Hospital has been completed. Although energy technology improvements are incorporated in the design, overall carbon savings in the upgraded facilities may be offset by the increased area footprint and installation of additional electrical consumers required for clinical treatment and patient comfort.

New facilities added to the estate during 2018/19 were:

- New Modular Theatres at Wrexham Maelor Hospital.
- Extension to ED at Ysbyty Bangor
- Medical records building extension @ Ysbyty Bangor
- New Endoscopy suite incorporating air con @Ysbyty Bangor – this is a decontamination suite so has many services (air con etc)
- Hafan Ion @Pwllheli
- Replacement roof covering @Llandudno x-ray department with improved insulation .

Rationalisation to corporate assets has continued with disposals during 2018/19 including the following sites which have been vacated :-

- Caergwle Clinic
- Ala road clinic @Pwllheli

As mentioned in previous years in addition to the general management arrangements for monitoring and, where possible, reducing energy consumption, the Health Board participates in a number of national programmes that link in to the UK energy strategy. We still participate and are involved with activities aimed at reducing the electrical intake to a minimum at one of our major sites at peak times of demand on the UK electrical infrastructure. We are fortunate that at Ysbyty Bangor we can use the site's emergency generators running in parallel with the national grid supply so that there is no risk to the electrical supplies on the hospital site whilst this activity is ongoing. This activity is supported by the Welsh Government and for participating in this activity, BCUHB receives a financial benefit.

The same electrical generating systems in Ysbyty Bangor are also used by the Health Board to participate in the National Grid's Short Term Operating Reserve (STOR) programme. The Health Board partners with a UK "Aggregator" who then operate a "virtual power station" by using the collective generation capacity of a number of their partners. This collective generation capacity is called upon at peak times of demand on the UK's National Grid when spare national generating capacity is at a low level, which has in part been caused by the closure of less efficient and more polluting power stations, many of which were coal fired. The Health Board receives a financial benefit for participating in this programme. In addition, it allows the generator to be run on full load regularly, which ensures it is well tested for immediate start up when required. Generators that are not tested frequently are more likely to fail in an emergency situation, so this activity improves its reliability and state of readiness.

We are also investigating opportunities at a number of our sites for small and medium scale solar photovoltaic arrays which may bring benefits to the organisation including a further reduction in the production of CO_2.

The Health Board has also initiated a feasibility study in the use of alternative technologies. This alternative technology is in the form of Geo-thermal Ground Source heat / cooling pumps at one of it main acute hospital campus'. This basically uses the "earth" as a storage battery. As excessive heat is removed from air conditioning this is stored in the body of the earth at depths of 200+ metres, when "heating" is required this stored energy is recovered from the earth and re-used as a source of initial primary heat before being topped up by further processes. This process can also be reversed so that "cold" can be stored in a separate location and again processed by further processes when the need arises.

The Health Board at one of its community hospitals some time ago as part of a new build initiative has a Biomass (woodchip) boiler installed. Although the purchase of wood chips is generally by weight and then the boiler burns the fuel for heating and hot water generation, BCUHB took the initiative to purchase woodchips by the quality and quantity of the heat produced. In other words that if the fuel was of poor quality then the burn to energy ratio would be poor and hence the payment to the fuel provider would be low; therefore there in an incentive to the fuel provider to provide high quality wood burning chips. This Biomass plant does not continuously run all year round, it runs seasonally October to May to pick up heat load so to allow the biomass boiler to run efficiently, it also does allow flexibility for the community hospital to have an alternative fuel source should the need arise.

BCUHB has recently been asked also to participate in an all-Wales Biomass fuel tendering process to achieve greater potential savings on bulk purchasing.

Comments on Gas Reporting
A rolling program continues for the installation of smart gas meters on BCUHB properties where they currently don't exist. This is being facilitated by the gas service provider British Gas Business (BGB) along with their installation company. The benefit to this is that meter readings are directly sent to the data collector for utility bill creation although BCUHB still undertakes direct local readings regularly as outlined below. Small gas meters generally only have one reading as their consumption is less susceptible to environmental conditions, however large gas meters normally have "correctors" fitted, this allows for local variation of gas temperature so to produce a more accurate consumption reading.

Comments on Electricity Reporting
A rolling program continues for the installation of smart electricity meters on BCUHB properties where they currently don't exist. This is being facilitated by of gas service provider British Gas Business (BGB) along with their installation company. The benefit to this is that meter readings are directly sent to the data collector for utility bill creation although BCUHB still undertakes direct local readings regularly as outlined below. Unlike gas meters electricity is un-affected by temperature, however electricity consumption can vary depends on the type of tariff the property is contracted to. A typical non – domestic electric meter can have a "day and night" tariff or in the case large premises' 3phase supplies with multiple tariffs being applied.

Gas, Electricity, Water and Oil Consumption
Each property as far a practicable is visited on a monthly basis and Estates staff records the gas, electricity, water and where applicable oil consumptions. There are some issues in relation to obtaining meter readings in a timely manner from each property and access is not always possible, however we always strive to achieve this consistent approach. Some sites have remote telemetry that automatically sends the meter reading to the data collector and on to the utility supply company, while this reduces the need to visit sites by the data collector in person, our checks and balances internal processes requires us to verify the "automatically" gathered data against an actual manual reading to ensure validity.
Further checks are undertaken on property utility consumptions at the point of utility bill payment to ensure there are no substantial "excessive" over usage / miss readings of meter data and or potential leaks regarding water or oil.
Should an over consumption be detected then the Estates teams will investigate the property for potential problems.

Unfortunately during this last year we sustained a significant water leak @WMH and a less significant leak @Llandudno Hospitals. Like any water leak that is subsurface detecting and locating can take some resources and time to find, they have since been located and remedial work carried out to fix.

The Estates Business Support unit is exploring the possibilities of a complete energy management software package that will collate supplier meter reading and self read data and provide analysis of consumptions and usage trends. It will hopefully also provide an external data feed into the payment system to pay the utility invoices after checks and balances validation.

2018-19

BCUHB is part of an all Wales NHS energy group (in which all NHS Wales health boards are represented) that purchases gas and electric in advance at more favourable costs per KWH than the “day ahead” price which most users pay. The price of the commodity is influenced by the supply and demand of the global oil economy which in turn is influenced by global pressures like an oil producing country civil war / Opec oil production / production and manufacturing outputs / seasonal weather influences (beast from the east) / UK and Europe gas / oil storage levels or the status of the intercontinental energy connectors.
While the commodity is only about 60% of the overall energy bill (the rest is made up of transportation charges, metering costs, climate change levy etc) the NHS Wales energy group gathers all this information and makes decisions when the best time is to buy the commodity in advance; thereby hopefully reducing the risk factors of global and seasonal supply and demand pressures which does affect market prices.

While there has been a reduction in gross Co2 tonnage compared with 2017-18. The annual expenditure has increased although the during the winter months it was generally milder. While the cost of the energy utility commodity (the product) continue to increase the NHS Wales purchasing group strives to get the best price at the best time for all Health Boards.

Water Management
BCUHB in partnership with Welsh Water attained access to the Welsh Water “Water core” national network of commercial water meter telemetry.
There are currently 5 sites across the BCUHB patch that we as users can monitor remotely the water consumption on 2minute basis at the following premises:-

1. Ysbuty Gwynedd - Bangor
2. Abergele Hospital - Abergele
3. Llandudno Hospital - Llandudno
4. Bryn y Neuadd Hospital - Llanfairfechan
5. Glan Clwyd Hospital – St Asaph

The benefits of this is that any excess consumption can be quickly detected which may arise from a faulty process or system or a potential water leak, so the potential impact can be addressed sooner rather than later.
Further BCU properties will hopefully identified to have similar smart water meters in the near future.

Transport
The Health Board’s Travel and associated carbon emissions continues to be monitored, and reported to Welsh Government. This includes business travel by staff in their own cars and Health Board fleet vehicles, and also mileage from the transportation of eligible patients to and from hospital. Overall business miles for the Health Board decreased slightly in 2018-19 to 15.158M miles, with initiatives ongoing to reduce this further including a review of grey fleet, lease and pool car usage, and the promotion of alternatives to travel.

The Health Board continues to work closely with the Welsh Ambulance Service, as we move towards the novation (new contract arrangements) to a new national Non-Emergency Patient Transport Specification. All ad-hoc patient transport requests continue to be channeled via a single conduit, ensuring safe and governed travel by approved transport providers.

The Health Board is working with NHS Wales Shared Service Partnership to transfer in-house courier services to the NHS Health Courier Services. This partnership will generate efficiencies whilst supporting improved continuity and resilience of the service.

	2017-18		2018-19	
	Tonnes CO2	Miles/Litres	Tonnes CO2	Miles/Litres
Private-Use Lease Cars	599	2,590,257	638	2,760,038
Grey Fleet	1,725	7,463,640	1,662	7,190,738
BUO Cars & Vans	1,297	5,278,560	1,277	5,207,685
Total	**3,620**	**15,332,457**	**3,576**	**15,158,461**

Summary of performance
The 2018-2019 data comparison provided in the Summary of Performance table is compiled from data received to 2018/19 year end.

Greenhouse Gas Emissions		**2016/17**	***Change from previous year***	**2017/18**	***Change from previous year***	**2018/19**	***Change from previous year***
Non-Financial Indicators (tonnes of CO_2)	Total Gross Emissions	39,334	*-10.1%*	39,448	*0.3%*	*39,555.29*	0.27%
	Total Net Emissions	39,334	*-10.1%*	39448	*0.3%*	*39,555.29*	*0.27%*
	Gross Emissions Scope 1* (Direct) Gas & Oil	20,764	*-7.6%*	21,298	*2.6%*	*25731.42*	*20.82%*
	Gross Emissions Scope 2 & 3** (Indirect)	18,570	*-12.8%*	18,150	*-2.3%*	*13,823.87*	*-23.8%*
Related Energy Consumption (tonnes of CO_2)	Electricity : Non-Renewable	0		0			
	Electricity : Renewable "Green" Supply Contract	18,570	*-12.8%*	18,150	*-2.3%*	*13,823.87*	*-23.8%*
	Gas	20,358	*-8.0%*	20,022	*-1.7%*	*22,155.42*	*10.6%*
	LPG	0		0		*0*	
	Other - Oil	406	*16.7%*	***1276	*214%*	****3576*	*180.25%*
Financial Indicators (£)	Expenditure on Energy	8,437,285	*-4.3%*	8,667,513	*2.7%*	*9,876,460*	*13.9%*
	CRC Licence Expenditure (2010 Onwards)	120		120		120	120

	Expenditure on Accredited Offsets (e.g. GCOF)	0		0		*0*	*0*
	Expenditure on Business Travel	8,823,883	*4.1%*	8,769,017	*-0.6%*	9,512,021	8.5%

Synopsis on Energy trends

Over the past several years there have been some major site developments at YGC and new builds at WMH and YG. While capital investments and technological advancements will improve the consumption of energy and water, the modern clinical environment is somewhat different from past installations. A typical clinical area may now include zone space heating, specialised lighting and zone air conditioning units in order to maintain critical temperatures and or air quality with frequent air changes per hour. Alarm systems which include nurse / patient / security and gas monitoring (from a building prospective) all require a power source and the higher rates of air change results in higher levels of energy being consumed to heat it. Of course there are many other patient related medical systems that also require electrical power hence why electrical consumption is at a premium. Many complex hospital sites that offer a wide range of specialist services have increased in size in the services that they offer on a particular campus'; this coupled with the increase in core operating hours in some instances will obviously impact on utility consumption.

There has been a reduction of 0.27% in gross volume of Co2 produced compared with the previous year but an increase of 13.9% in financial terms. Reasons for the change are likely to include the change in year on year government reporting conversion factors for Co2, seasonal factors affecting the volume of the commodities that are consumed and market pressures affect the price of the commodity; all can have an influence in the statistical data. (The current trend for conversion of Kwh electricity to Tonnes Co2 is dropping due to the continued growth in the usage of cleaner renewable energy sources such as wind and solar power).

Across the BCU Estates divisions in the majority of sites the consumption of gas has increased (by 10%. This includes both gas, gas oil (kerosene) and diesel / petrol powered road vehicles data).

The cost of the gas commodity and the fuel pump prices for vehicles all reflected in the 10.6% rise in financial terms which is evident by the previous comments in the body of this report. The electricity consumption from the previous year (in terms of GWH's – Gigawatt hours) has reduced from 0.0464GWH in 2017-18 compared with 0.0453GWH in 2018-19 but this relates to a reduction of 23.8% in Co2 volume (mainly due to the change in Kwh/Co2 conversion factor). It's worth noting again that the commodity is only about 60% of the cost, the rest is made up of transportation network charges, metering costs, supplier overheads and CCL (climate change levy's) and again factors that could influence the data are the governmental conversions factors, building general electricity consumption, capital investment in lighting and controls in building management technology, or changes to procurement of more "A" graded (energy rated) goods and products.

Synopsis on Transport trends

Transport:- The cost of fuel has increased for all the lease car users. The reimbursed cost is at 10p per mile as compared to 9p per mile for the previous financial year. The national trend in previous year was that diesel cars were more economical that petrol alternatives; however with the national shift in co2 emissions and cleaner air – diesel is no longer the preferred fuel of choice.
The expenditure on business travel from the previous year has increased by 8.5% which could be attributed to an increase in fuel pump prices. These increased costs will have a direct impact on the BCU fleet of pool cars and their subsequent running costs. BCU has changed their fleet standards for pools cars. The revision vehicle spec is a 1.0ltr petrol model as opposed to small diesels when ordered from the fleet hire company, so decreased fuel efficiency will also have a direct impact on fuel costs via our fuel cards.

Note:- In previous years the “other oil” Co2 figure only included BCU cars and vans; however this year’s figure also includes private lease and grey fleet Co2 data hence the significant change in numbers. (Without the private and grey fleet figures the value would be 1277)

Notes
***Scope 1 - Direct Greenhouse Gas Emissions -** These occur from sources owned or controlled by the organisation and include. Examples include emissions as a result of combustion in heating boilers owned or controlled by the Health Board, emissions from our vehicles and fugitive emissions from refrigeration gas leakage.
****Scope 2 - Indirect Energy Emissions -** Emissions that result from the generation of electricity and steam which is supplied by another party for use in our buildings.
****Scope 3 - Other Indirect Greenhouse Gas Emissions -** Emissions which occur as a consequence of our activity, but are not directly owned or controlled by the Health Board, including those linked to consumption of waste and water, sustainable procurement, biodiversity action planning and emissions relating to official business travel directly paid for by the organisation.
*****Other (oil) -** Information provided indicates total volume (litres) of vehicle fuel purchased via fuel cards and converted to tCO2 and private and grey fleet vehicles
****Total fuel costs via business cards and staff reimbursement

Greenhouse Gas Emissions are measured by means of collecting corporate consumption data and converting this data into carbon dioxide equivalents (CO2e) by means of official Department for Business, Energy and Industrial Strategy conversion factors. The CRC Carbon Reduction Scheme issues the official conversion figures annually, and these figures have been used to calculate corporate energy emissions.

Waste		**2016/17**	***Change from previous year***	**2017/18**	***Change from previous year***	**2018/19**	***Change from previous year***
Non-Financial Indicators (tonnes)	Total Waste	4586	*-8.2%*	5,333	*16.3%*	*5289**	*-0.8%*
	Landfill	370	*34.5%*	217	*-41.4%*	*116*	*-46.5%*
	Reused / Recycled	2,258	*-18.4%*	3,025	*34.0%*	*3200*	*5.8%*
	Composted	0		0		*0*	
	Incinerated with energy recovery	0		0		*328*	

	Incinerated without energy recovery	260	*-11.6%*	340	*30.8%*	*0*	*-100%*
Financial Indicators (£)	Total Disposal Cost	1,440,446	*1.7%*	1,169,840	*-18.8%*	*1,152,445 **	*-1.5%*
	Landfill	51,613	*49.5%*	51,032	*-1.1%*	*25,439*	*-50.2%*
	Reused / Recycled	371,076	*-5.3%*	411,044	*10.8%*	*460,860*	*12.1%*
	Composted	0		0		*0*	
	Incinerated with energy recovery	0		0		*152,879*	
	Incinerated without energy recovery	203,755	1.9%	145,401	*-28.6%*		*-100%*

*

- BCUHB waste data 2018-2019 includes all Hospital and aggregate sites.
- The table above only requires incineration waste data.
- Total waste tonnage & costs includes incineration waste, Alternative Heat Treatment (AHT) waste as below, recycled and landfill waste data.
- Reused/recycle tonnages & costs include WEEE waste.

  Figures for AHT Waste as below:-
  - Central 512.32 tonnes - £159949.72
  - West 489383 tonnes - £155922.83
  - East 642.85 tonnes - £204438

Synopsis on waste trends

The total Waste is showing a reduction of 0.8% by volume and a reduction of 1.5% in financial terms this is likely to be due to the 2 ward closures at Ysbyty Glan Clwyd (YGC) and closures during the redevelopment and due to some improvements in some specific waste streams. e.g. WEEE – (waste electrical and electronic equipment) waste. This has been undertaken by working closely with our appointed Waste Contractors.

Landfill waste is showing a reduction of 46.5% by volume and a reduction of 50.2% in financial terms. The Environment Team has worked closely with the appointed Waste Contractors to recycle more and limit what is sent to landfill. The BCU target is zero to landfill by 2025.
The reused/recycled waste volume is showing an increase by 5.8% and an increase of 12.1% in financial terms. This is due to the Environment Team working closely with the appointed Waste Contractors to reuse and recycle more of our waste.

With regard to the incinerated waste; we have received confirmation from Steriycle (our approved clinical waste contractor) that all our incinerated waste goes for energy; unfortunately in previous years we could not confirm this statistic.

Finite Resource Consumption	**2016/17**	***Change from previous year***	**2017/18**	***Change from previous year***	**2018/19**	***Change from previous year***

Non-Financial Indicators (m^3)	Water Consumption (All)						*8.7%*
	supplied	486,407	*5.4%*	528,694	*8.7%*	587,990	
	abstracted	0		0			
	Water Consumption (Non-Office Estate)						
	supplied	0		0		*0*	
	abstracted	0		0			
Financial Indicators (£)	Water Supply Costs (All)	1,279,850	8.3%	1,448,191	*13.2%*	*1,668,924*	*8.1%*
	Water Supply Costs (Non-Office Estate)	0		0			

Synopsis on water trends

Compared with last year the BCU divisions (East, Central / West) have shown some increases and decreases across the area as a whole.

In the East division of the BCU Estates property portfolio we showed a significant increase in cost and water volume. This can be attributed to the substantial leak at the Wrexham Maelor Hospital. The average consumption through this water meter in question should have been approx 8,000ltrs / month (approx £20k / month) however during the leak period it was approx 17,000ltrs / month (approx £45k / month). We fortunately were able to re-coup some of the losses as a sewerage rebate of £140k as a portion of the water consumed by the site did not go to drain it went to ground – hence it was not processed by the water authority.

In the West division a leak occurred at Llandudno Hospital, while it was not on the scale of the East leak – it was substantial for the size of the hospital premises.

In Central division there was a reduction in consumption across the area and costs accordingly.

Appendix 3: Occupational Health and Safety Improvement Plan.

Occupational Health, Safety & Wellbeing Strategy 2019-2022

1. Rationale for 3 year improvement plan

There is a requirement for a fundamental shift in the corporate approach to managing occupational health, safety and wellbeing; this is evidenced by the numbers of legal notices received by the organisation from the Health and Safety Executive from 2010-2017 (28 improvement notice and 1 prohibition notice). The organisation requires to make significant improvements in structure, systems and processes that protect employees and others who may be affected by their work activity. The aim of the strategy is to develop a learning culture that avoids making the same mistakes and ensures staff are happy, healthy and here. The 3 year Occupational Health, Safety and Wellbeing Strategy is based on the Health and Safety Executive (HSE) HSG65 management system which looks at the basic principles of Plan, Do, Check and Act process methodology.

The key focus of this strategy is on prevention, through continuous improvement via the assessment of occupational risks and control of hazards at source, which arise from the constantly changing world of work. The focus will be on coordination, cooperation and consultation mechanisms to ensure dialogue and exchange of best practice between staff and their representatives; The development of systems that identify, record and notify the Board of activity ensuring that effective analysis and targeting is undertaken of those areas of most concern. The process will review the systems for the Board to keep up to date with legislation and ensure competent advice is given from the Corporate OHS and Wellbeing Team. The strategy supports a training program that includes the integration of OHS at all levels to ensure that training is relevant and raises awareness of risks to all relevant stakeholders.

The Health Board's ultimate vision, by the end of the 3rd year, is to be the market leader in Occupational Health, Safety and Wellbeing NHS care across the whole of Wales. This will be achieved by engaging and empowering staff at all levels on Occupational Health and Safety. The 3 year improvement plan will be based on the gap analysis undertaken from June – July 2019 which will review 50 premises within the Board including secondary care, community health, GP Practices, laboratories and mental health services. The data collated using 180+ questions based on 33 pieces of legislation will provide the framework for the further development of this strategy.

2. The 4 key elements of the OHS Strategy include:-

2.1 Plan - As part of the planning stage consideration of where we are now and where we need to be will be considered. This is a key element in building effective foundations required for the safety management system. The review of the organisation status requires the Board to be fully assured OHS is covered in all of its premises. The safety culture may be different in certain parts of the organisation and not aligned to compliance levels expected. A key part of the planning process is to develop clear policies, guidance and safe working practices that covers all aspects of the OHS management system. The strategy aims to measure the success of the plans for OHS by systematically evaluating performance against the Policy.

The strategy will measure pro-active and re-active work being undertaken by the organisation leads. A health surveillance program will enable the Board to identify emerging risks from known indicators such as night work, latex, dermatitis, training feedback, inspections and pro-active audits and self-audit systems currently in place. When accidents occur they will be reported in a timely manner to enforcing authorities and lessons learnt not just in one area but all areas. A communication plan will be developed to communicate effectively the plans and development of an intranet site will provide up to date information and guidance. Part of the planning process will be to develop a fully accredited Safe Effective Quality Occupational Safety and Health service. The planning will require provision for fire, security and other emergencies. Co-operation is required with anyone who shares our workplace and we need to co-ordinate plans with them, this includes contractors and subcontractors to make it clear who has responsibility for safety and how it is monitored.

2.2 Do - The review aspect of 'do' section requires specific pieces of legislation to be adhered to that apply to the Board, examples include bio-hazards, environmental, radiation, lead, legionella, asbestos, COSHH, pseudomonas etc. We will need to develop the systems that tell us we are compliant in all service areas. The Board requires assurances that covers all the work activities being undertaken. This applies to all staff and any significant gaps will be identified to develop the risk profile both positive and negative. The strategy will identify what could cause harm in the workplace, who it could harm and how, and what you will do to manage the risk. The right people and equipment in the right place is key to a successful business and OHS strategy. The strategy aims to identify the biggest risks, risk rank them and decide on an action plan to mitigate such risks. All Senior Leaders have the ability to influence the safety culture, decide on the preventive and protective measures needed and put them in place. We need to identify if our supervisors act as role models to make sure that arrangements are followed or do they ignore safety advice. We need to be assured safety happens when we are not looking.

2.3 Check - The checking element will emphasise on a shift from reactive to pro-active measuring of performance. We will need to establish key performance indicators that give evidence that the safety plans we have put in place are working. The plans require implementing to make sure that they have been implemented, 'paperwork' on its own is not a good performance measure. What actually happens on the ground is the reality of the Occupational Health and Safety system. A cultural survey tool or staff surveys can support and determine attitudes to occupational health safety and well-being. We will assess how well the risks are being controlled through an inspection, audit and safety tour system in specific work areas, ensuring the findings are reported quarterly and annually to the Board through the Strategic Occupational Health and Safety Group and Governance structure. Root cause analysis investigations will identify the causes of accidents, incidents or near misses and actions will be centrally logged for RIDDOR to ensure they are completed and re-occurrence of the same event minimised. We will also check that Senior Directors are suitably trained on their corporate responsibilities.

2.4 Act - A review of the performance of the OHS in all service areas will be required with all staff held accountable. We will require to identify if what we planned to happen actually happened in reality. Learn from accidents and incidents, ill-health data, errors and relevant experience. Sharing of best practice from other organisations will ensure we follow best practice. The act part of the process will involve revisiting plans, training, policy documents and risk assessments to see if they are adequate and are still relevant in controlling the hazards at source. Working to ensure risk assessments are site specific not generic in nature. This will ensure a continued cycle of improvement is effectively implemented.

This Occupational Health, Safety and Wellbeing Strategy if fully implemented will support the Board by keeping staff ‘Happy, Healthy and Here’. This will not only help to reduce the likelihood of accidents and ill health, it will also help to improve time for staff to give care to patients, help to reduce financial waste and will help to improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 3 year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to endeavour change.

Appendix 3: OHS & Wellbeing 3 year Strategy.

Occupational Health, Safety & Wellbeing Strategy 2019-2022					
Policies/Procedures	Risk-Control	Sickness/Accidents	Training	Audit-Process	Evaluation
The development and regular review of the all OHS and Wellbeing related Policy procedures and safe working practices ensure that the documentation influences the safety management for staff, volunteers, patients and contractors. Ensure plans are aligned to all appropriate laws and legislative guidance documentation.	The systematic approach for the identification assessment and control of hazards. This includes governance, risk assessments that directly influence work activity and are seen as working documents.	Effectively investigate sickness absence, incidents/accidents to enable appropriate follow up to identify data sources and ensure that hotspots for injury, claims, sickness absence are identified and controlled. Including Datix reporting aligned to OH referrals system and reports from OH Services including health surveillance program.	The implementation of comprehensive communication strategy will ensure the e-learning package and training are effectively implemented. The training needs analysis will be required at structured training for all staff and implementation over the 3 year strategy.	The audit system will look at 4 elements of the Policy including training, reporting of accidents, risk assessment and equipment management maintenance and control. The audits will be based on specific Policy development as a result of data collection process.	The strategy will require an annual review to include policy, planning, implementation monitoring, audit and review supported by the Board and both the Wellbeing and OHS agenda. The annual report will also have pre-determined KPI's to measure outputs from the Department.

Year 1.					
Policies/Procedures	Risk-Control	Sickness/Accidents	Training	Audit-Process	Evaluation
Undertake gap analysis of legislation and wellbeing initiatives. Ensure the Strategic OH&S Group is clear on process and systems with clear Terms of Reference that oversees all the key elements of the Policy. Ensure Policy available on intranet and additional guidance. Develop a range of policies and work with key stakeholders on effective implementation.	Develop risk register for project with actions to mitigate risk. Ensure risk evaluation and management is easily understood and effectively implemented across service areas.	Datix system reports and staff clinic on quarterly basis. Hotspots identified and strategies to minimise risks. Contractors in all service areas clinical/non-clinical to report centrally on incidents. Root cause analysis to identify trends and avoid re-occurrence.	Annual calendar training plan established. Ensure the training is accredited by appropriate authority. Develop OHS & Wellbeing leads in service areas who can cascade to key staff with additional competent in key service areas. Implement corporate manslaughter training for Senior leaders.	The audit system will undertake 50 audits in both clinical and non-clinical areas to see if the baseline audit has significant impact on the strategy. A data collection system will be required to collate information and provide reports to the Board on a quarterly basis.	Establish key performance indicators to include number of training events, incidents reported and investigated, competence assessments undertaken. Evaluate effectiveness of training including e-learning. Review if plans have been developed in line with Strategy.
Focus will be on the gaps identified in the system. Develop new policies to identify who is responsible	Ensure the Committee structure escalates risk appropriately in a timely manner.	Review RIDDOR and accident investigation process to ensure lesson are learned across the	The specific training requirements will be identified within service areas as a result of the	The audit process will identify if the self-audit process is aligned to the gap analysis of legislation.	A report that identifies areas of concern in service areas will be provided to the Strategic

and owners for such risks.		organization. Identify, produce and disseminate appropriate Fact/Guidance/Information Sheets across the organisation in the classification and reporting of RIDDOR	legislative review. The Training needs analysis will identify the level and scope of training such as Directing and Managing safely (IOSH) should form part of the review.		Occupational Health and Safety Group and Board and a project timeline will show how the Board can be assured of progress against the progress made.
Document control and process to manage the safety management system including self-referral and internal audit process that tests the audit system.	The audit system will be cross referenced with self-assessment data to ensure the compliance system is working effectively.	Data from sickness absence and incidents will be evaluated with hotspot areas. It would be anticipated that those areas who are well engaged through OHS will have lower rates of sickness and incidents.	Additional local training will be undertaken on gaps identified. It will be clear from the self-assessment and more formal OHS led audits what level of training will be required.	The audit will be undertaken on a rolling program with quarterly and annual reports on progress samples of areas will be undertaken to provide a clear picture of compliance in all service areas.	The Quarterly reports will be used as part of the evaluation of the whole system to ensure constant learning is undertaken throughout the Board.
Policies/Procedures	Risk-Control	Sickness/Accidents	Training	Audit-Process	Evaluation
Review OH SEQOSH accreditation system. Requires approximately 300 documents and all	Quality controlled OH Department will ensure that the systems in place are accurate, timely	A review of hotspots from pro-active health surveillance will support the development of	A review of service and organisational needs to be undertaken to determine if specialist training	SEQOSH requires a self-audit system to be implemented once accreditation is obtained this requires constant monitoring of	Annual self-assessment. Full accreditation expected within 12 months of development of

policies and procedures to be in date and gone through the Governance structure.	and have the most influence on staff Occupational Health and Wellbeing.	positive OH management in all service areas. Stress and MSK are the biggest areas of sickness absence.	is required including audiometry, lung function tests, vibration monitoring evaluation forming part of TNA.	the service. SEQOSH will review the whole system every year and undertake a full audit every 3 years to ensure the quality standard is maintained.	documented system.
Develop effective COSHH Policy to ensure it is commensurate with the needs of the organisation.	Ensure that suitable data sheets risk assessments are in place to manage the COSHH risks. Ventilation, PPE, risk escalation procedure and data base system review to centrally control products.	Engage with Occupational Health to collate appropriate data and statistics of those negatively impacted from exposure to COSHH controlled items including long term sickness/absence.	Training programme where identified as a requirement. Identify and establish appropriate guidance and instruction on Management, Storage and Use of COSHH controlled items across the organisation	The audit system will be part of the 6 monthly review of all service areas. This will ensure that products are procured appropriately, eliminated or safer product used were possible and risk assessments relate to specific work activity.	Prioritise substances and processes that need Health Surveillance into High/Medium/Low category risk and distribute list to all appropriate services. Evaluate the use of products and systems that are required to ensure constant evaluation is undertaken.
Manual Handling Musculoskeletal Disorders Review of Policy and system of managing ill health and structure of team.	The focus of the manual handling program has predominantly been on training with records of attendance above 85%. However	Musculoskeletal disorders account for 10.5% of all sickness absence. There will be a review of recorded incidents as there are large numbers	On-site training and further development of the champion's network to be established to ensure that staff have access to	There will be a six monthly audit system established with quarterly reports to the Strategic Occupational Health and Safety Group to ensure	The evidence of a successful manual handling program will be a reduction in ill health conditions of staff and a better experience for

	the controls at local level require further evaluation. The gap analysis of 20 premises will form part of the review of implementation.	not recorded in the Datix system. A targeted approach of hotspot areas is required once clear data is evidenced.	competent advice in the workplace. Additional work on specialist bariatric equipment and training will be required in year 1.	progress is further developed.	patients. To establish quicker recovery times as staff mobilize patients. Evidence of Datix and sickness require cross referencing with OH data.
Review Sharps Policy to include procurement, contractor control, non-safety devices and post exposure prophylaxis (PEP) system in place to support staff.	Ensure suitable risk controls are in place including safe systems of work. Risk assessments and information on client when incidents occur.	Review system for dealing with staff when have been exposed. PEP system and accessing patient data in a timely manner.	Ensure adequate infection control training is in place and specific training on products from manufacturer if required.	Review hotspot areas and undertake a review of positive and poor areas provide feedback to Departments on numbers of staff identified as receiving sharps and sickness absence and training.	Evaluate the effectiveness of the Policy through the gap analysis process targeting hotspot areas.
A review of the Asbestos Policy systems and control measures to ensure no staff or contractors are exposed to asbestos.	Ensure all premises have a rolling program of asbestos surveys and reviews high risk areas to be escalated via the risk register.	Review numbers of staff potentially exposed and keep adequate records of exposure for 40 years in line with EH40 requirements. Consider emergency procedure and	Ensure all key operatives have adequate asbestos awareness training all work sheets for maintenance staff to highlight if asbestos in area of work activity. Understand	Undertake an audit of the systems and processes in place that are aligned to the Policy. Ensure clearly indicate where asbestos is and what condition it is in. Visit sites and review documented process sample a number of premises annually.	Consider if lessons are learned regarding asbestos and evaluate number of training session's reviews and control measures being implemented. Highlight most high risk premises first.

		support for staff as necessary.	emergency procedure.		
Wellbeing Strategy and Plan that includes a stress management system to target hotspot areas and is clearly communicated to the organization through effective planning.	Implement risk evaluation of areas of highest concern and target for workshop programs. The establishment of the Health and Wellbeing Group is required to track activities and work towards a healthier happier workforce through a range of strategies.	Stress is the biggest cause of sickness absence with 25% of all sickness recorded being evidenced in 2018-2019 figures. There is a requirement to have a fundamental review of all records in relation to stress and what are the key themes this should link with V&A review and WOD strategy.	Ensure an effective training programme is implemented to reduce ill health and stress awareness. Pro-active campaigns looking at mindfulness for managers and support to be reviewed and further established. Developing positive links with Heads of WOD.	Undertake quarterly audits of stress in the workplace to ensure the program is working towards reducing the causes of stress and ill health in the workplace.	Evaluate the effectiveness of mindful sessions and feedback forms provided. Promote through quarterly reports on performance against targets set in WOD strategy.
Violence and aggression (Security) Identify if the current system in place is fit for purpose. This includes Policy and process for implementation.	A gap analysis of all systems including lone workers, CCTV, Contract management and control, violence to staff and aggression training etc.	Consideration of numbers of staff who have reported sick as a result of V&A incidents will require reviewing including what support has been provided by local managers, security	Training is to be evaluated to ensure it is safe and appropriate. Specific training is available in mental health services	Audit Security V&A to provide a systematic review of all incidents. Ensure the policy is effectively being implemented and all control measures possible are available and being used to reduce as far as possible risks to staff	Evaluate the effectiveness of systems and processes put in place including training to reduce V&A incidents across all service areas.

		and Occupational Health.		and other patients who may be placed at risk.	
Year 2					
Policies/Procedures	Risk-Control	Sickness/Accidents	Training	Audit-Process	Evaluation
Review the Policies to ensure it is still effective. Review TOR of Committee and its members.	Risk register reviewed and action plans implemented. Identify numbers of risk assessments implemented in service areas with 100 undertaken per annum. Datix system used to inform outcomes.	Interventions can be evidenced with numbers of reported ill health incidents reducing. All service areas are aware of risks and mitigating actions. The overarching well-being strategy is implemented and pro-active plans are put in place to include fit for work campaign.	All staff on induction receives appropriate training. OHS & Wellbeing leads training reaches 500 additional staff. All Contractor's work in line with organisational Policy for training risk assessment and effective management procedures.	The development of an audit program based on gaps in legislation and hotspot areas identified from data sources. High risk premises to have focus and evaluation of assessments, accident statistics and OH clinic reports. Develop plans in place to deal with most significant areas.	Leadership engaged and is part of the system now in place. Evidence learning and systematic approach to OHS & Wellbeing. Review KPI's to ensure we achieved what we set out to do. Are the policies driving change are risks being mitigated. Is there evidence from enforcement authorities that the work plan is effectively implemented in all service areas.

Implement SEQOSH in OH Service. This will ensure the system can be effective in managing sickness absence and be Quality assured OH Department.	Quality assured system will require maintaining to keep up accreditation. Risks	Evidence impact of system in place and reduction in reducing sickness absence in the workplace and interventions have kept staff in work evidenced on COHORT system.	The staff will be required to be trained on maintaining the quality assured system and CPD of practitioners evidenced through peer review and CPD.	The system requires annual audit self-assessment to be undertaken followed by a three year formal audit by SEQOSH.	Standard measures identified and reported on quarterly/annual basis. COHORT to be used to provide standard KPI's for service.
V&A Security Review and Policies standard operating procedures protect staff. Ensure suitable tracking system in place of violent patients and lone worker controls in place.	Ensure protected vulnerable groups are supported from hate crime. Establish clear controls for violent patients markers on records lone worker devices etc.	Reduction in numbers of violent incidents should have a significant effect on sickness absence and volume of V&A incidents a 20% target should be evidenced.	Ensure training can evidence the reduction of harm in hotspot areas including mental health and acute settings.	Ensure risk assessments are put in place are available and audited to ensure cross boundary controls are put in place in all services and staff are informed about high risk patients.	Evaluate the effectiveness of interventions in reducing the range and type of V&A incidents. Plan effectively future premises and control measures.
Contractors to have effective policies in place that influences their work force and effective induction program. Ensure pre-tender procedure has 2 phase approach.	Ensure 1st Stage tender uses Contractor Health and Safety Scheme (CHAS) to ensure first tender stage is undertaken to ensure basic compliance a 2nd stage review will	The contractor control system will reduce risks of litigation and ensure safe systems of work are evidenced. This will add control to the system and reduce	Ensure that contractors clearly evidence records of safety training and provide specific risk assessments for work on BCU premises.	Review the system with procurement to ensure that all expected control measures are being implemented track the tender process and on site management of a number of contractors to ensure they are compliant.	Evaluate the level of compliance based on the documented process for all works activities likely to be more risks with smaller contracts than larger capital builds.

	be required on more complex schemes.	the risks of serious accidents.			
Slips, trips and falls Policy cleaning and falls procedure address large numbers of staff slips, trips and falls.	Ensure all surfaces free from obstacles and in good condition consider cleaning times and placement of signage which can become trip hazards. Risk assessments required for specific areas and work activities.	A large number of incidents are as a result of slips, trips fall and require RIDDOR reporting. A system to design low slip surfaces and continual monitoring is required. Particularly icy surfaces and poor work surfaces.	Identify areas most staff are suffering from slips, trip and falls and place adequate control measures in place. Falls risk assessment for patients evidenced and training on RCA to ensure lessons are learnt.	Undertake specific audits based on the workplace regulations that identify specific control measures and slip tests of surfaces. Ensure all cleaning materials are compatible with floor surfaces to ensure risks are not increased.	Review if revised risk assessment policy and procedure are having a positive effect on outcomes for staff and patients.

Develop intranet site to ensure information and self-help guides are readily available to staff.	Ensure all documents are approved and clear on what responsibilities all staff have to adhere to. Be user friendly and are simple and not too onerous.	Identify clear pathways for staff on sickness absence self-referral system in place. Ensure that guides and support services can be easily accessed to support staff.	Ensure all training materials are readily available through self-help guides.	Review how many staff have accessed the system and develop feedback mechanism on the intranet site.	Evaluate the effectiveness of the system to ensure it is easily navigated by all staff consider equality issues when designing system.
Establish training processes. E/learning packages that engage staff and ensure they provide good framework for work activities.	The risk of staff or patients being injured or made ill by adequate training should be clearly evidenced in numbers of ill health conditions being evidenced in OH and sickness data	Accident and ill health conditions require tracking along with HSE guidance and themes that may indicate what specific ill health conditions are being evidenced through health surveillance.	Training will need to target the areas of highest risk and include stress, mental health support, asbestos' legionella work at height COSHH and slips trips falls management and control.	Audit the training to ensure it is quality assured and receive adequate feedback from on line and face to face candidates,	Review the training needs analysis to ensure it remains fit for purpose. Ensure Senior Leaders continue to receive the latest information and requirements for OHS subjects.
Year 3					
Policies/Procedures	Risk-Control	Sickness/Accidents	Training	Audit-Process	Evaluation
Review Policy and program of the Strategic Occupational Health and Safety Group is working as planned. Look at development of ISO	Update risk register and risk assessment process. Ensure evidence of risk actions are being mitigated. Review if new technology	The data base systems support staff evidencing the effectiveness of interventions. MSD's are reduced to lowest possible level. Stress	Evidence numbers who have completed the e-learning and training. Include contractors training to the appropriate level.	The audit should be undertaken in all service areas by the local managers who will understand the importance of OHS & Wellbeing on service delivery and act as	Evaluate all aspects of work activity outcomes and feedback to Committee. The feedback from audits will help improve learning.

45001 and certification of the service. Ensure TOR and membership of the OHS Group is continually adding value. All documentation is up to date and in line with law and readily available on the intranet site.	can be used to reduce risk in the workplace using best practice. Ensure principles are embedded with evidence available.	sickness absence reduced. Research is undertaken to further drive down MSD's and support staff to get back to work via a fast track healthcare system. This will ensure the sickness level is improved and staff engagement.	Continue to ensure all staff work to organizational standards.	champions to reduce the risks within all service areas.	Risks are being effectively mitigated. All staff are clear on roles and responsibilities evidenced.
Annual report on progress of 3 year strategy. To be provided to the Board showing KPI's and actions undertaken to control significant risks.	Risk register clearly reflects organization risk of 33 pieces of legislation and actions clearly stipulated and owners.	The annual report will provide evidence of progress made against strategic objectives.	The training needs analysis should be fully implemented and provide assurance that the training is timely and effective in reducing ill health incidents and accidents.	Review audit program in all service areas, stress, manual handling, security, sharps, OHS etc. to ensure still fit for purpose.	Evaluate if what we set out to do in the Plan, do check act framework has been effective in providing assurance to the Board that OHS is effectively managed.
RIDDOR, RCA Policy to be reviewed. Training in RCA evaluated to ensure constancy across all service areas.	A tracking system will be required and evidence of non-compliance escalated through the Governance system.	Review accident data base system once baseline information on RIDDOR and accidents is stable look at reducing reportable accidents.	Update training plan to ensure it is targeted and directly influences outcomes consider IOSH Directing and Managing safely accredited courses.	A group established to evaluate claims, incidents accidents and sickness to be established to ensure root cause analysis process is effective and audited against.	100% of investigations and accidents have 85% of actions completed within 42 days.

Wellbeing Mental health first Aid and support framework. Implement Mindful Managers program and form part of induction program.	Ensure that stress assessments and mental health and wellbeing activities are clearly evidenced in all service areas deemed high risk.	Reduce stress related ill health and anxiety and depression. Consider the whole person not just work activity as all have a detrimental effect on worker wellbeing.	Train managers in positive interventions on well-being ensuring the appraisals include specific questions on stress and wellbeing.	Audit Departments to ensure they have clearly implemented well-being initiatives and assess the effectiveness of mental health interventions.	Identify through data how well our staff feel through staff survey results data from OH Service and evaluate effectiveness of interventions.
Manual handling review of Policy systems and processes,	Place clear responsibilities in job descriptions to ensure that 1-10 staff in wards are manual handling champions and support the training program.	Evidence sickness absence rates reduced and staff reduction in musculoskeletal disorders and referrals for physiotherapy from OH Service.	Site specific training undertaken by Manual handling champions 10-1 in all wards ensure equipment is procured appropriately and staff trained on use.	Audit equipment, lifting techniques of staff including acute, community, mental health etc.	Report quarterly and annually on progress against KPI's and training that directly affects outcomes.

Quality, Safety and Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Listening and Learning from Experience Report
Report Author:	Ms Carolyn Owen (Head of Patient and Service User Experience) Mr Peter Morris (Patient and Service User Experience Manager – West)
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	To provide a summary of the service user experience within BCUHB in line with the Health Board's mandatory responsibility to listen, learn and act on from feedback (Welsh Government, 2015a), as the basis for identifying key themes and trends, interventions arising from these, and detailing key actions aimed at improving the capacity and capability of BCUHB to listen, learn and act on service user feedback in 2019/2020.
Approval / Scrutiny Route Prior to Presentation:	No prior scrutiny
Governance issues / risks:	BCUHB has a mandatory responsibility to listen, learn and act from patient/service user experience; key policy frameworks include: • NHS Delivery Framework 2018/2019 (NHS Wales, April 2018) • Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a) • Equality Act 2010 • Health Care Standards for Wales (WG, 2015b) • Wellbeing of Future Generations (Wales) Act (WG, 2014a) • Social Services and Wellbeing (Wales) Act (WG, 2014b) • Parliamentary review of Health & Social Care in Wales (2018) This report describes and supports how the health board meet some of the recommendations of the Parliamentary review of Health and Social Care in Wales (2018) and the Welsh Government's *National Framework for Assuring Service User Experience (2015).* This report aims to demonstrate how the health board measures the performance of the BCUHB Patient and Service User Experience against the core deliverable objectives in the NHS Wales' Listening and Learning framework of 'the Quadruple Aim'. The Patient and Service User Experience Improvement Strategy 2019-2022 mandates

	listening to and learning from patient experience to deliver safe and compassionate care by ensuring sufficient coordination of all its activity related Patient and Service user experience. An overview of the feedback received is demonstrated in this report. The results of all patient and service user feedback is regularly shared with clinical areas. When negative feedback is received an action plan is devised and implemented to demonstrate 'listening and learning' from patient and service user experience. In line with 'Being Open', the information is shared with the patients, carers and relatives by the staff in "*You said, we did*" display posters. The Patient and Service User Experience team ensures every action is taken to improve quarter on quarter / year on year developmental growth in the feedback received. Governance Leads and all BCUHB Services meet quarterly to feedback a) The feedback/data received from their Patient and Service Users and b) What service improvements are being made, inclusive of Complaints, Incidents and Clinical Negligence Claims trend analysis to gain a holistic insight into all services. The Listening and Learning Group (LLG) is chaired by the Associate Director of Quality Assurance. LLG focus on outlining targets and reporting frameworks to link the connections between service user feedback and service improvements. Focusing on 'YOU SAID WE DID'. Real-time patient feedback survey indicates that for BCUHB as a whole service users report an average overall satisfaction rating of 8.85/10 for Q4-2018/2019 compared with 8.89/10 for Q1-2019/2020 see figs 1 & 2 below. This improvement is also seen in other items from the CRT/Viewpoint Survey – see Figs 1a & 1b Additionally return rates for CRT/Viewpoint whilst historically lower in the Centre and West than in the East have seen an upward improvement in Q1-2019/2020 most dramatically within the Centre, which have moved from an average of 150 month in April 2019 to approx. 600/month in June 2019. Responses to the NHS Inpatient Survey, would indicate that patients and service users continue to report their experiences in an extremely positive light compared with previous reporting periods see Fig 9. Based on the data analysed, as in previous reporting cycles, patients and service users are more likely to report their experience in a positive than a negative manner with the number of positive comments far outweighing negative comments. This effect is seen across all care settings especially in Community Hospitals in the Centre where the Patient Advice and Liaison Service (PALS) utilises a Care2Share Approach – see fig 16.

The Quality of Care itself, Staff Attitude and Approach and Basic Nursing Care are frequently reported as being associated with a **positive experience**. This reinforces the importance of staff attitude as an essential element of effective 'customer care'.

Improvement actions outlined below build on existing interventions in order to develop a framework which provides improved organisational assurance in relation to BCUHB's mandatory responsibility to listen, learn and act on service user feedback.

Improvement Actions for Q2-2019/2020 and beyond (Proposed Controls)

The actions identified in Sections 4.2 and 4.3 for completion in Q2-2019/2020 are designed to operationalise the Patient & Service Experience Strategy (BCUHB, May 2019), have been developed to address the above risks/issues.

Looking further forward, in addition to those actions detailed in section 4.3 and summarised below; key milestones to be achieved within 2019/2020 which will improve BCUHB's ability to listen, learn and most importantly act on patient and service user experience include:

Action	To be completed By
• Reestablishment of the Listening & Learning group – to improve organisational accountability in relation to BCUHB's mandatory responsibility to act on feedback.	Sept 2019
• Implementation of a standardised PALS services across all three operating areas, derived from the PALS Model	Sept 2019
• Routine, development and implementation of service improvement action plans at ward/dept/speciality level derived from PALS activity – to support a 'You told us', 'We did' culture.	End of Q3-2019/2020
• Improved reporting of Service User experience using the IRIS system in order to identify 'hot spots' and to support proactive improvement, which combines existing 'Harms' and complaints metrics with CRT/Viewpoint feedback.	Pilot to be completed in the West by Oct 2019
• Evaluate the above and roll out to other operating areas.	End of Q4-2019/2020

Collectively the above actions are integral to the Patient and Service Experience Strategy and will improve, in subsequent reporting periods, the Health Board's ability to act on patient and service user experience, in line with our mandatory responsibilities.

Financial Implications:	The roll out of the Patient Advice & Liaison Service (PALS) and Patient and Service User Experience Strategy along with the other improvement actions within this report will be achieved within existing funding levels agreed in 2018/2019.
Recommendation:	The Committee is asked to: 1. Endorse the improvement actions identified within this report and provide feedback in relation to additional interventions which may address the identified issues and risks, especially in relation to developing improvement organisational and operational accountability for Listening, Learning and Acting on patient and service user experience.

Listening and Learning from Experience Report

Executive Summary

BCUHB has a mandatory responsibility to listen, learn and act on patient/service user experience; key policy frameworks include;

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)

This report provides an overview of service user feedback received and the associated themes and trends, as the basis for Quality/Organisational Assurance and Service Development. Data from CRT/Viewpoint™ real time patient feedback system, Datix™ Complaints and Incidents reporting, Patient Comment Cards and Patient Advice and Liaison Service (PALS) activity is used to provide an overview to patient and service user experience and lessons learned, and data for Q1-2019/2020 is compared with previous quarters.

Key Findings

Feedback from real time patient feedback survey indicates that for BCUHB as a whole service users report an average overall satisfaction rating of 8.85/10 for Q4-2018/2019 compared with 8.89/10 for Q1-2019/2020 see figs 1 & 2 below. This improvement is also seen in other items from the CRT/Viewpoint Survey – see Figs 1a & 1b

Fig 1a	**Mean Scores/4**	
BCUHB CRT/Viewpoint Items	**Q4 2018-2019**	**Q1 2019-2020**
Did staff introduce themselves to you?	3.58	3.64
Do you feel you were listened to?	3.64	3.67
Were you given all the information you needed?	3.58	3.60
Did you get assistance when needed?	3.72	3.73
Were you involved in decisions about care?	3.58	3.60
Did staff take the time to understand what matters to you	3.63	3.64

Additionally return rates for CRT/Viewpoint whilst lower in the Centre and West than in the East have seen an upward improvement in Q1-2019/2020 most dramatically within the Centre, which have moved from an average of 150 month in April 2019 to approx. 600/month in June 2019.

Responses to the NHS Inpatient Survey, would indicate that patients and service users continue to report their experiences in an extremely positive light compared with previous reporting periods see Fig 9.

Based on the data analysed, as in previous reporting cycles, patients and service users are more likely to report their experience in a positive than a negative manner with the number of positive comments far outweighing negative comments. The

factors which contribute to a positive patient experience are on the whole different to those which contribute to a negative one. The exception to this being '*Staff Attitude'* which whilst often reported as contributing to a positive patient experience it is also reported as contributing to a negative experience.

The Quality of Care itself, *Staff Attitude and Approach* and *Basic Nursing Care* are frequently reported as being associated with a **positive experience**. *This reinforces the importance of staff attitude as an essential element of effective 'customer care'*.

Whilst *'Waiting Times'*, *'Delays'*, *'Parking'*, *'Noisy/hot/cold, 'Ward Environment'*, *'Lack of Involvement and Information'*, *'Food'*, *'Poorly organised/coordinated care*' and very less frequently cited *'Poor Staff Attitude'* are reported to contribute to a **negative experience**. (See Figs 13 & 14)

Special Note:

- As in previous reporting periods the level of patient satisfaction within Emergency Departments is lower than the acute site overall this is likely to be due to the point in the pathway where satisfaction is measured. Namely, post triage and before treatment.

Key Issues

As in previous reporting periods, without the PALS service being fully operational across all three operating areas, this report recognises that it is difficult given the current organisational infrastructure to definitively link service user feedback to specific service developments. This is not to say this is not occurring, but creating an auditable link at present is challenging. Hence the improvement actions outlined below build on existing interventions in order to develop a framework which provides improved organisational assurance in relation to BCUHB's mandatory responsibility to listen, learn and act on service user feedback.

Looking further forward, in addition to those actions detailed in section 4.3 and summarised below; key milestones to be achieved within 2019/2020 which will improve BCUHB's ability to listen, learn and most importantly act on patient and service user experience include;

Action	To be completed By
• Reestablishment of the Listening & Learning group – to improve organisational accountability in relation to BCUHB's mandatory responsibility to act on feedback.	Sept 2019
• Implementation of a standardised PALS services across all three operating areas, derived from the PALS Model	Sept 2019
• Routine, development and implementation of service improvement action plans at ward/dept/speciality level derived from PALS activity – to support a 'You told us', 'We did' culture.	End of Q3-2019/2020

• Improved reporting of Service User experience using the IRIS system in order to identify 'hot spots' and to support proactive improvement, which combines existing 'Harms' and complaints metrics with CRT/Viewpoint feedback.	Pilot to be completed in the West by Oct 2019
• Evaluate the above and roll out to other operating areas.	End of Q4-2019/2020

Collectively the above actions are integral to the Patient & Service Experience Strategy and will improve, in subsequent reporting periods, the Health Board's ability to act on patient and service user experience, in line with our mandatory responsibilities.

Key Improvement Actions for Q2-2019/2020 – The Next Steps

This report makes the following key recommendations;

- Implementation of bilingual PALS service in the East and West based on the Care2Share model in order to provide BCUHB wide access to *'patient advice and support services.'* (See section 4.3.1)
- Development of improved real/near time feedback and reporting systems such that patients and service users are easily able to provide managers and front line staff with the information necessary to support service improvements. (See section 4.3.2)
- Use real/near time service user feedback to support service improvement. (See section 4.3.3)
- Delivery of a rolling programme of customer care, patient stories and using feedback to improve services, workshops. (See section 4.3.4)
- Use 'Feel Good Friday' to share positive feedback with front line staff across all regions on a weekly basis. (See section 4.3.5)
- Provide the leadership and operational support necessary to ensure that BCUHB is compliant with *Accessible Information & Communication for People with Sensory Loss* standards (WG, 2013), in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019. (See section 4.3.6)
- Ensuring that the work plans developed to support the Patient Experience Strategy, are compliant with the requirements of the Welsh Language Act, Welsh Language Measure (Wales, 2011) and Welsh Language Standards through the implementation of a bilingual Patient Advice and Support (PASS) service, ensuring that service users are able to provide feedback on their experience in Welsh for example via; Real Time Feedback Systems, NHS Wales Inpatient Satisfaction Service, Care2Share, via Patient Stories etc. (See section 4.3.7)
- Ensuring that the work plans developed to support the Patient Experience Strategy adopt where practically possible a tri-lingual approach; that is ensuring that British Sign Language (BSL) as well as Welsh are given equal prominence with English. (See section 4.3.8)
- Re-establish the Listening & Learning from Experience Group based on the revised Terms of Reference (TOR) in order to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning. (See section 4.3.9)

- Develop a library of patient stories which can be utilised for service improvement and to ensure that they are available for use in organisational QSE Committee and Quality Safety Group (QSG) and other strategic meetings. Thus ensuring that the voice of the patient is always central to the provision of health care services, and that BCUHB becomes increasingly adept as a learning organisation
- Complete the appointment of the Patient & Service Experience Project manager in order to provide a deputy function to the Head of Patient & Service User Experience and to provide the leadership and management necessary to ensure the above objectives are realised.

1 Aims

BCUHB has a mandatory responsibility to listen, learn and act on patient/service user experience; key policy frameworks include;

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)

This report provides an overview of service user feedback received and the associated themes and trends, as the basis for Quality/Organisational Assurance and Service Development. Data from CRT/Viewpoint™ real time patient feedback system, Datix™ Complaints and Incidents reporting, Patient Comment Cards and Patient Advice and Liaison Service (PALS) activity is used to provide an overview to patient and service user experience and lessons learned, and data for Q1-2019/2020 is compared with previous quarters.

The purpose of this report is to analyse themes and trends from service user feedback and provide assurance that lessons have been learned and improvements initiated. It is based on the secondary analysis of the following data sets and patient/service user real time feedback systems.

In line with Welsh Audit Office requirement; delivering the learning from patient experience: key questions for NHS Board Members document, the Patient and Service User Experience Improvement Strategy 2019-2022 clearly specifies that BCUHB will learn from patients. This report supports the strategy to review and measure the performance of the BCUHB Patient and Service User Experience against the core deliverable objectives in the NHS Wales' Listening and Learning framework of 'the Quadruple Aim' and mandates listening to and learning from patient experience to deliver safe and compassionate care by ensuring sufficient coordination of all its activity related patient and service user experience.

This report demonstrates that the right resources will be in place by September 2019 to support learning from patients and service users through the newly appointed six PALS officers in addition to the three already in post in Central . The PALS officers will serve across all regions to support to ensure the patient experience pathway is improved. BCUHB are leading the way in Wales by demonstrating investment in effective systems to capture and analyse data, measuring, tracking and driving quality improvements forward.

The triangulation of patient information with other important data will be further developed to provide rounded feedback across the organisation through the Quality Safety Experience report covering patient experience, quality and safety, complaints and outcomes.

The BCUHB Ward Accreditation model, Community Health Council independent clinical visits and Health Inspectorate Wales support the patient experience is measured holistically across all areas. Care to Share clinics are inclusive of listening

to staff feedback and triangulated with patients' views. These are openly shared on clinical areas notice boards along with the weekly patient experience real-time feedback weekly comments reports.

'Honest Reporting' of patient feedback is paramount to the public, and the strategy highlights the development of transparency in openly sharing the 'You said/We did' communication methodology, going hand in hand with clinical effectiveness and safety. Celebrating positive feedback and comments through sharing on social media not only raises staff morale but also improves patient and service users' confidence in the organisation.

Patient and service user experience journey starts at the beginning with first contact and ends with the last. These form first and last impressions. Getting Patient and Service Experience right will support the learning.

2 Collecting, Disseminating and Using Patient and Service User Feedback

Currently BCUHB deploys the following mechanisms for collecting and acting on Patient and Service User Feedback.

2.1 How is feedback collected?

CRT/Viewpoint Real-time Patient Feedback Survey

This survey is deployed across all care settings including some primary care GP managed practices and provides a mechanism for reporting in real/near time on NHS Wales core Patient related Experience Measures (PREMs). In order to ensure compliance with our mandatory obligation to listen learn and act on patient and service user experience feedback (WG, 2015a; WG, 2015b). The patient and service user experience teams in each operating region oversee the dissemination of weekly and monthly ward reports, to ward and department managers. Additionally, the system enables the e-mail alerting of negative feedback which is shared with ward/department managers as the basis for learning and service improvement.

The requirement to fully implement the CRT/Viewpoint Survey along with the ability to listen, learn and act on such feedback is an integral requirement of the ward accreditation system. The utilisation of service user feedback from CRT/Viewpoint and data sets arising from Healthcare Inspectorate Wales (HIW) and Community Health Council (CHC) monitoring visits along with incidents and harm metrics monitoring, provides an important source of evidence in support of ward accreditation.

NHS Inpatient Satisfaction Survey

This is a postal survey administered quarterly to a randomly generated sample of n=1,000 inpatients, proportionally selected across the three operating areas. The survey is complementary to CRT/viewpoint, in that it provides a broader retrospective analysis of patient and service user experience, in line with BCUHB's mandatory requirements (WG, 2015a).

Patient Comment Cards

Comment cards are deployed within a limited number of non-clinical locations within the Health Board, such as main foyers, within some community settings, in order to provide a mechanism for enabling patients and other service users to provide us with general qualitative feedback. The feedback is recorded within the DATIX™ PALS module, themed and forwarded either for information or action to the relevant ward/department manager. (E-mails, thank you cards and letters from patients and service users can be recorded and acted on in a similar manner).

PALS Service

Currently the Patient Advice and Liaison Service is in operation in the Centre, based in Ysbyty Glan Clwyd. The recent appointment of an additional 6 x 1.0 wte PALS officers will enable the development of a similar service in the East and West commencing in Q2-2019/2020. The key remit of the service is to improve patient and service user experience by providing the advice and support required to deal with inquiries in real time, and to support the provision of feedback to ward/departmental managers via Care2Share Clinics and by proactively promoting the other mechanisms cited in this section. PALS activity is recorded with the DATIX™ PALS module, themed and forwarded for information or action to the relevant ward/department manager in real time. Thus providing a key mechanism for listening, learning and acting on patient and service user feedback which minimises the need for service users to resort to the formal complaints process, via proactive and collaborative problem solving in patient/service centric manner.

Patient Stories

Patient Stories provide a framework for patients and service users to tell us about their experience and results in a themed narrative review that enables the identification of key learning which is forwarded to the relevant service managers as the basis for service improvement. The guidelines on patient stories (ISUE01) have recently been reviewed to encourage a broader approach including the use of multi-media recording, utilisation of focus groups, picture/art elicitation, 'Have Your Say' events and extended 'Care2Share' approaches. In order to make available a library of patient stories to support the organisational learning required to implement patient centred service development.

Incident & Complaints Monitoring

The analysis of secondary data arising from the implementation of Putting Things Right (PTR) and incident reporting and management, provides indirect evidence of the experience of our patients and service users by location. Which enables the targeted implementation of the PALS service and other interventions/mechanisms cited above which are integral to the Patient & Service User Experience Strategy (BCUHB, May 2019) and organisational compliance (WG, 2015a, 2015b).

2.2 Data Sets Analysed for this Report

Patient/Service User Experience:

- ***CRT Viewpoint real time feedback system***, resulting in a **total of 8, 261** responses (n=4,548 for Q4-2018/2019 and n=3,713 for Q1-2019/2020) – see also note (ii) below.
- ***NHS Inpatient Satisfaction Survey****,* resulting in a **total of 620** responses (n=326 for Q1-2018/2019 and n=294 for Q4-2018/2019) – see also note (iii) below.
- ***Comment Cards*** resulting in a **total of 449 comment**s, (n=219 for Q4-2018/2019 and 230 for Q1-2019/2020) – see also note (ii) below.
- ***PALS Activity*** for resulting from n=87 contacts and n=80 Care2Share clinics in (n=41 for Q4/2018/2019 and n=39 for Q1-2019/2020) – see also note (ii) below.

Complaints & Incidents Monitoring

- **Complaints** a **total of 2,825 complaints** were reviewed by theme and sub-theme for the purpose of triangulation; n = 1,346 for Q4-2018/2019 and n = 1,479 for Q1-2019/2020.
- **Datix™ (Incidents*)* a total of 16,784 incidents** were reviewed by theme and sub-theme for the purpose of triangulation; n = 8,516 for Q4-2018/2019 and n = 8, 268 for Q1-2019/2020.

Special Notes;

(i) For the purposes of analysis and triangulation, the frequencies (no of occurrences) of the top eight sub-themes are reported for incidents, which is different from the total number of incidents cited above.

(ii) The data was extracted on 24th June 2019 and may not take account of any subsequent additions or changes from this period or previous periods.

(iii) Data sets for NHS Inpatient Survey for Q2 & Q3 2018/2019 are not available due to the requirements of General Data Protection Regulation (GDPR) regulations to review the sampling mechanism.

3 What are Patients/Service Users Telling Us?

CRT/Viewpoint Real-time feedback System; feedback real time patient feedback survey indicates that for BCUHB as a whole service users report an average overall satisfaction rating of 8.85/10 for Q4-2018/2019 compared with 8.89/10 for Q1-2019/2020 see figs 1 & 2 below. This improvement is also seen in other items from the CRT/Viewpoint Survey – see Figs 1a & 1b below.

Fig 1a	**Mean Scores/4**	
BCUHB CRT/Viewpoint Items	**Q4 2018-2019**	**Q1 2019-2020**
Did staff introduce themselves to you?	3.58	3.64
Do you feel you were listened to?	3.64	3.67
Were you given all the information you needed?	3.58	3.60
Did you get assistance when needed?	3.72	3.73
Were you involved in decisions about care?	3.58	3.60
Did staff take the time to understand what matters to you	3.63	3.64

Fig 1b

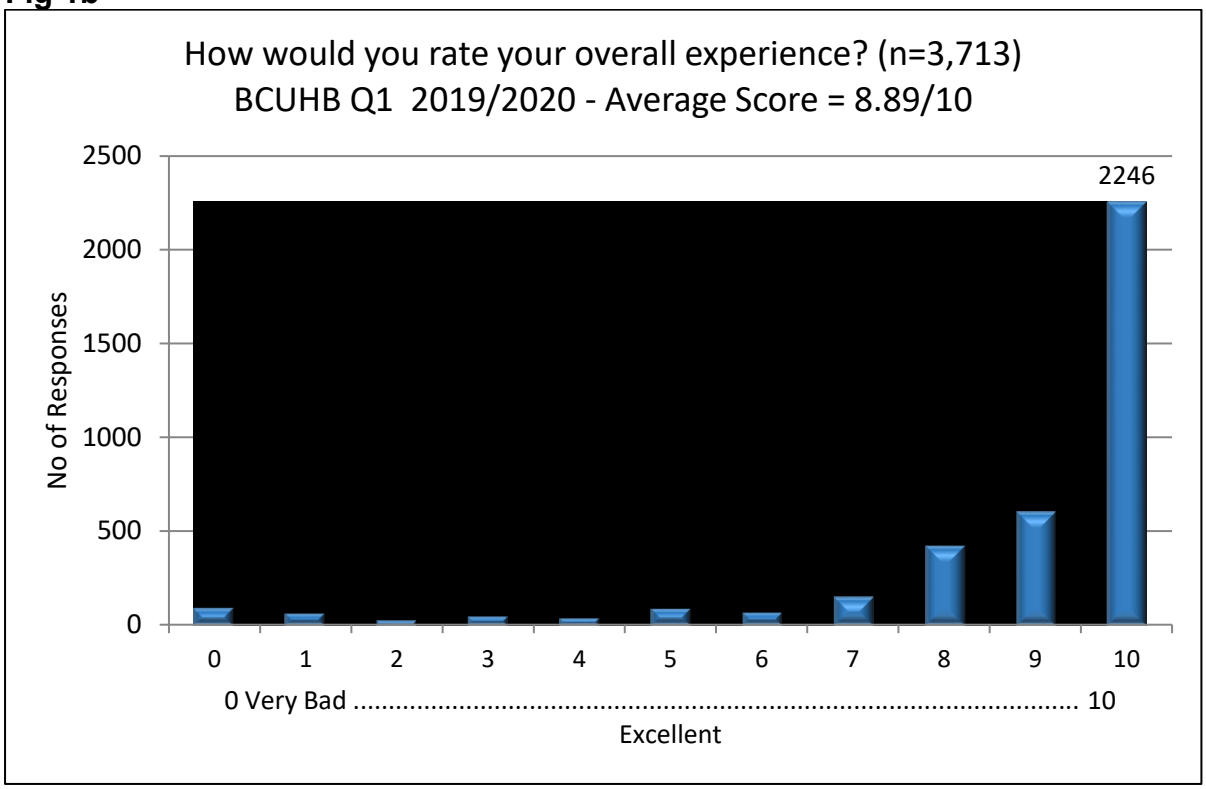
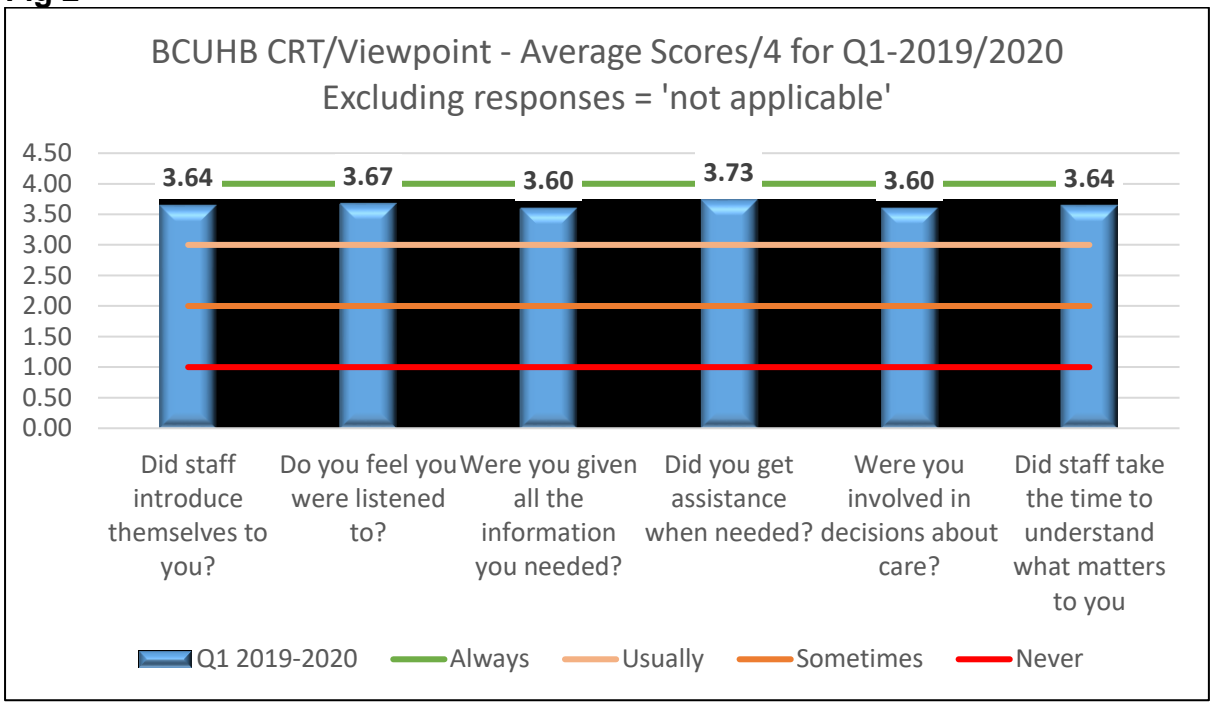


Fig 2



Thematic Analysis of a random sample of n=197 responses from all operational area in relation to the following items; *'What Was Good about your experience?'* and *'Was there anything that could be improved?'* identified the following key positive and negative themes, see figs 3 & 4 below.

Fig 3

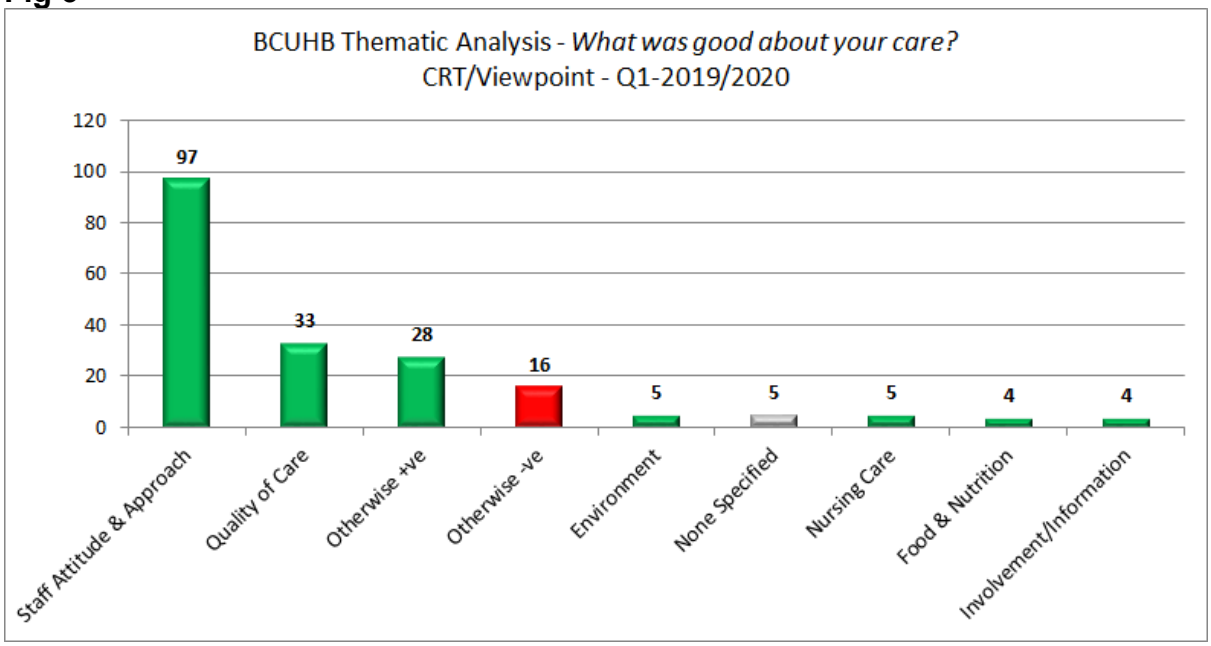
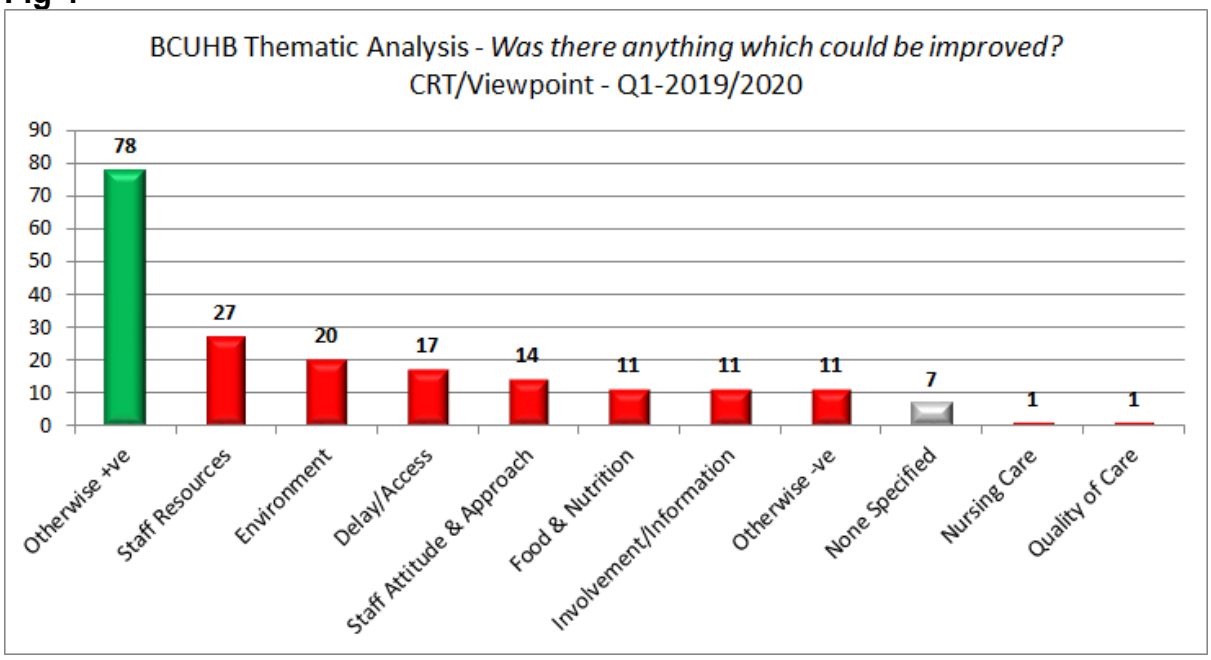


Fig 4



Special Note; the *'Staff Resources'* theme relates to perceptions of the level of resources, and is not an accurate reflection on safe staffing levels.

Analysis of Patient Comment Cards; analysis of feedback from patient comment cards identifies that *'Basic Nursing Care'*, *'Staff Attitude'* and *'Coordination of Care'* contributed to a positive patient experience whereas *'General Facilities (Environment)'*, *'Parking'*, *'Waiting Times'*, not *'receiving information*' and *'(Poor) Staff Attitude'* contributed to a negative experience.

Fig 5

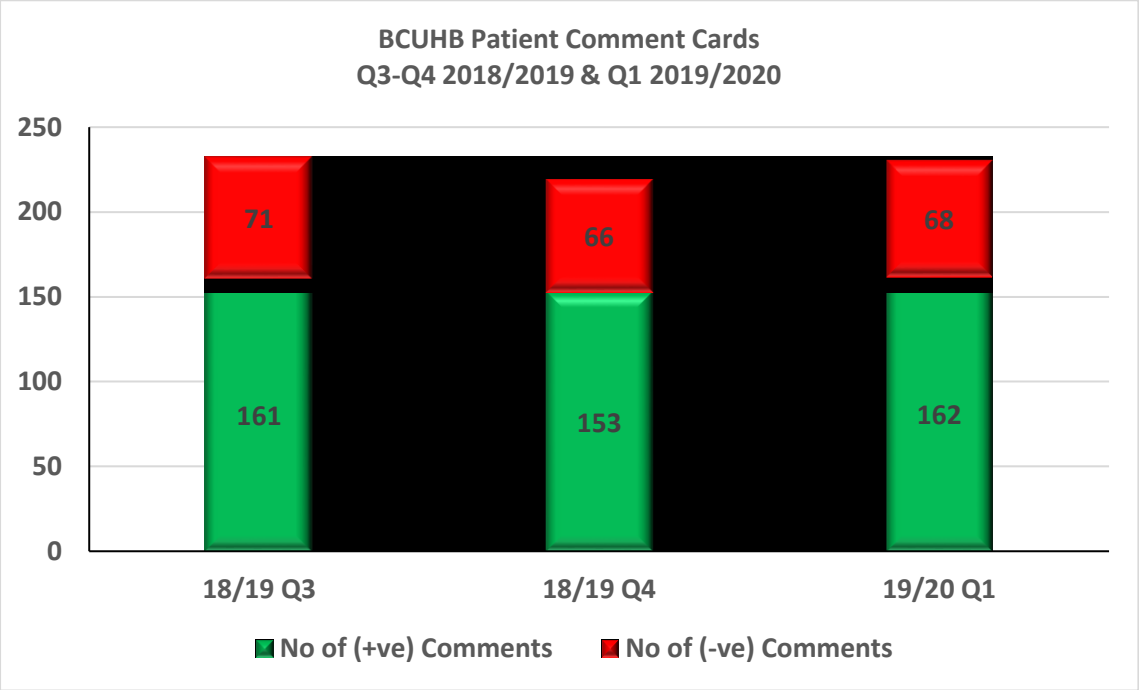
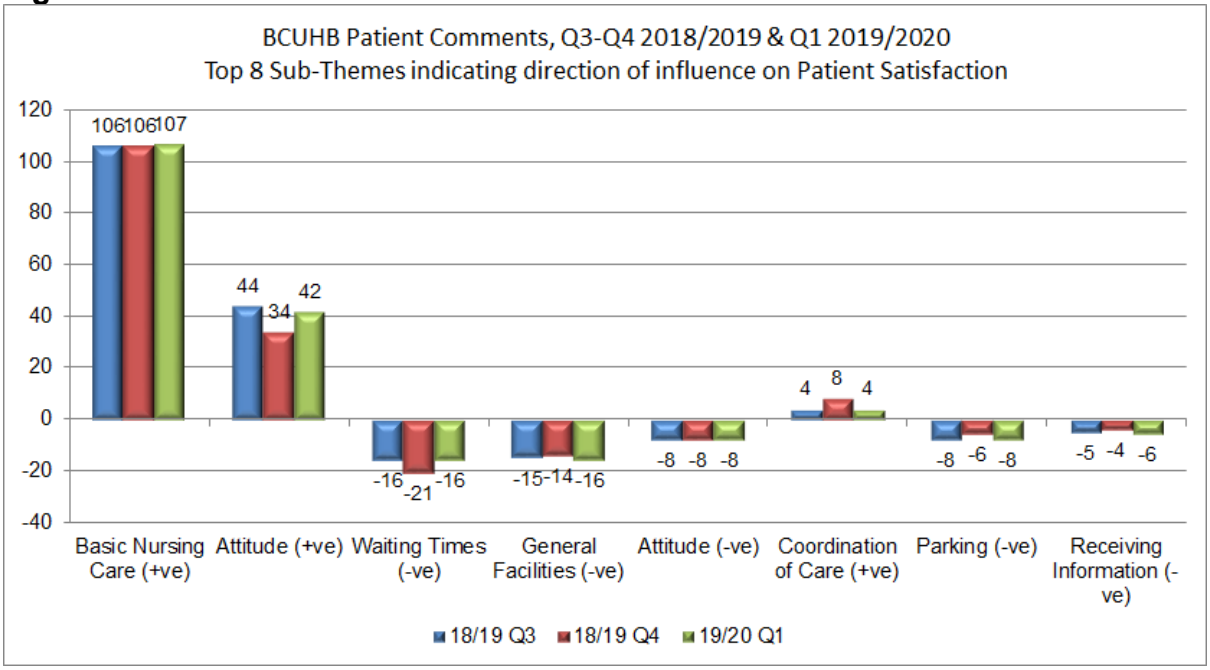


Fig 6



The analysis of patient comment cards and thematic analysis of patient comments from CRT/Viewpoint and NHS Inpatient Survey indicates that the number of positive themes for Q1-2019/2020 continues to far outweigh the number of negative themes. Which indicates that our services continue to contribute to a positive patient experience.

Patient Advice and Liaison Service (PALS)

PALS Contacts; analysis of activity derived from the PALS service in Ysbyty Glan Clwyd (YGC) indicates that the negative aspects of service which resulted in resolution of inquiries related to the sub-themes detailed in Fig 7 below.

Fig 7

Sub-theme	18/19 Q3	18/19 Q4	19/20 Q1
Coordination of Care – Negative	87	51	38
Waiting Times - Negative	64	23	4
Receiving Information - Negative	27	11	16
Communicating in a timely way - Negative	25	11	9
Attitude - Negative	12	5	5
Miscellaneous - Negative	10	4	4
Basic Nursing Care - Negative	7	2	5
Coordination of Care – Positive	1	3	1
General Facilities - Negative	1	0	3
No value	0	1	2
Receiving Information - Positive	1	1	0
Basic Nursing Care - Positive	0	1	0
Communicating in a timely way - Positive	1	0	0
Communicating Sensory Loss - Negative	0	1	0
Parking - Negative	1	0	0
Total	237	114	87

A high proportion of the activity represented in Fig 7 above resulted from resolving inquiries from patients and service users related to Outpatient and Emergency departments.

PALS Care2Share; within Q4-2018/2019 and Q1-2019/2020 in line with the Patient & Service User Experience Strategy (BCUHB, May 2019) the PALS service in YGC was deployed in an increasingly proactive, intelligent manner, utilising Care2Share approaches within wards/departments. The key sub-themes relating to patient and service user experience identified by this approach are summarised in Figs 8 & 9.

Fig 8

Sub-Theme	18/19 Q3	18/19 Q4	19/20 Q1	Total
Attitude (+ve)	0	8	1	9
Basic Nursing Care (+ve)	1	6	15	22
Communicating in a timely way (+ve)	0	0	1	1
Communicating Sensory Loss (+ve)	0	1	0	1
Coordination of Care (-ve)	0	0	1	1
Coordination of Care (+ve)	3	21	8	32
General Facilities (+ve)	0	6	0	6
Receiving Information (+ve)	0	7	0	7
No value	0	0	5	5
Total	4	49	31	84

The analysis within figs 7 and 8, indicates that once patients and service users have accessed care services their experience is an overwhelming positive one. Within this period Care2Share has been implemented within all Community Hospitals in the Centre and has provided an important proof of concept which will be rolled out all operating areas as the PALS service becomes BCUHB wide in Q2019-2020.

Special Note

(iv) The care2share data has been recorded within Datix™ at the patient/services user level, in other words n=31 patients/service users provided feedback within Care2Share clinics for Q1-2019/20 – see Fig 8.

NHS Inpatient Satisfaction Data

Analysis of responses to the NHS Inpatient Satisfaction Survey indicate a positive overall level of satisfaction with the service, see fig 9 below.

Fig 9

	Average Scores/4 for Items 1-12 Average Score /10 for item 13			
Items in Descending order of influence on Patient Satisfaction.	Q3-2017/18	Q4-2017/18	Q1-2018/19	Q4-2018/19
Q1. Do you feel that people were polite to you?	3.69	3.77	3.77	3.75
Q11. Were things explained to you in a way that you could understand?	3.41	3.67	3.57	3.68
Q6. How clean was it?	3.72	3.65	3.68	3.63
Q9a. If you asked for assistance: Did you get it?	3.56	3.55	3.61	3.59
Q10. Were you involved as much as you wanted to be in decisions about your care?	3.27	3.40	3.39	3.57
Q8. Did you feel that everything you needed for your care was available?	3.48	3.56	3.53	3.54
Q5. From the time you realised you needed to use this service, do you feel you had to wait:	3.50	3.10	3.03	3.53
Q12. Did you feel you understood what was happening in your care?	3.43	3.40	3.46	3.52
Q4a. Were you: Given the support you needed to help with any communication needs?	3.60	3.53	3.68	3.51
Q2b. Do you feel that you were given all the information you needed?	3.36	3.31	3.45	3.47
Q3. Do you feel you were given enough privacy?	3.51	3.57	3.49	3.47
Q7. Did you see staff clean their hands before they cared for you?	3.51	3.48	3.54	3.45
Q9b. Get it when you needed it?	3.36	3.36	3.49	3.45
Q2a. Do you feel that you were: Listened to?	3.43	3.50	3.45	3.40

Q4b. Were you: Able to speak in Welsh to staff if you needed to?	2.40	2.70	2.50	2.71
Q13. How would you rate your overall experience?	8.39	8.50	8.30	8.41

Responses to item 4b tend to be an indirect measure of the utilisation of spoken Welsh, which varies by operating region. A breakdown of this data is available on request from the report authors. Thematic Analysis of a random sample of n=294 responses from all operational area in relation to the following items; *'Item 14 - What Was Good about your experience?'* and *'Item 15 - Was there anything that could be improved?'* identified the following key positive and negative themes, see figs 10 & 11 below.

Fig 10

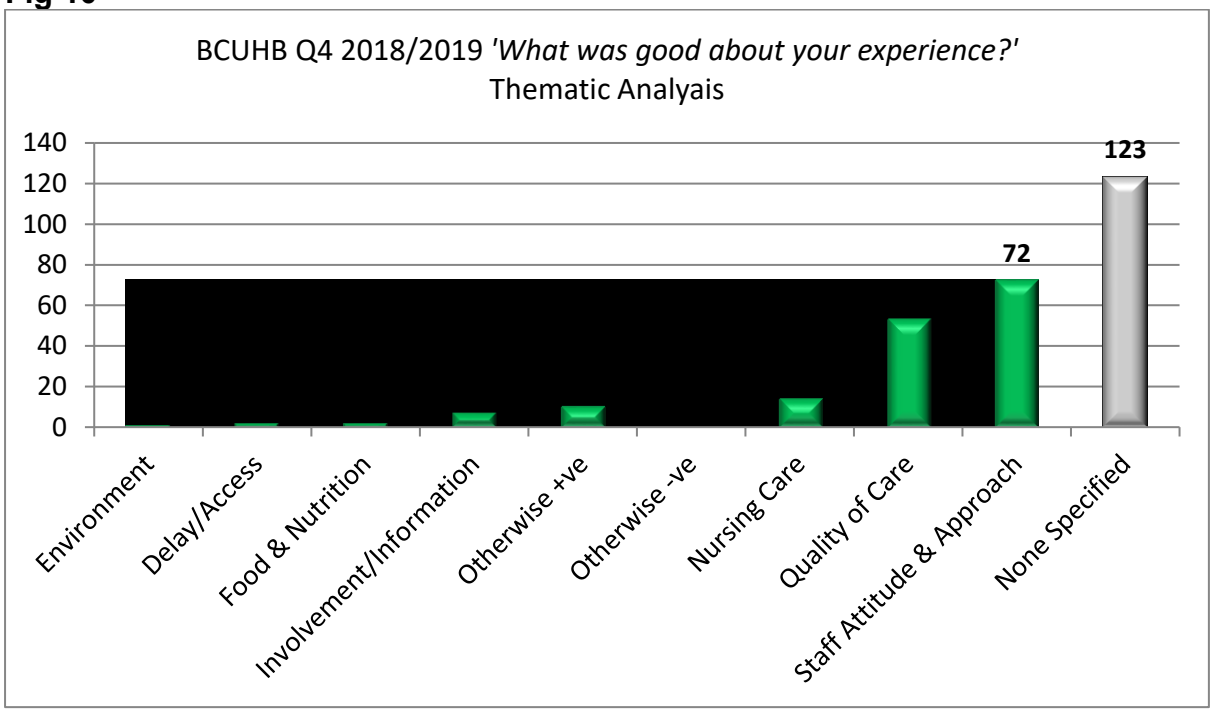
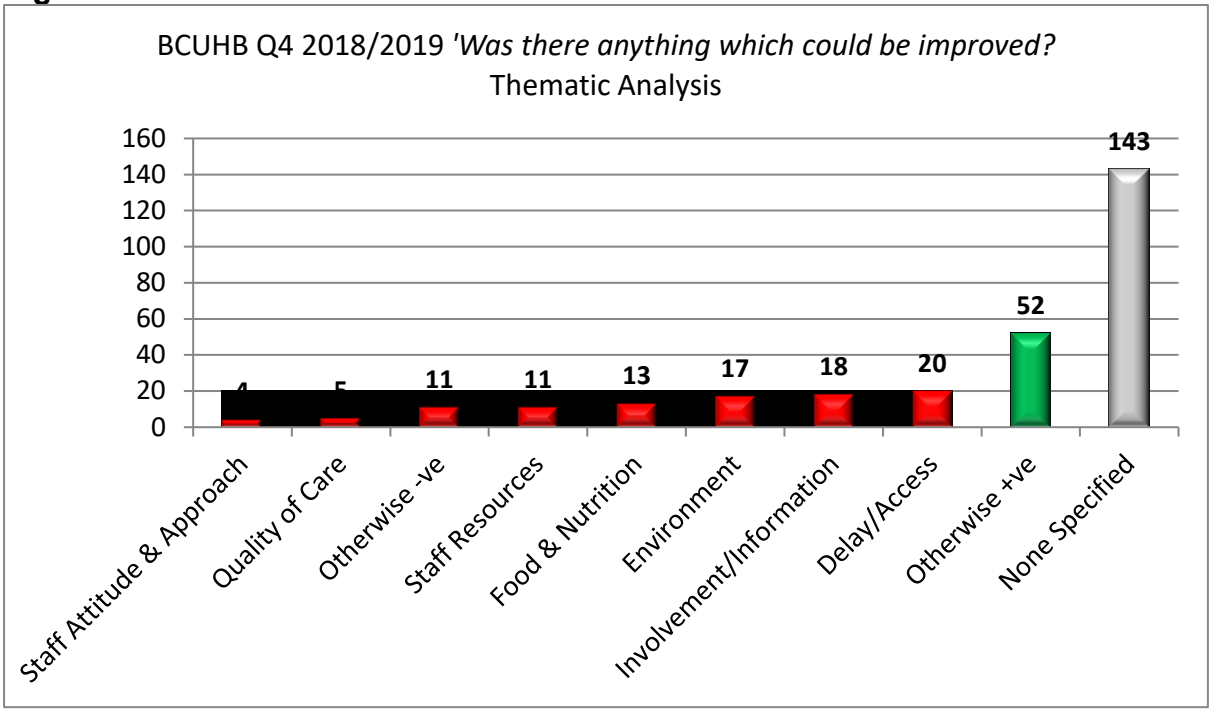


Fig 11



Analysis of Complaints Data by Sub-Theme

Analysis of complaints opened by Top 10 Sub-themes is detailed in Fig 12 Below.

Fig 12

Sub-Theme	18/19 Q3	18/19 Q4	19/20 Q1
Communication with the patient (other than consent issues)	150	169	199
Unacceptable Waiting Time	116	163	235
No value	139	118	127
Communication with family	54	60	45
Date for admission cannot be given to the patient	32	51	56
Delay in admission	27	46	46
Assessment - other	45	39	31
Co-ordination of medical treatment	22	30	49
Cancellation of appointment	31	28	42
Inappropriate Discharge	27	38	26
Total	643	742	856

Summary – Some Key Insights

As alluded to in previous sections the analysis of patient comment cards and thematic analysis of patient comments from CRT/Viewpoint and NHS Inpatient Survey indicates that the number of positive themes for Q1-2019/2020 continues to far outweigh the number of negative themes. Which indicates that our services continue to contribute to a positive patient experience. Feedback from the NHS Inpatient Survey and CRT/Viewpoint indicate that previously high levels of patient satisfaction which were a feature in previous reporting periods have in the case of

the NHS Inpatient Survey been maintained and in terms of the feedback received from CRT/Viewpoint improved across all items for the organisation as a whole. Additionally return rates whilst lower in the Centre and West than in the East have seen an upward improvement in Q1-2019/2020 most dramatically within the Centre, which have moved from an average of 150 month in April 2019 to approx. 600/month in June 2019.

Based on the data analysed, as in previous reporting cycles, service users are more likely to report their experience in a positive than a negative manner. The factors which contribute to a positive patient experience are on the whole different to those which contribute to a negative one. The exception to this being '*Staff Attitude'* which whilst often reported as contributing to a positive patient experience it is also reported as contributing to a negative experience. *This reinforces the importance of staff attitude as an essential element of effective 'customer care'*. The factors contributing to a positive and negative patient experience are summarised in Figs 13 & 14 below. An additional insight worthy of note, is that features of the service which contribute to a negative experience tend to relate to the infrastructure and processes supporting access to services. Once patients access our services their response to the experience is overwhelmingly positive. This feature is probably best illustrated in the PALS data, see Figs 9 & 10, but is also reinforced by all other sources of patient and service user experience data.

Fig 13

Factors reported as contributing to a Positive Patient Experience ***"What do we do Well?"***	Factors reported as contributing to a Negative Patient Experience ***"What are the opportunities for improvement?"***
• Quality of Care • Staff Attitude & Approach • Basic Nursing Care • (<<) Food & Nutrition • (<<) Coordination of Care • (<) Information/Involvement Key: (<) Less Frequent (<<) Very Less Frequent (>) More Frequent (>>) Much More Frequent	• Waiting Times (Access & Delays) ▪ (>>) *Coordination of Care* ▪ *Unacceptable Waiting Times* • Environment (General Facilities, Parking, Ward Environment) • (>) Food & Nutrition • Information & Involvement ▪ *Receiving Information* • Communication in a Timely Way ▪ *Communication with patient other than consent* ▪ *Communication with family* • Organisation/Coordination of Care • << Staff Attitude & Approach ▪ *Staff Attitude*

Italics indicate Datix™ Sub-Themes where available.

Fig 14 - And in the words of our patients

"What do we do Well?"	***"What are the opportunities for improvement?"***
"After a frightening shock of my husband suffering a severe stroke I was comforted and reassured of his continual care on Prysor Ward by all nursing staff. Their total care and commitment towards my husband is second to none and met all his needs in a dedicated way. I was kept informed and involved at all times." *"During my stay on the ward I felt at ease. Every member of staff whatever their designation always treated you with respect and dignity. Whilst a patient on the ward I experienced NHS care at its best. I felt that all staff were committed to their job and worked as a team rather than individuals."* *"The professionalism of the staff, their clarity, respect and empathetic position. This was particularly striking in the young staff."*	*Food that comes is not to everyone taste it's same every week. More choice be nice."* *"INFECTION CONTROL, BASIC NURSING CARE, IV-ANTT, MULTIPLE IMPROVEMENTS."* *"Communication between wards. Food choices not always delivered. New pillows are too hard."* *"Breakfast. No toast - no brown bread! Told fire hazard? Yet you have polystyrene tiles on ceiling! Big fire risk."* *"More staff. Improve the food. A bit dated, old fashioned menus. Less sugar, less salt."* *"Communication with hospital. Wasn't made aware of her going into a home."* *"Not happy with the way consultant spoke to me. I do realise he wants what's best for his patients but he needs to have more of a bedside manner."* …/Ctd

"What do we do Well?"	*"What are the opportunities for improvement?"*
"The care and attention on this ward is second to none. Well done all staff members. God bless you all."	*"Night times are difficult in hospital for anyone but a little bit more understanding from night staff would have been appreciated."*
"Friendliness of staff and efficiency in providing care. Especially in this busy environment. Obvious team spirit. Happy staff equals happy patient."	*"More equipment. More staff. Did no like food. Sometimes got wrong meal that was ordered."*
"Everyone listened, respected me. Took time to listen even when they were under pressure, they had the kindness to enable me to recover and go home at ease."	*"Waiting time, filling the paper work in there, don't take into consideration that I might not be able to read or write, which I do struggle with and I feel it's best to look for help."*
"Written on behalf of my father: Dad's comfort at this stage of his life is of great importance. Staff on all levels are very kind and have also supported me at a sad time of my life. Despite being very busy, they always have time to check Dad is OK and are very approachable."	*"It would be helpful if staff could be more patient and give more time to explain and check that elderly people have understood the information they need."*
"My experience of this ward has been marvellous - the staff are very helpful, nothing too much trouble. I'm very happy to be going home but I will miss you. Thank you for everything."	*"Information re condition and detailed information of what should be done."*
"Every member of staff has been nothing but friendly and very caring. Even when I felt low there has been someone to have a chat to. I feel a totally different person to when I arrived and that is all due to the tremendous care I have been given".	*"Better communication between different departments including across hospitals, also for the doctors to listen to the patient and not age discriminate against those who are below 40 and over 60. People tend to know their own medical history as well as their body."*

Maternity Services

A recent review of patient and service user feedback from Maternity Services in relation to effective communication for 2018/2019 indicated the following key themes;

Fig 15

CRT/Viewpoint Items	Percentage of 'Always Responses'		
	Centre	East	West
Do you feel you were listened to?	85%	86%	87%
Do you feel you were given all the information you needed?	83%	85%	86%
Did you get assistance when needed?	84%	87%	90%
Were you involved as much as you wanted to be in decisions about your care?	92%	90%	91%
How would you rate your service overall (Percentage of 'Always Responses' rated 10/10)	66%	70%	87%
How would you rate your service overall (Percentage of 'Always Responses' rated less than 5/10)	4%	2%	5%

Fig 16

Positive Themes	**Negative Themes**
Centre • Staff – described as friendly, kind and caring • Patients received great care and aftercare • Patients felt supported • Patients were comfortable on ward(s) • Patients felt listened to with good communication • Patients felt they were treated fairly and the hospital has a good understanding of diversity	Centre • Staffing levels/pressures on staff • Food • Communication and co-ordination between teams/departments • Bathroom/shower room cleanliness • Parking
East • Staff – described as friendly, kind, helpful and supportive • Patients received good care and aftercare • Patients felt supported • Patients felt comfortable and happy with the cleanliness • Patients felt listened to and appreciated the availability of information/communication • Patients were happy with the support with breastfeeding help/advice …./CTD	East • Communication with patient and between staff • Waiting times for medications/pain relief • Staff workloads/more staff needed • Ward temperature (too hot) • Food (lack of vegetarian options) • Parking

Fig 16 … /Ctd

Positive Themes	Negative Themes
West • Staff – described as friendly, caring and supportive • Patients felt cared for • Patients felt supported • Patients were comfortable on ward(s)	West • Patients would like extended/more flexible visiting times for fathers • Communication between staff and with patients could be better • More staff needed • Heating/lack of air conditioning on ward • Waiting times for medication/pain relief

4. What have we done with this feedback?

4.1 Sharing of information

- Feedback from CRT/Viewpoint system is provided to the ward/department managers on a weekly basis, aggregated by speciality, and escalated to the relevant matron/speciality managers. The requirement to display and act on such feedback is a required component of the new ward accreditation system currently being rolled out throughout BCUHB.
- All comments received via the comment card system are shared with the relevant ward/department and followed up if improvement actions are identified.
- Feedback from services users accessing the Patient Advice and Support Service (PASS), which currently operates in the Centre, is forwarded to the relevant operational managers in order to facilitate a collaborative problem solving and real time resolution of 'inquiries', thus enabling BCUHB to listen, learn and act on what service users are telling us, (WG, 2015a; WG, 2015b).
- Local Quality Safety and Effectiveness reports are provided to all operational areas and divisions; this report includes performance data, themes and trends, in relation to complaints, incidents, claims, ombudsman reports, coroner's cases, and real time service user experience feedback.
- Quarterly reports of all patient experience activity (including incidents and complaints) and themes and trends are provided to Listening and Learning from Experience meeting; Divisions are requested to report on lessons learned and improvement actions to inform this report.
- Feedback in relation to the experiences of service users with protected characteristics as defined by the Equality Act (UK, 2010) are provided on a quarterly basis to BCUHB's operational and strategic equalities groups, and disseminated to operational managers.

4.2 Improvement actions Completed in Q1-2019/2020

As in previous reporting periods, without the PALS service being fully operational across all three operating service, this report recognises that it is difficult given the current organisational infrastructure to definitively link service user feedback to specific service developments. This is not to say this is not occurring, but creating an auditable link at present is challenging. Hence the improvement actions detailed in section 4.3 build on existing interventions in order to develop a framework which

provides improved organisational assurance in relation to BCUHB's mandatory responsibility to listen, learn and act on service user feedback.

Some key improvements to note within this reporting period are;

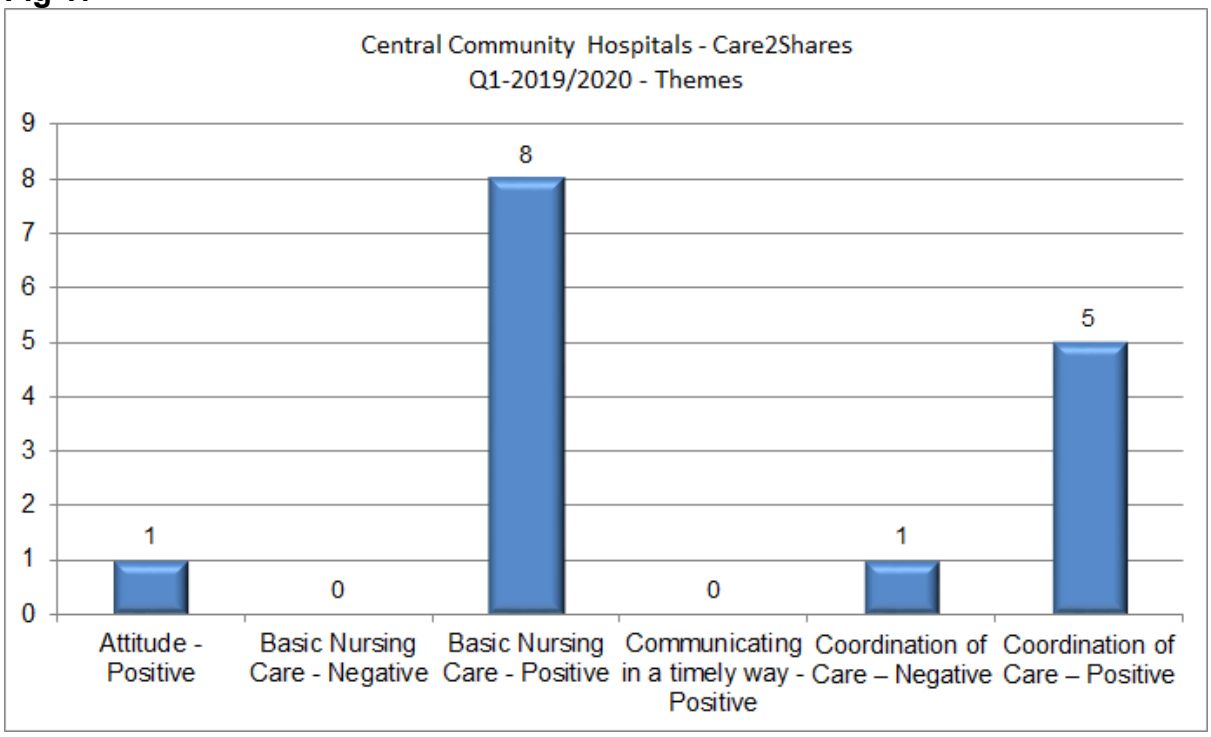
4.2.1 Improvement in CRT/Viewpoint returns in the Central region, which are on an upwards trajectory and are now averaging approx., n=600/month.

4.2.2 Targeted work with Maternity and Mental Health Services to identify key service improvement themes and to develop interventions to support service improvement. (See figs 15 & 16 above)

4.2.3 CRT/viewpoint has been rolled out in managed practices in the West and Centre.

4.2.4 PALs Care2Share clinics have been established in all community hospitals in the Centre, which has (i) provided valuable experience and proof of concept prior to mainstreaming across BCUHB and (ii) feedback from patients and service users within these settings has been overwhelmingly positive and relates to the following sub-themes.

Fig 17



4.2.5 The East Patient and Service User Experience team has for the past 12 months developed a process to share all patient feedback received via the Viewpoint real-time survey with the services. This in the forms of weekly comment reports to inform the views and improvement suggestions from patients on a regular basis, and monthly performance feedback to highlight the positives and areas which could be improved. These reports are delivered both electronically and in paper form to Matrons, Sisters and Ward Managers to be displayed as part of their ward accreditation requirements.

The engagement work carried out in conjunction with the Quality Improvement team to promote ward accreditation has led to an improvement in value from services of the Patient and Service User Experience real-time feedback survey.

Due to the success of the reporting formats supplied by the East team, this is now being rolled out across all three sites to ensure consistency.

With the implementation of the additional PALS resources, the current reports will be used in conjunction with Care2Share and You Said/We Did outcomes to drive service improvements and share best practice.

4.2.6 Area Community Services

Development and engagement work has taken place between the Patient and Service User Experience with Community Hospital Services to promote patient feedback and improve the real-time response rates for the Community wards. In the East area the Community Services lead has sourced 8 tablet devices for use with the CRT Viewpoint real-time survey. The overall aim is to increase participation in collecting patient feedback, which can be used to drive service improvements going forward.

District Nursing Engagement

The East Patient and Service User Experience team have met with the District Nursing teams to introduce the real-time patient feedback survey, with a view to capturing feedback from patients who are being treated outside of the acute hospitals by the District Nursing teams.

The team was very impressed with the level of information fed back from the real-time survey, and the types of data and information they can extract. The teams are working closely together to move forward with the implementation of the real-time survey into District Nurses, initially as a pilot in the East area, with a view to developing into all areas in the near future.

Community Child Health Services -Health Visitors

The Health Visiting service is eager to engage with the Patient and Service User Experience team to promote the implementation of the real-time patient feedback survey into their services. Arrangements are currently taking place to meet with the East Community Child Health Visiting Lead to look at how this can be piloted. A patient story is under consideration from the specialist Syrian refugee health visitor to highlight the value and importance the Syrian population in Wrecsam place on this unique service.

4.2.7 Work is continuously ongoing to improve the awareness and relativity of patient and service user experience throughout the BCUHB services. There is evidence to support the continual recruiting of new areas for inclusion in the real-time patient feedback survey with five new wards/departments introduced in the East area alone over the last quarter.

Increased Real time feedback in Ysbyty Glan Clwyd hospital and the Central area has seen a significant improvement. During the first quarter (April until the end of June 2019), a noticeable increase of real time feedback has been recorded (from 209 feedback on March to 662 on June 2019). Improvements are noticed particularly in the Gastroenterology ward (April 15 –June 123), the Primary Options for Acute Care (POAC) (April 0 –June 116), Day of Surgery Admission (DOSA) (April 0-14 June), North Wales Cancer Treatment Centre (March 22-46 June) and Radiotherapy (April 0-24 June). This reflects the increased interest of the wards staff of collecting and learning from the feedback regarding the services they are providing to patients and service users. It is a success for the short term with the intention to learn more of all the collected feedback, which will influence the PALS specific efforts accordingly. For instance, an increased number of the Gastroenterology enquiries is a good start as we receive many inquiries and issues to resolve from them Moreover, additionally Ysbyty Glan Clwyd Hospital wards and community hospitals, including Llandudno, Colwyn bay and Denbigh hospitals are requesting more collection boxes for their real time feedback. It is essential to mention that despite this improvement, the Welsh language is still an aspect that needs further support to ensure patient and service user accessibility to Welsh language speakers or translation services as required. This area is being monitored by the Patient and Service User Experience team.

Across the board there are increasing requests to support services in their focus group work as they plan to develop a service and are keen to have their patient and service users feedback. The PALS officers in Central region will be supporting the Cochlear Implant User Group. Following on from this a patient story request will follow to support shared learning.

4.3 Development of a Patient Experience Strategy and Patient Experience Function

The Patient Experience Team was restructured in November 2018 in order to provide an improved organisational capability to listen, learn and act on patient feedback, which is clearly differentiated from the Complaints and Incidents functions. An updated Patient and Service User Experience Strategy has been completed and is pending approval and identifies a number of key of interventions which will become common to each operating region within 2019/2020. Sections 4.3.1 – 4.3.10 outline progress made within Q1-2019/2020 in relation to the key tenets of the Patient and Service User experience Strategy.

4.3.1 PALS Service: an additional 6 x 1.wtes PALS officers have been appointed to enable the deployment of 3 x 1 wtes in each in the East and West from the end of Q2-2019/2020. A new PALS model has been developed and will be based on a proactive ‘Care2Share’ approach, supported by intelligent driven deployment derived from the feedback methods outlined in section 2.1 above. The new PALS operating framework will enable issues to be dealt with in a real time, early resolution manner, thus minimising the need for patients and service users to resort to the formal complaints procedure. The approach is currently being successfully piloted in the Centre. Demonstrated through the strong engagement with the Complaints and Governance teams in Ysbyty Glan Clwyd hospital which has ensured a close working relationship going forward to allow PALS officers to capture any early resolution enquiries reducing the need for patients and service users to enter into the

Putting Things Right regulation process. This ensures that patients/relatives/carers are receiving prompt responses to their enquiries, with timely resolutions and increased satisfaction for all concerned.

The PALS officers will be strategically located and visible at each hospital site for easy access between the hours of 8.00am and 6.00pm, Monday to Friday. PALS will engage with Community services, Mental Health and Learning Disabilities services, Women's services, Cancer services, Health Board Managed General Practices as well as the acute secondary care hospitals. The introduction of an evaluation process for PALS will ensure continuous monitoring of the PALS service, and will provide constructive feedback to implement improvements as necessary.

4.3.2 Collecting and Using Feedback; key activities/achievements within Q1-2019/2020 include:

- *CRT/Viewpoint Real Time Feedback System;* the roll out the system into managed primary care GP practices – which will be complete by the end of Q2-2019/2020, improving response rates from Centre and West which whilst lower than in the East are on an upward and sustainable trajectory, the standardisation of weekly and monthly reporting across BCUHB in support of service improvement and ward accreditation.
- *NHS Inpatient Satisfaction Survey;* following a review of the information governance arrangements, the approach to sampling was reviewed in order to ensure compliance with GDPR (2018) requirements, and the survey was successful reintroduced in Q4-2018/2019 in order to provide a retrospective patient feedback in line with BCUHB's mandatory requirements (WG, 2015a)
- *Patient Comment Cards;* whilst the comments card pro-forma are now only utilised where it is not possible to utilise the CRT/Viewpoint survey, they continue to provide insightful feedback, which enables managers and operational staff to understand their service through the voice of the patient and other service users. Additionally, within Q1-2019/2020 there has been a focused effort on utilising the DATIX Patient Comment module to record and disseminate for information or action, other forms of narrative feedback, such as letters of compliment, thank you cards etc.
- *Patient Stories* – within Q1-2019/2020 the guidelines on patient stories (ISUE01) have been reviewed and simplified in order to encourage a more pragmatic, broader approach to collecting patient stories including the use of multi-media platforms, patient/service user diaries, and picture/art elicitation. The patient and service user experience team have continued to support the collection of patient stories and the development of a patient storey library, which is key tenet of the Patient and Service User Experience strategy.
- *Development of Internal Reporting Arrangements – sharing feedback*; within Q1-2019/2020, a review of reporting arrangements has resulted in the streamlining and standardisation of feedback provided to managers and operational staff commensurate with BCUHB's mandatory responsibility (WG, 2015a; WG, 2015b), to listen, learn and act on feedback. Key reporting mechanisms include; weekly and monthly CRT/Viewpoint summary reports, monthly Quality Safety and Effectiveness and organisational QSG reports. Additionally, the analysis of incidents and complaints, and 'Harm' metrics by location enables trends to be combined into a 'hot spots' report which

underpins the intelligence drive deployment of PALS officers in line with the Patient & Service User Experience Strategy.

- *All Wales Reporting of Service User Experience* – the Patient & Service User experience team are proactively contributing to the ongoing development of an all Wales specification for patient and service user experience feedback system. Whilst there remains some concerns that such a specification may result in a less functional system than that which is currently utilised within BCUHB, the risks associated with this approach will be managed by the development of improved internal data warehousing approaches and the development of IRIS reporting in relation to patient and service user experience feedback. This is a key target for Q2-2019/2020.

4.3.3 Facilitating Service Improvement; given that learning from service user feedback such that managers and front line staff *'see'* and *'do things'* differently in a sustainable and patient focussed manner clearly underpins improved experience, governance and organisational performance. Within Q1- 2019/2020 the patient experience team has;

- Ensured the effective reporting and triangulation of service user experience feedback to operational managers and front line staff, in near/real time where possible, as outlined in sections 4.1 and 4.3.2, in order to support organisational improvement efforts such as; reducing Health Acquired Pressure Ulcers (HAPUs), Falls, Medical Device and Medication Errors, Improving Nutrition & Hydration, Improving Dementia Care, and improvement projects arising from Ward Accreditation Efforts.
- Utilised the 'Care2Share' PALS model in the Centre, in order to develop a more proactive approach to service improvement, see figs 7 & 8.
- Developed the intra and inter organisational relationships necessary to develop and adopt patient/service user centric approaches to service improvement, including collaborative working with MHLDS service improvement coordinators, Cancer Support Networks, Acute/Community/Primary Care Governance Teams, Primary Care Cluster Development Teams, Centre for Sign Sight and Sound, Action on Hearing Loss, etc., as well as national collaboration such as Head of Patient Experience (HoPE), Patient Experience Mangers Forum, Accessible Health Care – Senior Officers Group, amongst others.
- Provided targeted training on the use of service user feedback to drive and sustain service improvement, (see also 4.3.4)
- Continued to support and develop the Ward Accreditation Scheme, within Q1-2019/2020 contributed to the review of the ward audit instrument to include the reference to the Accessible Communication and Information Standard for people with sensory loss (WG, 2013) and via the provision of summary report of patient and service user experience as preparation for accreditation visits.

4.3.4 Training, Education and Service Development; the greatest leverage for change in many cases rests with the human element of the health care system, and in order to support the improvement efforts cited above, it is essential that managers and front line staff become aware of the impact that their behaviours have on the experiences of our service users and are supported to make changes where necessary. Within Q1-2019/2020 the Patient experience teams in each region have developed an ongoing programme of training sessions in the following key areas:

- Customer Care,
- Using Service User Feedback to improve services
- Using Patient Stories to improve services

Whilst attendance has been disappointing due to the pressure of providing a 24/7 service, an ongoing review of provision is underway, towards a more blended learning approach, supported by the development of e-learning materials, which is a key target for Q2-2019/2020. Additionally, within Q1-2019/2020 a one day session has been delivered for n=90 undergraduates nurses (Adult, Mental Health/LDS) studying on the BNr degree at Bangor university. Further sessions will be delivered within Q3-2019/2020 and where possible to include undergraduates from the BSc in Medical Sciences. Thus, ensuring that BCUHB's future workforce are aware of the importance of service user feedback and their role in providing services which contribute to a positive experience.

4.3.5 *'Feel Good Friday'* - Developing a Motivated Workforce; whilst training and development is clearly important in this respect, it is also critical that positive feedback is shared with front line staff; because such feedback is overwhelmingly representative of the experience of most patients and other service users, (see section 3 above).

Within Q1-2019/2020 the Patient experience teams in each region have built upon the success of *Feel Good Friday*; which provides a certificate of achievement to the ward/department who are deemed to have had the most motivational comment of the week! These are selected by the Patient Experience Teams in each of the regions, and publicised on social media. Some recent examples include;

> *"All staff are so polite and helpful. Never felt a nuisance, always listened to, staff constantly asking if I need anything which really made me feel at ease and supported. Wonderful team of people and professional."*
>
> *"The male nurse looking after me was so good and took the time to check I was OK. Did his job brilliant to be honest, made me feel at ease. I'd go as far as saying best nurse I've come across."*
>
> *"Everything your staff, sister are simply the best staff money can't buy the girls are simply angels, they attend to everyone in turn not just my mum, the work and effort in everything one asks for is amazing with love, care and attention never ending."*

4.3.6 Accessible Information and Communication for People with Sensory Loss (WG, 2013); the Patient Experience Team will in 2019/2020 continue to provide the leadership and operational support necessary to ensure that BCUHB is compliant with these standards, in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019. Within Q1-2019/2020 BCUHB has been nominate for an Action of Hearing Loss excellence Wales award which recognises businesses and organisations in Wales who ensure that they are accessible to the one in six people who are deaf or have hearing loss. Following successful lobbying by the Head of Patient Experience & Head of Equalities, BCUHB has been selected to host the launch event for 'It Makes Sense 2019', the annual NHS Wales Sensory Loss awareness week scheduled for November 2019. Additionally, in-line with the agreed organisational action plan with WG, within Q1-

2018/2019 the sensory loss awareness Toolkits (both Acute and Primary/Community Care variants) have been updated and electronic versions are now available, along with support materials on BCUHB's intranet pages http://howis.wales.nhs.uk/sitesplus/861/page/48396 The importance of the provision of information and effective communication for service users with sensory loss was a feature of across all three regions of the recent patient safety week, which helped raise awareness of the issues.

4.3.7 Welsh Language Standards; BCUHB provides an exemplar of practice in relation to ensuring that the *'positive offer'* of accessing and receiving health care services in Welsh is an everyday reality for our service users. Within Q1-2019/2010 key achievements include

- The appointment of 6 x 1.0 wtes PALS officers ensuring the bilingual provision of this service in line with BCUB's statutory obligation.
- Implementation of an updated CRT/Viewpoint survey and underpinning data model to include the item *'Were you able to speak Welsh to a member of staff if you needed to?'* to bring the survey in line with the NHS Inpatients Satisfaction Survey and to ensure that both instruments support full compliance with the all Wales Patient Related Experience Measures (PREMS).
- Specific focus on understanding the needs of Welsh speaking patients and service users, via patient stories, resulting in 'Author's Story'.
- Continued review of frameworks for listening and learning from patient and service user experience are fully compliant with the Welsh Language Measure (Wales) (WG, 2011).

4.3.8 Adopting a Tri-Lingual Approach; a guiding principle of the Patient Experience Strategy will be the adoption of a tri-lingual approach to listening, learning and acting from service user feedback. That is ensuring that BSL as well as Welsh given equal prominence with English. Within Q1-2019/2020, BSL training has been commissioned from the Centre for Sign Sight and Sound (COSS) and will form an integral component of the PALS officer's induction programme. Additionally, discussions are on-going with COSS to provide BSL video interpretation of key information contained on the Patient and Service User Experience web pages, this is key action for Q2-2019/2020 once the review of content has been undertaken.

4.3.9 Listening and Learning from Experience Group; the Terms of Reference (TOR) for this group have been reviewed within this period, and group relaunched in Q2-2019/2020 to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning.

4.3.10 Patient Safety Week

All three BCUHB Patient and Service User Experience teams participated in the recent Patient Safety Week in June 2019. The East team worked around a theme of "communication" and produced a number of information packs for containing valuable information such as; language line posters, contact details for the Accessible Health Service, contact details for interpretation services, Dementia Carers guides, Putting Things Right leaflets and posters, Welsh translation service contact information and useful Welsh phrases.

In total, 36 communication packs were produced and delivered to all wards within the Wrexham Maelor, Mental Health and Learning Disabilities services Heddfan wards and the community wards at Deeside, Chirk and Mold hospitals.

The Central team worked in partnership with the Dementia Care Nurses to set up a display area within the main hospital at Ysbyty Glan Clwyd hospital to promote various services relative to patient safety. The display included materials for; Dementia Care, North Wales Police safety information, Accessible Health Care information, WITS details, Health and Wellbeing events, Cancer Patient Forum and Support Groups and PALS service information. The PALS Officers also visited the Community hospitals to promote these services.

In the West area, a display table was set up at the entrance of Ysbyty Gwynedd to promote; Safe Clean Care, Dementia awareness, Putting Things Right, Wellbeing Services as well as other information relating to linking in with the community and resources available at home. Information packs containing details of how to request appointments for BSL and sensory loss were disseminated across the main hospital wards, community areas and managed GP practices. Visits also took place to carry out Care2Share interviews to aid service improvement on Children's Ward.

5. Next steps – Actions for Q2-2019/2020

Looking further forward, in addition to those actions detailed in below; key milestones to be achieved within 2019/2020 which will improve BCUHB's ability to listen, learn and most importantly act on patient and service user experience include;

Action	To be completed By
• Reestablishment of the Listening & Learning group – to improve organisational accountability in relation to BCUHB's mandatory responsibility to act on feedback.	Sept 2019
• Implementation of a standardised PALS services across all three operating areas, derived from the PALS Model	Sept 2019
• Routine, development and implementation of service improvement action plans at ward/dept/speciality level derived from PALS activity – to support a 'You told us', 'We did' culture.	End of Q3-2019/2020
• Improved reporting of Service User experience using the IRIS system in order to identify 'hot spots' and to support proactive improvement, which combines existing 'Harms' and complaints metrics with CRT/Viewpoint feedback.	Pilot to be completed in the West by Oct 2019
• Evaluate the above and roll out to other operating areas.	End of Q4-2019/2020

Collectively the above actions are integral to the Patient & Service Experience Strategy and will improve, in subsequent reporting periods, the Health Board's ability to act on patient and service user experience, in line with our mandatory responsibilities.

Critical to improving BCUHB's capability to listen, learn and act on service user feedback, and therefore its capacity to respond to its mandatory responsibilities is the rapid approval of the Patient Experience Strategy and Improvement plan. As articulated in previous sections key elements include;

- Implementation of bilingual PALS service in the East and West based on the Care2Share model in order to provide BCUHB wide access to *'patient advice and support services.'* (See section 4.3.1)
- Development of improved real/near time feedback and reporting systems such that patients and service users are easily able to provide managers and front line staff with the information necessary to support service improvements. (See section 4.3.2)
- Use real/near time service user feedback to support service improvement. (See section 4.3.3)
- Delivery of a rolling programme of customer care, patient stories and using feedback to improve services, workshops. (See section 4.3.4)
- Use 'Feel Good Friday' to share positive feedback with front line staff across all regions on a weekly basis. (See section 4.3.5)
- Provide the leadership and operational support necessary to ensure that BCUHB is compliant with *Accessible Information & Communication for People with Sensory Loss* standards (WG, 2013), in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019. (See section 4.3.6)
- Ensuring that the work plans developed to support the Patient Experience Strategy, are compliant with the requirements of the Welsh Language Act, Welsh Language Measure (Wales, 2011) and Welsh Language Standards through the implementation of a bilingual PASS service, ensuring that service users are able to provide feedback on their experience in Welsh for example via; Real Time Feedback Systems, NHS Wales Inpatient Satisfaction Service, Care2Share, via Patient Stories etc. (See section 4.3.7)
- Ensuring that the work plans developed to support the Patient Experience Strategy adopt where practically possible a tri-lingual approach; that is ensuring that BSL as well as Welsh are given equal prominence with English. (See section 4.3.8)
- Re-establish the Listening & Learning from Experience Group based on the revised TOR in order to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning. (See section 4.3.9)
- Develop a library of patient stories which can be utilised for service improvement and to ensure that they are available for use in organisational QSE & QSG and other strategic meetings. Thus ensuring that the voice of the patient is always central to the provision of health care services, and that BCUHB becomes increasingly adept as a learning organisation.
- Compete the appointment of the Patient & Service Experience Project manager in order to provide a deputy function to the Head of Patient & Service User Experience and to provide the leadership and management necessary to ensure the above objectives are realised.

References

Accessible information and Communication Standards for People with Sensory Loss (WG, 2013)

Health Care Standards for Wales (WG, April 2015a)

Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015b)

NHS Delivery Framework and Reporting Guidance – 2018/2019 (March 2018, WG)

Patient Experience Review – Betsi Cadwaladr University Health Board, (Elliott Blanchard Ltd, August 2018)

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Patient and Service User Experience Strategy 2019-2022
Report Author:	Ms Carolyn Owen Head of Patient and Service User Experience
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The Aim of the Patient and Service User Experience Improvement Strategy is to provide and support the vision for BCUHB Patient and Service User Experience Improvement Strategy reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim': • Better population health and wellbeing through prevention. • Better experience and quality of care. • Better engagement of the workforce. • Better value from the funding. BCUHB is committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.
Approval / Scrutiny Route Prior to Presentation:	The strategy has been built on long standing collaborations between amongst many others, 3rd sector organisations such as Centre for Sign Sight & Sound, Vision Support, Wales Interpretation & Translation Service (WITS), Help the Aged etc., internally between Patient and Service Experience and Equalities Departments, between managers who are supporting Patient and Service User Experience within their regions and departments including Secondary Care, Community and Primary Care. The strategy was discussed and ratified at the Quality Safety Group (QSG) on the 2nd July 2019.
Governance issues / risks:	BCUHB has a mandatory responsibility to listen, learn and act from patient/service user experience; key policy frameworks include: • NHS Delivery Framework 2018/2019 (NHS Wales, April 2018) • Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government (WG), 2015a) • Equality Act 2010 • Health Care Standards for Wales (WG, 2015b)

	• Wellbeing of Future Generations (Wales) Act (WG, 2014a) • Social Services and Wellbeing (Wales) Act (WG, 2014b) • Parliamentary review of Health & Social Care in Wales (2018) The plan includes how we meet some of the recommendations of the Parliamentary review of Health and Social Care in Wales (2018) and the Welsh Government's *National Framework for Assuring Service User Experience (2015).* This strategy will measure the performance of the BCUHB Patient and Service User Experience team against the core deliverable objectives in the NHS Wales' Listening and Learning framework of 'the Quadruple Aim'. This strategy mandates listening to and learning from patient experience to deliver safe and compassionate care by ensuring sufficient coordination of all its activity related Patient and Service user experience. The feedback received will be shared with clinical areas. Should the report highlight negative feedback an action plan will be devised and implemented to demonstrate 'listening and learning' from Patient and Service User Experience . In line with 'Being Open', the information will be shared with the patients, carers and relatives by the staff in "*You said, we did*" display posters. The Patient & Service User Experience team (PSUET) will ensure every action is taken to improve quarter on quarter / year on year feedback. Where this is not happening, the PSUET will be responsible for escalating to the Director of Nursing, which will be reported via the Listening and Learning Group (LLG). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient and Service User feedback and service improvements. Governance Leads and all BCUHB Services meet quarterly to feedback: a) The feedback/data received from their Patient and Service Users and b) What service improvements are being made inclusive of Complaints, Incidents and Clinical Negligence Claims trend analysis to gain a holistic insight into all services. The LLG is chaired by the Acting Executive Director of Nursing & Midwifery. LLG focus on outlining targets and reporting frameworks to link the connections between service user feedback and service improvements. Focusing on 'YOU SAID WE DID'.

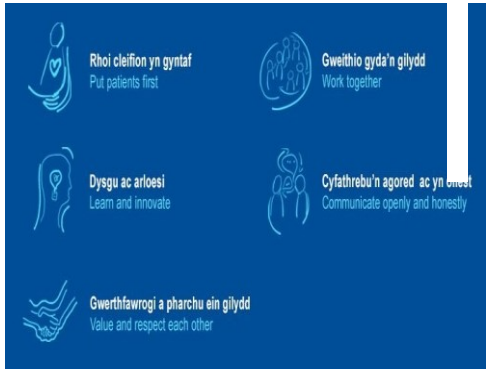
Financial Implications:	There are no further additional financial resources implications. BCUHB have invested significant resource to support NHS Wales' Listening and Learning framework of 'the Quadruple Aim'. This strategy has the right resources in place to learn from patients.
Recommendation:	The Committee is asked to : 1. Endorse the ratification of the Patient and Service User Experience Improvement Strategy for organisational and operational delivery to be adopted across BCUHB.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Engagement			
Equality Impact Assessment Please see attached EqIA document			

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

Gwrando Listen
Dysgu a Gwella Learn and Improve

Patient & Service User Experience Improvement Strategy 2019 - 2022



Listening and Learning from Patient Feedback

Contents

1. INTRODUCTION

The Aim of the Patient and Service User Experience Improvement Strategy:

The vision of this BCUHB Patient and Service User Experience Improvement Strategy reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim':

- Better population health and wellbeing through prevention.
- Better experience and quality of care.
- Better engagement of the workforce.
- Better value from the funding.

BCUHB is committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.

The strategy will be the blueprint of the work improvement plan to drive Patient and Service User Experience to reflect the voice of the patients and service users who use BCUHB services.

Patient and Service User Experience feedback is fundamental to BCUHB to understand how care and treatment has made them feel which provides a learning platform for service improvements.

Capturing the range of views gives balanced feedback data that will demonstrate 'what we do well' and provide insight into 'areas to improve'. By developing systems to 'listen and learn' from Patient and Service User Experience will enable BCUHB to reduce the need for patients and service users to formally complain by incorporating active listening, resolving and seeking resolution in real-time.

BCUHB staff will be empowered by having an understanding of the voice of the patient to take action.

2. NATIONAL DRIVERS

BCUHB has a mandatory responsibility to listen and learn from patient/service user experience; key policy frameworks include:

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Equality Act 2010
- Health Care Standards for Wales (WG, 2015b)
- Wellbeing of Future Generations (Wales) Act (WG, 2014a)
- Social Services and Wellbeing (Wales) Act (WG, 2014b)
- Parliamentary review of Health & Social Care in Wales (2018)

The plan includes how we meet important elements of the recommendations of the Parliamentary review of Health and Social Care in Wales (2018) and the Welsh Government's *National Framework for Assuring Service User Experience (2015).*

BCUHB has placed improving patient and service user experience at the heart of the Quality Improvement Strategy (2017 -2020) *"a promise to learn a commitment to act: ensuring the patient voice is heard at every level of the service".* There is a commitment that patients will be listened to and that feedback from patients and service users will be obtained, published and acted on by BCUHB.

In line with the 'Assuring Service User' framework, the Patient and Service User Experience team are striving to improve the quality of feedback by analysis and reporting the rich data from feedback. The following diagram reflects the four quadrants of the All Wales model:

- Actively utilized Real-time feedback system with weekly and monthly reports produced
- Care to Share clinics
- BCUHB comment cards
- Patient Advisory Support Service (PALSS) officers in all regions
- "Have Your Say" engagement clinics

- Accessible Healthcare Standards - Sensory Loss
- Inpatient postal survey
- Positive staff feedback model (e.g. Friday Feel Good)
- Positive Patient Experience (via social media)
- Reporting to inform and support ward accreditation process
- "You said, we did" model
- Public engagement events (targeting specific groups)
- Recording compliments

- PALS "Care to Share" clinics - staff involvement is key (posters in wards, clinics)
- Website development to promote online and electronic feedback and PALS service
- Listening and learning from feedback to inform improvement
- Stakeholder engagement
- Specialist services
- Development of Social Media and Staff App usage
- Website platform to display Patient Stories and feedback

- Positive and negative feedback methods
- Care to Share library
- Patient stories - develop a 'Trilingual' digital library (including BSL)
- Coproduction with the Communications Team, Engagement Team, Quality Improvement Groups in collaboration with the Quality Steering Groups and Quality & Safety
- Deliver Customer Care and Patient Stories Training

3. HOW WE COLLECT AND USE FEEDBACK

The overall intention is to provide a range of accessible methods for patients, their family and carers to feedback on BCUHB services. Patient and Service User Experience feedback data is collected through a number of different frameworks including: the Real-time feedback surve system, retrospective inpatient postal survey, Comment Cards, Patient Stories, compliments and letters, 'Care to Share' via the Patient Advice and Liaison Support Service (PALS) and 'Have your Say' engagement events; but also from complaints, clinical negligence claims and patient safety incidents.

The Listening and Learning Strategic forum for Patient and Service Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture the correct attendees in alignment with QSE and QSG).

It was agreed that the LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements.
Governance Leads and all BCUHB Services meet quarterly to feedback a) The feedback/data received from their Patient &Service Users and b) What service improvements are being made. Inclusive of Complaints, Incidents and Clinical Negligence Claims trend analysis to gain a holistic insight into all services. The LLG is chaired by the Associate Director of Quality Assurance. LLG focus on outlining targets and reporting frameworks to link the connections between service user feedback and service improvements. Focusing on 'YOU SAID WE DID'.

The Patient &Service User teams will support quarterly capturing feedback on patient satisfaction in regards to PTR. Random samples of total number of complaints annual survey of 50% of total number of formal complaints.

The aim of this strategy is to enable BCUHB to develop the existing feedback and reporting systems to ensure that staff, managers, the Board and stakeholders are able to access the collated Patient and Service User Experience data to facilitate Quality Assurance and Service Improvement. This will demonstrate BCUHB's commitment to continuous listening, learning and improvement. This information aligns with the four domains of the Assurance for Service User Experience Framework (WG, 2015a): Real-Time, Retrospective, Proactive/Reactive and Balancing as illustrated.
The Patient & Service User team are accountable for the management of the feedback process. Services must ensure that Patients & Service Users are provided with every opportunity to provide their feedback on their experiences.

PROACTIVE

Patient Advice & Liaison Service (PALS) – Patient Advice & Liaison Service (PALS) *was* piloted in the Central region in July 2017. Following its success the service will be rolled out to the East and the West from April 2019.

'Care to Share': The PALS service has initiated 'Care to Share' clinics on various wards across both Acute and Community Services sites. The clinics provide patients, carers and relatives with an opportunity to contribute any feedback around care and treatment with a view to resolving. There is an opportunity to speak informally with the Ward Manager and PALS officer during the allocated timeslot. The Care to Share clinics are to be advertised with posters and flyers displayed on the wards, bays, cubicles and corridor areas.

Have your Say: To be established across outpatients clinical areas on all sites in order to gather the service user feedback on the services we provide to help us improve and influence future plans.

The feedback received will be shared with clinical areas. Should the report highlight negative feedback an action plan will be devised and implemented to demonstrate 'listening and learning' from Patient and Service User Experience . The information will be shared with the patients, carers and relatives by the staff in "*You said, we did*" display posters.

Increasing the management of 'inquiries': The introduction of the PALS service across BCUHB regions will enhance the ability to respond to inquiries from patients, carers and relatives in real-time to seek resolution and satisfactory outcomes. Therefore providing a pathway to avert the need for formal complaints to be raised wherever possible.

Customer Care and Patient Stories training: Monthly sessions in each BCUHB region for clinical and administrative staff in collaboration with the BCUHB Corporate Nurse Education team. The focus of the Patient & Service User Experience training is to identify the key components of effective customer service within the NHS and strategies to:

Ensure staff will meet the needs of customers professionally, courteously and efficiently by:

- Treating all customers with respect and courtesy.
- Listening to what patients and service users have to say.
- Personalising services to the needs and circumstances of each patient and service user where practical.
- Always doing what they say they are going to do, or by updating the appropriate people promptly if things change, offering an explanation for the change
- Responding to enquiries promptly and efficiently.
- Consulting patients and service users about their service needs.

Patient Stories training equips staff to successfully capture and share experiences. Capturing the 'lived experience' is fundamental to understanding the challenges faced and also the lasting impact of the care pathway. Developing a trilingual digital library of patient stories utilising audacity software, videos and British Sign Language (BSL) which would be accessible via BCUHB website.

Supporting Quality Improvement: It is essential that the voice of the patients and service users is placed at the heart of BCUHB service improvement models. This approach is integral to engendering sustainable change in line with BCUHB's core values and policy directives. Patient and Service User Experience feedback will be utilised in key service improvement projects including:

- Reducing Health Acquired Pressure Ulcers (HAPUs)
- Reducing Falls
- Reducing Medical Device and Medication Errors
- Improving Nutrition & Hydration
- Improving Dementia
- 'John's Campaign'
- Improvement Projects arising from Ward Accreditation
- End PJ paralysis
- TODAY ICAN (MHLD) projects

REAL TIME PATIENT AND SERVICE USER EXPERIENCE FEEDBACK:

Viewpoint: BCUHB utilises Viewpoint™ to provide real-time service user feedback to staff and managers as the basis of quality assurance, ward accreditation and service improvement in line with its mandatory responsibilities (WG, 2015a; WG, 2015b). The survey questions reflect the WG validated service user questions and updated Framework for Assuring Service User Experience '*Your NHS Wales Experience*' questionnaire (2018). The real-time survey needs to be available in electronic and paper formats within all BCUHB wards and departments in both Acute and Community Services.

Real-time feedback is critical in ensuring that the voice of the patients, carers and relatives reach staff and managers in a timely manner. To support BCUHB service improvement projects the Patient and Service User Experience team will ensure that this data is accessible to triangulate with other key quality metrics. The Patient and Service User Experience team will continually review the functionality and value for money offered by the current and/or any replacement system in order to ensure that it is fit for purpose. Specifically that the real-time feedback is:

- Accessible at ward/departmental level to staff and managers across BCUHB
- Triangulated with Complaints, Incidents, HARMS metrics to build a comprehensive picture of '*what our service users are telling us'* via the BCUHB IRIS dashboard
- Encourage the involvement of patients, carers, relatives, volunteers and other service users in the provision of experience feedback
- Capture external providers by seeking views from those who provide services to our population e.g. English providers, private providers, other welsh health bodies etc.

Sharing complimentary correspondence and ensuring daily 'alerts' are systematically shared and distributed with key relevant staff.

It is required that all services ensure every opportunity is taken to capture feedback from Patients & Service Users. Every service must ensure a minimum of 80/20 (1in 5) patients and service users either

discharged or patient appointment feedback is captured. Therefore a minimum of 20% is required.
The Service User Team will support the principle of ensuring that service users are provided with every opportunity to provide their feedback.

The Patient & Service User Experience team (PSUET) will ensure every action is taken to improve quarter on quarter / year on year feedback. Where this is not happening, the PSUET will be responsible for escalating to the Director of Nursing – which will be reported via the Listening and Learning Group.

RETROSPECTIVE:

Social media: The Patient and Service User Experience team monitor, capture and share patient feedback and use Facebook to demonstrate the positive experiences and compliments received. BCUHB's Communications team and the Workforce and Organisational Development (WoD) staff support this work to enhance the reputation by promoting and celebrating a positive view of the organisation.

NHS Wales Patient Satisfaction Postal Survey: The survey is administered quarterly to a random sample of 1,000 inpatients. BCUHB obtains a high response rate to this survey of approximately 35%. The Patient and Service User Experience team will ensure that feedback from this survey is triangulated with real-time feedback in order to ensure that the retrospective views of patients after discharge is reported and shared with staff and managers in a timely manner.

Newsletter: A quarterly Patient and Service User Experience newsletter to develop a continuous engagement model capturing 360° experiences to share with service users and stakeholders to promote open and honest communication. This will be available online via the BCUHB website and in paper format. The golden thread influencing all the various Patient and Service User Experience feedback formats is to ensure links to Secondary and Community Care, Mental Health and Learning Disabilities, Women's and Children Services are Primary Care actively reflect care pathways of BCUHB patients.

BALANCING:

Friday 'Feel-good' Comment of the Week: Provides feedback to the ward/department who are deemed to have had the most motivational feedback comment of the week! They are selected by the Patient and Service User Experience teams in each of the regions every Friday and publicised on BCUHB social media. The ability to utilise service user feedback to increase staff motivation, well-being and job satisfaction is an extremely important consideration for BCUHB.

Patient Stories: Patient stories can be a powerful tool to improve services, gain feedback and highlight the patient's experience. Stories are about learning and actively listening to patients, relatives and carers. Patient stories will ensure that the patient's voice is recognised as being centrally important in the drive for service improvement. This work is being supported by the Communications team and further developments are planned with regards to

increasing the number of patient stories and development of the patient stories digital database.

Engagement Events: The Patient and Service User Experience team will attend and present at BCUHB engagement events to network with the third sector, stakeholders and relevant groups to promote 'Have your Say' events. National Patient and Service User Experience network events will be attended to build effective working relationship with other Health Boards and Trusts. The Patient and Service User Experience team will support the joint Macmillan / BCUHB '*Transforming Cancer Pathways'* project.

Strategic Relationships: The Patient and Service User Experience team will build effective, collaborative and engaging external networks with Public Health Wales, Welsh Ambulance Service Trust (WAST), the Children's Commissioner, the Older People's Commissioner, the Welsh Language Commissioner, the North Wales Community Health Council and Equalities leads across Wales. By sharing our ambition with stakeholders 'we can and should do better' because we are listening and engaging to continuously improve Patient and Service User Experience by actively evaluating the difference we are making.

The Patient and Service User Experience team will revise and develop the strategic focus of the Listening and Learning Forum to ensure comprehensive and rigorous development in co-production with the BCUHB Performance Improvement team, WoD (including the Equality team) and the Quality and Safety teams to achieve shared mandatory responsibilities to reflect BCUHB strategic objectives:

Internal Engagement

- Operational Managers
- Regional and Organisational Governance (QA) Teams
- Transforming Health Care Team
- Workforce and Organisational Development
- Service Improvement and Programme Management Office
- Engagement Team/Regional Officers
- Communication Team
- BCUHB Quality Improvement Hub

External Engagement

- Primary Care Cluster Development Teams
- All Wales Service User Experience Forums
- Welsh Heads of Service User Experience Forum
- NHS Wales Senior Officers Group
- Centre for Sign Sight and Sound, Vision Support
- Other centres of excellence

Develop consistent, equitable relationships with BCUHB Quality, Nursing and Allied Health Professionals (QNAP) in:

- IP&C (Infection prevention and control)
- Information Governance & Risk (including Datix)
- Quality and Transforming Care
- NHS National Safeguarding Team
- NHS Centre for Equality and Human Rights
- Concerns, Claims and Redress (PTR)
- Corporate Safeguarding

3.1 STAFF EXPERIENCE:

BCUHB is committed to achieving excellent staff experience as part of the quadruple aim. In order to deliver excellent care and treatment staff need to have a positive work environment to support the outstanding commitment and drive demonstrated across BCUHB consistently. By having the voice of the patient at every level enables staff to recognise the positive impact and difference they can all make every day.

4. OUR AMBITIONS

To develop the capacity of the organisation to listen and learn from feedback as the basis for developing in a co-productive manner, services which are better able to meet the needs of patients and other service users. The Patient and Service User Experience Team will:

1. Enable and engage with patients, carers and their families to encourage feedback on how they feel about their experience of BCUHB services.
2. Develop clear, accurate and relevant reports to share Patient and Service User Experience feedback with BCUHB staff, managers, and the Board to support and inform service improvement.
3. Develop the PALS service and will support the timely resolution of inquiries to enable effective communication between staff and patients, carers and their families. This will promote immediate learning and positively influence the services. Therefore, reducing the need to raise systemic formal complaints.
4. Triangulate Patient and Service User Experience feedback to identify trends and themes, which celebrate best practice and identify areas to improve. Ensuring that BCUHB staff receive clear information that allows understanding to take action on what patients and service users are telling us about their experiences.
5. Raise the profile of the Patient and Service User Experience work streams and the reputation of BCUHB both locally and nationally.

The ambition of the BCUHB Patient and Service User Experience team is to work locally and nationally to develop and deliver a model of collecting and reporting feedback that ensures the views, opinions and experiences of how patients, carers, relatives and service uses feel is heard from ward to Board by '*seeing services through the eyes of our patients'*.

5. How will Patient and Service User Experience be reported?

Patient and Service User Experience feedback data will be reported to obtain a balanced understanding of '*what it feels like to be a patient or service user'* accessing BCUHB services. The approach to collecting patient and service user feedback must be robust, relevant,

and timely and reflect the principles of the Welsh Government Framework Welsh Government's *National Framework for Assuring Service User Experience (2015a).* It will facilitate learning, improvement and celebrate best practice.

This strategy promotes and supports the need to use data effectively to build upon the foundations of the Ward Accreditation programme. The Patient and Service User Experience data will triangulate feedback from complaints, clinical negligence claims, patient safety incidents, compliments and patient surveys to provide a comprehensive 360° report. Feedback from patients and service users is captured and measured through a broad range of initiatives consistent with this framework for gaining and reporting on service user feedback (as illustrated in the following cycle matrix).

The Patient and Service User Experience team will produce relevant weekly, monthly and quarterly reports to all levels of BCUHB staff to ensure the patient voice is heard.

Moving Forward - Implementation

Strategy. This strategy is a clear approach that sets out how BCUHB will learn from patients

This strategy will measure the performance of the BCUHB Patient and Service User Experience team against the core deliverable objectives in the NHS Wales' Listening and Learning framework of 'the Quadruple Aim'. This strategy mandates listening to and learning from patient experience to deliver safe and compassionate care by ensuring sufficient coordination of all its activity related Patient and Service user experience.

Resources. This strategy has the right resources to learn from patients

BCUHB have committed significant additional resources to deliver this strategy with nine PALS officers serving across all regions to support to ensure their experience pathway is improved. BCUHB are leading the way in Wales by demonstrating investment in effective systems to capture and analyse data, measuring, tracking and driving quality improvements forward.

The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice.

Methods. The strategy has a wide enough range of methods for learning from patients and service users

The strategy stipulates organisational coverage of all services and locations in BCUHB will ensure a minimum 20% of all patients and service users either discharged or patient appointment feedback is captured with year on improvements. This includes hard to reach groups and those seldom heard through 'Care to Share' clinics, Patient Stories and active involvement with forums.

As an organisation BCUHB is committed to capturing tri-lingual Welsh, BSL and English feedback in real-time; in-depth; narrative/patient stories and retrospectively with easy read functionality.

The BCUHB Patient and Service User Experience revised website development will support patients providing their views at any time, in a variety of ways.

Triangulation. This strategy will triangulate patient information with other important data

A rounded feedback across the organisation is captured in the Quality Safety Experience report covering patient experience, quality and safety, complaints, concerns, incidents and outcomes. The BCUHB Ward Accreditation model, Community Health Council independent clinical visits and Health Inspectorate Wales support the patient experience is measured holistically across all areas. Care to Share clinics are inclusive of listening to staff feedback and triangulated with the patient views. These are openly shared on clinical areas notice boards along with the weekly patient experience real-time feedback weekly comments reports. Through its continuous commitment to working with the All Wales network meetings BCUHB is instrumental in developing key areas of improvements in collaboration with other Health Boards, WAST and Public Health Wales.

Honest Reporting. This strategy will report patient feedback honestly and in public

This strategy highlights the developing transparency in openly sharing the 'You said/We did' communication methodology, going hand in hand with clinical effectiveness and safety. Celebrating positive comments by sharing on social media not only raises staff morale but also improves Patient and Service Users confidence in the organisation. This strategy supports a collaborative approach with Workforce and Development and Equality and Human Rights strategies to ensure the organisation responds and direct action to the feedback received.

Patient and Service User experience journey starts at the beginning with first contact and ends with the last. These form first and last impressions. Getting Patient and Service Experience right will support learning from Patient and Service User Experience.

The themes from the WG Listening and Learning Framework which demonstrate how this strategy will be applied are:

Theme 1 - First and Lasting Impressions

- The embedding of 'my name is' principle of customer care.
- The development and roll out of customer care training sessions in all regions.
- (See also Safe Clean Care and Ward Accreditation below)

Theme 2 - Receiving care in a Safe, Supportive, Healing Environment

- Continued utilisation and main streaming of patient safety huddles in all regions
- Safe Clean Care principles embedded in all areas.
- Development and embedding of the new Ward Accreditation Framework and associated action planning.
- Following on from the above the use of service user feedback data to support service improvement relating to reducing Health Acquired Pressure Ulcers, reducing Health Acquired Pressure Ulcers (HAPUs), reducing Falls, reducing Medical Device and Medication Errors, improving Nutrition & Hydration, improving dementia care.

- Development of Dementia Friendly ward environments, (see also John's Campaign and Positive Person approach).
- Establishment and monitoring of safe staffing levels in areas.

Theme 3 - Understanding of and Involvement in Care

- Standardisation of ward notice boards in line with Ward Accreditation standards in order to provide critical information to patients, staff and other service users including a summary of recent service user feedback.
- The BCUHB Muscular Skeletal Joint Service Advisory Group (MSK JAG) has been established to bring together key service user stakeholders. Predominantly third sector MSK groups e.g. Arthritis Action UK, Lupus UK, RSI Action, Scleroderma and Raynaud's UK etc.
- Continued support and funding for the Accessible Health Care Service which provides support for service users with sensory loss in accessing and using services in line with the requirements of the Accessible Communication and Information Standards (WG, 2013).
- Following on from the above the continued development and deployment of the Sensory Loss Toolkit to all areas including managed GP practices in the Centre

6. References

Accessible information and Communication Standards for People with Sensory Loss (WG, 2013)

Equality Act 2010, London: HMSO

Health Care Standards for Wales (WG, April 2015a)

Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015b)

NHS Delivery Framework and Reporting Guidance – 2018/2019 (March 2018, WG)

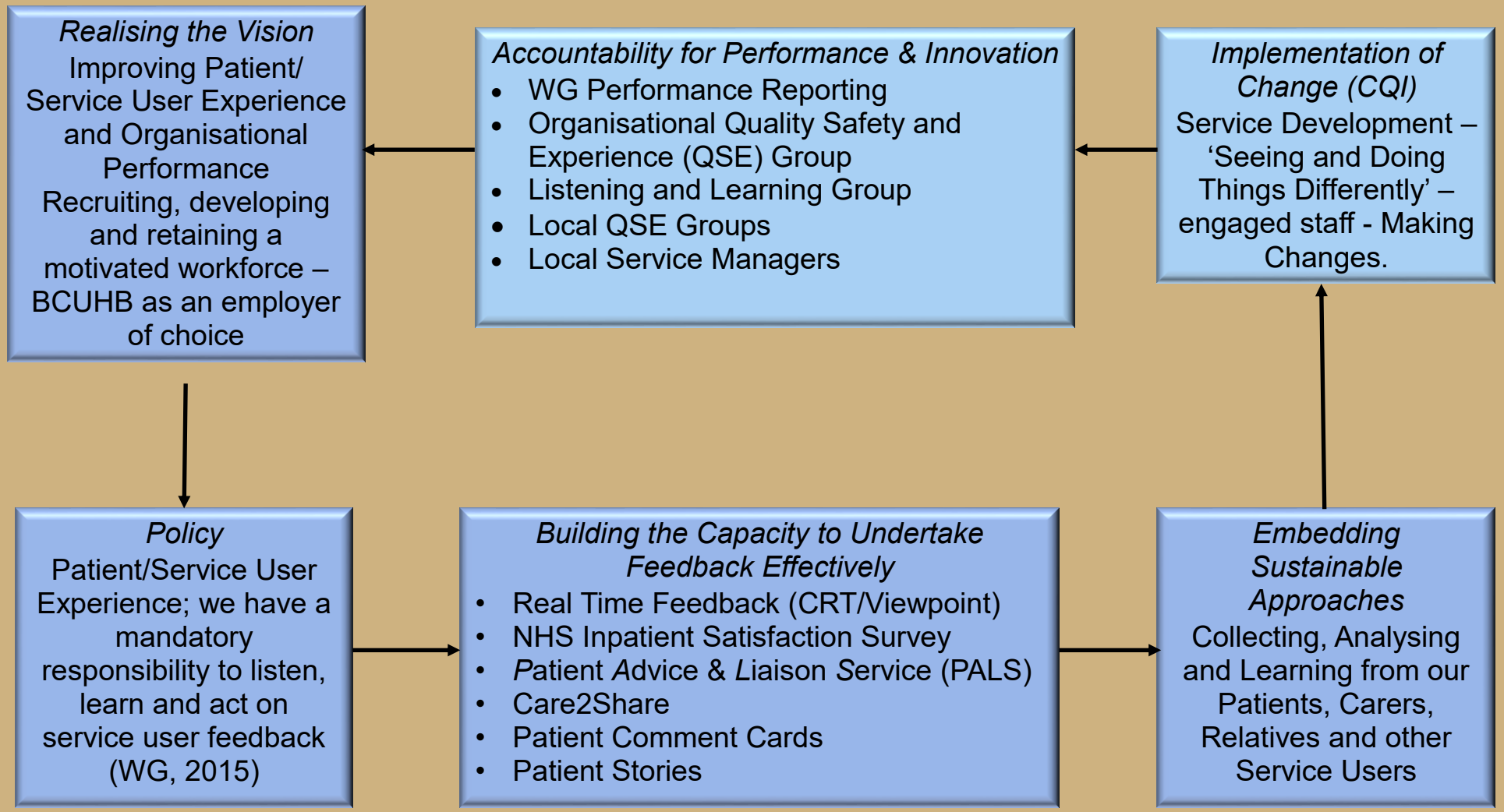
Parliamentary review of Health & Social Care in Wales (2018), London: HMSO

Patient Experience Review – Betsi Cadwaladr University Health Board, (Elliott Blanchard Ltd, August 2018)

Social Services and Wellbeing (Wales) Act (WG, 2014b)

Wellbeing of Future Generations (Wales) Act (WG, 2014a)

Fig 3 - Patient and Service User Experience Cycle



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

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Patient & Service User Experience Improvement Strategy 2019 - 2022
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This document aims to assess the impact of the service in relation to all protected characteristic groups to ensure the service is fair and non-discriminatory. Solutions will be recommended to minimise any adverse impact identified during this process. The vision of this BCUHB Patient and Service User Experience Improvement Strategy reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim': • Better population health and wellbeing through prevention. • Better experience and quality of care. • Better engagement of the workforce. • Better value from the funding. BCUHB is committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Head of Patient and Service User Experience then for full ratification at QSG Executive Board
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB has a mandatory responsibility to listen and learn from patient/service user experience; key policy frameworks include: • NHS Delivery Framework 2018/2019 (NHS Wales, April 2018) • Listening and Learning from Feedback – A Framework for Assuring Service User

		Experience (WG, 2015a) • Equality Act 2010 • Health Care Standards for Wales (WG, 2015b) • Wellbeing of Future Generations (Wales) Act (WG, 2014a) • Social Services and Wellbeing (Wales) Act (WG, 2014b) • Parliamentary review of Health & Social Care in Wales (2018) The plan includes how we meet some of the recommendations of the Parliamentary review of Health and Social Care in Wales (2018) and the Welsh Government's *National Framework for Assuring Service User Experience (2015).* BCUHB has placed improving patient and service user experience at the heart of the Quality Improvement Strategy (2017 -2020) *"a promise to learn a commitment to act: ensuring the patient voice is heard at every level of the service".*
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	The Patient and Service User Experience team will revise and develop the strategic focus of the Listening and Learning Forum to ensure comprehensive and rigorous development in co-production with the BCUHB Performance Improvement team, WoD (including the Equality team) and the Quality and Safety teams to achieve shared mandatory responsibilities to reflect BCUHB strategic objectives. The Patient and Service User Experience team will attend and present at BCUHB engagement events to network with the third sector, stakeholders and relevant groups to promote 'Have your Say' events. National Patient and Service User Experience network events will be attended to build effective working relationship with other Health Boards and Trusts. The Patient and Service User Experience team will support the joint Macmillan / BCUHB '*Transforming Cancer Pathways'* project. The Patient and Service User Experience team will build effective, collaborative and engaging

<table>
<tr><td></td><td></td><td>external networks with Public Health Wales, Welsh Ambulance Service Trust (WAST), the Children’s Commissioner, the Older People’s Commissioner, the Welsh Language Commissioner, the North Wales Community Health Council and Equalities leads across Wales. By sharing our ambition with stakeholders ‘we can and should do better’ because we are listening and engaging to continuously improve Patient and Service User Experience by actively evaluating the difference we are making.

The overall intention is to provide a range of accessible methods for patients, their family and carers to feedback on BCUHB services. Patient and Service User Experience feedback data is collected through a number of different frameworks including: the Real-time feedback survey system, retrospective inpatient postal survey, Comment Cards, Patient Stories, compliments and letters, ‘Care to Share’ via the Patient Advice and Liaison Support Service (PALS) and ‘Have your Say’ engagement events; but also from complaints, clinical negligence claims and patient safety incidents.</td></tr>
<tr><td>6.</td><td>What might help/hinder the success of whatever you are doing, for example communication, training etc?</td><td>To develop the capacity of the organisation to listen and learn from feedback as the basis for developing in a co-productive manner, services which are better able to meet the needs of patients and other service users.

<table><tr><td>Factor:</td><td>Item:</td><td>Work Stream:</td></tr><tr><td>Policy</td><td>Patient Experience; we have a mandatory responsibility to listen, learn and act on service user feedback (WG, 2015)</td><td>Triangulate patient feedback with other sources of data to identify trends and themes, which highlight good practice and identify areas for improvement work, ensuring that front line staff and managers have information necessary to understand and act on what patients and other</td></tr></table></td></tr>
</table>

				service users are telling us contributes to a positive experience of our services.
		Building the Capacity to Undertake Feedback Effectively	• Real Time Feedback • NHS Inpatient Satisfaction Survey • *P*atient *A*dvice & *L*iaison *S*ervice (PALS) • Care2Share • Patient Comment Cards • Patient Stories	Make it easy for patients, service users, carers and their families to give feedback on their experience of our services. Improve the capacity of BCUHB to resolve concerns quickly by improving access to '*On-The-Spot'* resolution through the development of the PALS service.
		Embedding Sustainable Approaches	Collecting, Analysing and Learning from our Patients, Carers, Relatives and other Service Users	Develop the capability of front line staff and managers to collect, analyse and act on feedback from patients and other service users.
		Implementation of Change	Service Development – 'Seeing and Doing Things Differently' – engaged staff - Making	Improve patient information to enhance communication between staff, patients and carers.
		Accountability for Performance & Innovation	WG Performance Reporting Organisational Quality Safety and Effectiveness (QSE) Group Listening and Learning Group Local QSE Groups Local Service Managers	Regularly share patient/service user experience feedback with the board, managers and front line staff in order to ensure quality and drive service improvement.

		Realising the Vision	Improving Service User Experience and Organisational Performance Recruiting, developing and retaining a motivated workforce – BCUHB as an employer of choice	Raise the profile of the Patient and Service User Experience work streams and the reputation of BCUHB both locally and nationally

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	Positive	High	The Patient & Service User Experience Improvement Strategy 2019 – 2022 reflects the Equality Act (2010). The strategy is designed to incorporate all BCUHB services and will be the blueprint of the work improvement plan to reflect the voice of the patients and service users of all ages who use BCUHB services. The aging population is becoming a permanent feature of the North Wales Population, this is steadily reflected on the increased and complex health and social care needs that should be met. Evidence suggests that elderly individuals may be of a higher vulnerability, hence the service may contribute in putting in place the suitable care plans that protect their dignity and enhance their independence as much as possible and whether the care is received at an acute or at a community settings (the Strategy for Older People in Wales 2013-2023). Both the real-time and retrospective postal patient experience feedback surveys referenced in the strategy reflect the age groups recommended by the Older People's Commissioner and the Children's Commissioner and the data can be analysis within the following age ranges: 0 – 15; 16 – 24; 25 -34; 35 – 44; 45 – 54; 55 – 64; 65 – 74; 75+ BCUHB Real-time Online Patient Experience survey The Patient & Service User Experience Improvement Strategy 2019 – 2022 reflects the Wellbeing of Future Generations (Wales) Act (WG 2014a) and the Parliamentary review of Health & Social Care in Wales (2018) therefore is inclusive of all ages. The is a palm-held tablet device with the Easy-read format of the feedback survey in each of the BCUHB Children's wards and Older Persons MHLD units. The easy-read formats were developed in conjunction with staff from Children's Services, CAMHS, Dementia leads and MHLD staff.

Disability	Positive	High	Sensory Loss: - The number of people in North Wales with a sensory loss is steadily increasing. There is evidence that people with sensory loss are more likely to face issues with accessing services. Therefore, the Patient & Service User Experience Improvement Strategy 2019 – 2022 promotes the provision of resources and materials which make the BCUHB services more accessible to people with disabilities and sensory loss. Service users report via NHS Inpatient Survey, Real-Time Survey and Patient Comments that easy access to our services including wheel chair access to our estate is not only essential to a positive experience but a prerequisite of being able to share that experience with use. In addition to (1-4 cited above) 1. ISUE01 explicitly cites the need to select a neutral venue, away from the environment in which care was provided, which facilitates access for services users with physical and/or sensory impairments and that the choice of venue is agreed with the service user in advance. 2. ISUE01 also explicitly states that BCUHB must actively respond to ensuring that patients are able to share their experience in a language of their choice including BSL. Advice has been sought from the Centre for Sign Sight and Sound (COSS) and via BCUHB's Accessible Health Care Scheme, BSL interpreters are available under the current SLA with WITS. COSS have via collaboration with BCUHB to develop the technologies to provide transcript summaries of patient stories undertaken via BSL. 3. BCUB has completed the recruitment of 9 (3 x 1Wtes per operating region) Patient Advice and Support Officers (PALS), who will have primary organisational responsibility for undertaking patient stories and will have specific training in relation to sensory loss and disability awareness and are able to operate bilingually. Thus, ISE01 will be adequately supported by PALS officers who will have a key responsibility to ensure that the inclusive aims of ISUE01 are implemented in practice.
Gender Reassignment	Neutral	Low	The Patient & Service User Experience Improvement Strategy 2019 – 2022 states a commitment to engaging with BCUHB patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups. The Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a) has four quadrants: Real-Time, Retrospective, Proactive/Reactive and Balancing. The Proactive/Reactive aspect (Patient Stories) referenced in the new Strategy collects Gender Reassignment data for monitoring purposes. Evidence shows that the lesbian, gay, bisexual, and transgender community LGBT may experience discrimination when receiving health care. This could result of avoiding seeking the required and timely health care. The PALS service will aim at reaching this specific group and making their voice heard as a first step of improving the provision of health care to LGBT individuals in North Wales. (Stonewell Report

			for LGBT Health in Britain, 2018) BCUHB Equality Operational Group and Sub-Groups enables general representation from service users relating to this protected characteristic, the Patient and Service User Experience Manager are also members of this group (rotational to maintain area of expertise). Therefore, whilst the experiences of these service users are sometimes difficult to identify using traditional survey methods; access to these service users and the reporting of their experiences, is integral to the general reporting of service user experience to the Equality Operational Group and will provide assurance that policy ISUE01 is inclusive in terms of this protected characteristic.
Marriage & Civil Partnership	Positive	Low	Anecdotally, the provision of health care is less likely to be affected by the martial/ civil partnership status of the patients. Evidence shows that Individuals may face some sort of discrimination in their workplace on that basis (working shifts, nature of duties, etc.). However, the Patients & Service User Experience Improvement Strategy may enable individuals to share their experiences and point out relevant issues as they arise.
Pregnancy & Maternity	Positive	Low	(see 1-8 above)
Race / Ethnicity	Positive	Low	Evidence shows that patients from Ethnic minority groups are more likely to face challenging experiences when seeking and receiving the health care. Individuals may be discriminated on the base of their skin colour. However, a poor experience of the health care maybe related to the culturally insensitive services or staff awareness of such differences. (NICE Guidance, 2018) Refugees and asylum seekers may struggle to understand the health care system and consequently seek the required health care on a timely basis. Language barriers may also contribute in the negative experience (Equality and Human Rights Commission, 2018). Hence the Patients & Service User Experience Improvement Strategy will facilitate collecting and learning from experiences shared by the ethnic minorities' groups. Tools will be provided to patients who would like to share their stories such as translated real feedback leaflets, or the suitable language translation.
Religion or Belief	Positive	Low	Evidence shows that patients from different religious groups may face challenging experiences in relation to the health care provided to them. This could be caused by the provision of religiously insensitive services (None Halal hospital food, etc.) Staff may also not be fully aware of such differences. (Department of Health DH, 2009).The Patient & Service User Experience Improvement Strategy 2019 – 2022 will facilitate collecting and learning from experiences shared by individuals that have different religions and faiths.
Sex	Positive	Low	Although not explicitly stated within the policy, in line with BCUBs approach to Dignity and the overarching aims of the Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019), via

			flexible deployment of PALS officers and Service Experience Managers, the Patient and Service User Experience team will ensure that service users are given the opportunity to share their experiences to a male or female story taker .This will be reinforced during induction training for PALS officers and during the training sessions for other BCUHB staff members.
Sexual Orientation	Positive	Low	Evidence shows that the lesbian, gay, bisexual, and transgender community LGBT may experience discrimination when receiving health care. This could result of avoiding seeking the required and timely health care. The PALS service will aim at reaching this specific group and making their voice heard as a first step of improving the provision of health care to LGBT individuals in North Wales. (Stonewell Report for LGBT Health in Britain, 2018)
Welsh Language	Positive	High	The Patient & Service User Experience Improvement Strategy 2019 – 2022 states a commitment to the Welsh Language Standards and the role of the Welsh Language Commissioner. All Patient Experience paper materials, resources, leaflets, newsletters and surveys (including Easy-read formats) are available in Welsh. All team members who are not fluent or confident are encouraged and supported to attend BCUHB Welsh Language training courses. The versions of the real-time feedback survey available both online and on palm-held tablet devices (both standard and easy-read) version are available in Welsh. All instructions, prompts, ward or department names are written in Welsh and the Welsh Language appears before the English text on the Easy-read tablet survey. In May 2019 to reflect the new regulations an additional question was included to the real-time survey (online, paper, tablets and kiosks) to record and monitor data in respect of the Active Offer: “Could you speak in Welsh to staff, if you wanted to?” The PALS team referenced in the Patient & Service User Experience Improvement Strategy 2019 – 2022 can undertake Care2Share stories, Have Your Say clinics, Patient Forums and Patient Stories in Welsh. The staff training programmes referenced in the Strategy raise awareness of the Welsh Language Standards and the importance of the ‘Active Offer’.
Human Rights	Neutral	Low	The real-time Patient Experience feedback survey is also available in standard paper format in both Polish and Portuguese. Enabling individuals to share their experiences and taking the learnt lessons forward; will protect basic human right of the health care employee ensuring their dignity is maintained and respects their specific needs and demands. It will enhance the provision of a patient centred and tailored care. The Patient & Service User Experience Improvement Strategy 2019 – 2022 is fully inclusive of the roles, remits, relationships and responsibilities of working with third sector.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	This EqIA itself has identified that there are controls in place either as a result of existing organisational frameworks which promote equality and diversity, as well as those specific to the Patient and Service User Experience agenda as defined in this Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019) and the resources associated with this, which have greatly been enhanced with the recent appointing of 3 x 1wte PALs Officers in each of the operating areas. The project team will consider the impact of the service on protected groups by seeking views of BCUHB Strategy & Planning Equality Scrutiny Group as part of this screening assessment.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The EqIA and the development of the Patient & Service User Strategy 2019-2022 (BCUHB) has enabled BCUHB to build on existing best practice to ensure that process of listening and learning from service users, is firmly integrated within the Equalities and Diversity agenda. Advice and guidance has been sought from the Equalities department and reporting of service user feedback by protected characteristics in terms of *listening* (what service users

	are telling us), *learning* (what insights we have gained) and *acting* (what has been done to improve services as a result) is now horizontally and vertically aligned with the Strategic/Organisational and Operational/Local, Quality Safety and Effectiveness and Equalities Groups. Such arrangements provides strong organisational assurance in relation to BCUHB's statutory responsibilities ensuring they become culturally embedded to not only listen, learn and act from service user experience but for promoting equality and diversity in the work place.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	This strategy has been built on long standing collaborations between, amongst many others, 3rd sector organisations such as Centre for Sign Sight & Sound, Vision Support, WITs, Help the Aged etc., internally between Patient Service and Service Experience and Equalities Departments, between managers who have supported the utilisation of listening and learning within their departments and staff. Collaboratively BCUHB has developed the ability to create a parallel learning structure which has enabled the organisation to be creative and innovative in ensuring that patients and service users, regardless of their individual needs are able to share their experiences with us, in a manner which promotes a culture of inclusivity commensurate with BCUHB's stated values. In reviewing this process through the lens of this EqIA; as an organisation we set out to improve our ability to listen and learn from service user experience, and have also developed a framework for promoting equality and human rights.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Patient & Service User Experience Improvement Strategy 2019 - 2022

2. Brief Aims and Objectives: (Copy from Form 1)	This document aims to assess the impact of the service in relation to all protected characteristic groups to ensure the service is fair and non-discriminatory. Solutions will be recommended to minimise any adverse impact identified during this process. The vision of this BCUHB Patient and Service User Experience Improvement Strategy reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim': • Better population health and wellbeing through prevention. • Better experience and quality of care. • Better engagement of the workforce. • Better value from the funding. BCUHB is committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No x
3b. Could any of the protected groups be negatively affected?	Yes	No x
3c. Is your decision or policy of high significance?	Yes x	No

4. Did the decision	Yes	No x

scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? The successful implementation of the Patient & Service User Strategy 2019-2022 (BCUHB, April 2019) and to promoting the equalities and human rights agenda within BCUHB is fundamental in its delivery and outcome measures. Having reviewed the guidelines in terms of their impact on each of the cited protected including human rights, the guidelines and/or the cited policies and/or the cited resources and/or the cited training and development provide sufficient controls in relation to any identified risk such that a full impact assessment is not required in this case.	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes (delete this box)	No x
	Record Details: 1. Executive Endorsement of the Patient & Service User Strategy 2019-2022 (BCUHB, April 2019). 2. Development of Training Materials and Intranet to support the development of skills and knowledge in relation to key components e.g. taking patient stories. 3. Incorporate Customer Care and Patient Stories training on Form 2 into the induction programme for the newly appointed PALS officers and then disseminate within the organisation as detailed within the Patient & Service User Strategy 2019-2022 (BCUHB, April 2019) 4. Improve the ability to report service user experience by protected characteristics, including via patient stories in order to develop services which are inclusive and free from discrimination.	

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes x	No
	How is it being monitored?	An action plan to monitor the progress, reports will be produced
	Who is responsible?	Carolyn Owen, Head of Patient and Service User Experience team
	What information is being used?	Service performance data, action plans, monthly meetings
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Annually alongside overall service review

7. Where will your decision or policy be forwarded for approval?	Associate Director of Quality Assurance for ratification in QSG Executive

	meeting in May 2019

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	The strategy has been built on long standing collaborations between amongst many others, 3rd sector organisations such as Centre for Sign Sight & Sound, Vision Support, WITs, Help the Aged etc., internally between Patient and Service Experience and Equalities Departments, between managers who are supporting Patient and Service User Experience within their regions and departments including Secondary Care, Community and Primary Care. Collaboratively BCUHB has developed the ability to create a parallel learning structure which has enabled the organisation to be creative and innovative in ensuring that service users, regardless of their individual needs are able to share their experiences with us, in a manner which promotes a culture of inclusivity commensurate with BCUHB's stated values. In reviewing this process through the lens of this EqIA it has highlighted how as an organisation BCUHB has set out to improve the ability to listen and learn from service user experience, and have also developed a strategy for promoting equality and human rights.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Carolyn Owen (Reviewer)	Head of Patient and Service User Experience
	Rachel Valentine	Patient and Service User Experience Manager (East)
	Sonia Khoury	Patient and Service User Experience Manager (Central)
	Peter Morris	Patient and Service User Experience Manager (West)
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No significant potential negative impacts identified. See actions outlined on Form 2 (1-11) above; especially in relation to the following protected characteristics; Disability, Gender Reassignment, Marriage & Civil Partnership Pregnancy & Maternity, Race / Ethnicity, Religion or Belief, Sex.	Head of Patient & Service User Experience, Patient & Service User Experience Managers, PALS Officers	Quarterly beginning Q2-2019/2020
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	The strategy has been developed to make explicit reference to the role of the Patient and Service User Experience team	Head of Patient & Service User Experience, Patient & Service User Experience Managers, PALS Officers	Quarterly beginning Q2-2019/2020
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	See actions outlined on Form 2 (1-11) above; especially in relation to the following protected characteristics; Disability, Gender Reassignment, Marriage & Civil Partnership Pregnancy & Maternity, Race / Ethnicity, Religion or Belief, Sex.	Head of Patient & Service User Experience, Patient & Service User Experience Managers, PALS Officers	Quarterly beginning Q2-2019/2020
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	No negative impacts on certain groups were identified therefore there is no reason to proceed without mitigating issues. Controls have been identified for all potential negative impacts see actions (1-11) outlined on form 2 above.	Head of Patient & Service User Experience, Patient & Service User Experience Managers, PALS	Quarterly beginning Q2-2019/2020

	Proposed Actions	Who is responsible for this action?	When will this be done by?
		Officers	
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	The Patient and Service User Experience team will revise and develop the strategic focus of the Listening and Learning Forum to ensure comprehensive and rigorous development in co-production with the BCUHB Performance Improvement team, WoD (including the Equality team) and the Quality and Safety teams to achieve shared mandatory responsibilities to reflect BCUHB strategic objectives. This strategy supports a collaborative approach with Workforce and Development and Equality and Human Rights strategies to ensure the organisation responds and direct action to the feedback received.	Head of Patient & Service User Experience, Patient & Service User Experience Managers, PALS Officers	Quarterly beginning Q2-2019/2020

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Mental Health Quality Safety and Experience Report [including progress against Quality Improvement Governance Plan (QIGP), Together for Mental Health Strategy and Performance]
Report Author:	Mr Steve Forsyth, Director of Nursing, Service Delivery and Operations Mrs Lesley Singleton, Director of Strategy and Partnerships Mr Adrian Jones, Assistant Director of Nursing
Responsible Director:	Mr Andy Roach, Director, Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide assurance on a range of QSE metrics and provide evidence of the progress made towards providing a safe, evidence based and quality service.
Approval / Scrutiny Route Prior to Presentation:	Divisional Directors
Governance issues / risks:	Number of Welsh Government (WG) reportable incidents that are overdue for closure
Financial Implications:	Update combined within the report and financial controls met
Recommendation:	The Committee is asked to: 1. Note the contents of the report

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	**x**	1.Balancing short term need with long term planning for the future	**x**
2.To target our resources to those with the greatest needs and reduce inequalities	**x**	2.Working together with other partners to deliver objectives	**x**

3.To support children to have the best start in life	**x**	3. Involving those with an interest and seeking their views	**x**
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	**x**	4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	**x**
6.To respect people and their dignity	**x**		
7.To listen to people and learn from their experiences	**x**		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

To identify progress against the Together for Mental Health Strategy, update on Quality Improvement Governance Plan, and the regulatory inspections

Key highlights of this report include:

- A full range of QSE metrics with progress made and areas for further challenge and improve
- Reviewing and improving the routine processes of the Mental Health Measure, bed management and patient flow
- Improving our response to section 136 arrangements, street triage or control room-based mental health staff. To work with partners to reduce the number of detentions of people under s.136 of the mental health act
- Sustain the improvement to limit the number of placements of local people outside North Wales
- Our progress against QIGP and our phase 2 work plan

Equality Impact Assessment

Not necessary this report is to provide assurance to the Committee on actions being undertaken within the MHLD Division

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Contents

Quality, Safety Experience (QSE)

Mental Health Learning Disability Division (MHLD)

1. Purpose

This paper provides an update on the range of quality safety experience metrics used across the MHLD Division. Integral to QSE is the work on the Mental Health Strategy and Quality Improvement and Governance Plan (QIGP), which is a specific requirement of the Special Measures Improvement Framework (SMIF).

The purpose of this paper is to provide assurance to the Committee that ongoing progress is being made within the MHLD Division. In particular, there will be key updates on the "Together for Mental Health" Strategy, the Quality Improvement and Governance Plan, TODAY ICAN and external assurance Healthcare Inspectorate Wales (HIW) actions.

The document details improvements reported through to the Public Accounts Committee March 2019 and the Health Board in May 2019.

2. Introduction

The Division has reported that Mental Health services in North Wales are continually improving and sustaining change in previous reports to the Health Board, external agencies and to Welsh Government. The mental health strategy provided the context for this direction of travel. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in North Wales requires simplified and strengthened leadership and accountability across the whole system. This is now beginning to show in our QSE metrics as our performance improves and the quality of the experience becomes more positive. Undertaking system wide change and shifting the culture across multiple organisations is complex and takes not only time but also constant focus to maintain the long-term, sustainable gains and importantly creating the right climate for the cultural shift to flourish.

The MHLD Division is committed to moving the direction and the pace of change to provide a safer and more purposeful service for patients and their carers across the whole of North Wales.

Through the TODAY ICAN team, MHLD are reaching out to staff and encouraging teams to take ownership for their ideas and use the TODAY ICAN methodology to make changes. Recognising that collectively small changes can have a huge impact on the culture, the services we deliver and patient/carer experience, we are noticing that more and more staff are talking about TODAY ICAN and the connection with the Mental Health Strategy. This report provides the evidence base that the culture has shifted that allows a positive climate to sustain innovation.

The Public Accounts Committee (PAC) report in May 2019 documents the progress and challenges for the MHLD Division. Steady progress is being made; with the Cabinet Secretary noting in November 2018 *'we are already verifying the progress*

so far and that is recognised by front line staff in mental health, and that is in addition to the Healthcare Inspectorate Wales inspection programme, which is also reporting progress. Improvements so far include the confirmation of a new and visible senior management team, appointment of a new mental health nursing director, creation of listening leads across front-line staff and the launch of the Today I Can approach'.

Further the PAC noted *'the committee welcomes the external evidence base and assurance that the Health Inspectorate Wales report have provided in terms of changes being embedded and continuous improvement being secured'*. It is acknowledged the Division has more work to do to embed the changes. This report provides a stock take on our achievements but also our challenges.

3. Background

The mental health strategy developed in 2016 was in response to mental health services facing numerous challenges identified through external reviews and independent investigations. At this point in time the strategy was developed to address the following key concerns:

- Demand for services exceeding capacity to respond
- Offering services in an integrated and holistic way
- A real focus on recovery and rehabilitation
- Explore ways to address clinical governance issues due to limited availability of modern information and communication systems
- Recruiting and retaining staff

3.1 Key Issues

- Key improvements are being noted in QSE metrics but this needs to be sustained and across a wider range of metrics
- Continued progress against the Special Measures Improvement Framework linked to out of area placements although and further work to do on our bed availability across the Division
- Further work to ensure compliance against the Mental Health Measure (MHM) and compliance for medical caseloads in Community Mental Health Teams (CMHTs)
- Phase 1 of the Quality Improvement Governance Plan has achieved the objective and work now begins on Phase 2 to drive forward the Mental Health Strategy
- Delivery of the mental health strategy and work of the transformation group, Local Implementation Teams and whole systems approach
- There has been progress managing the Serious Untoward Incident Management process to reduce the breach position for Welsh Government reported incidents but this remains a challenge

4. Risk & Governance

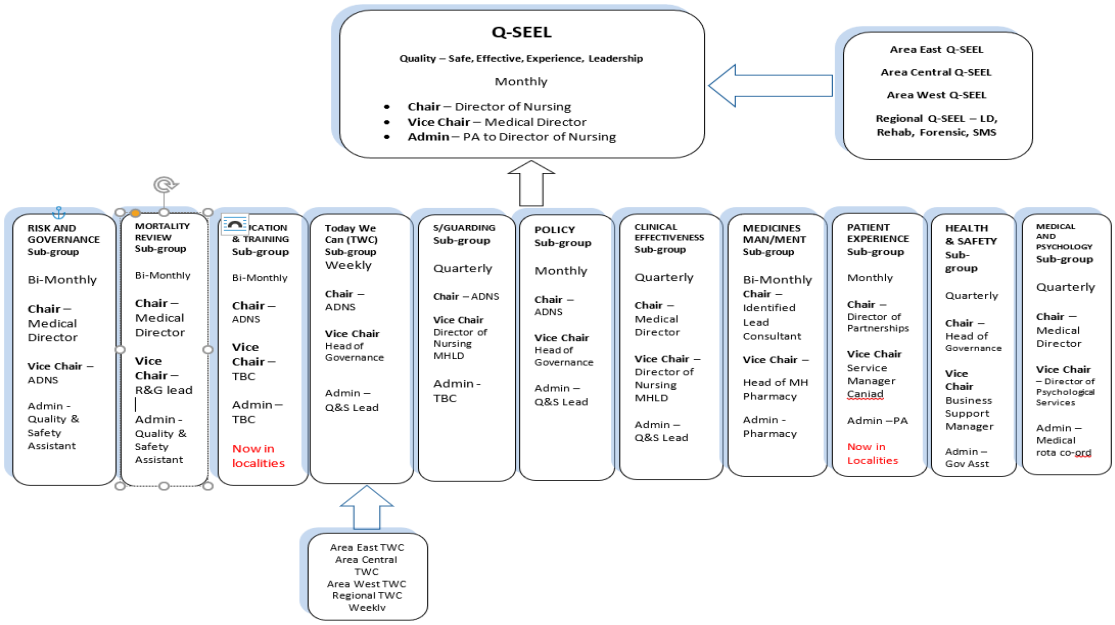
4.1 Update on MHLD Governance Arrangements and Sub Group Activity

The MHLD Division has a revised governance structure and this is beginning to show rewards in our ability to hold regular purposeful meetings. However, in order to improve compliance with internal audit recommendations this has recently been reviewed, with some responsibilities now delegated to localities.

Divisional Directors receive assurance from three main groups:

- Quality, Safe, Effective, Experience Leadership [Q-SEEL]
- Strategy and Service Re-Design [SSRD]
- Operational Accountability (Finance and Performance Group)

Each of these groups have a number of sub-groups reporting to them within an agreed cycle of business which will be aligned to Corporate Committees and groups to which they report. Each agenda will utilise the principles of the Quality SEEL framework (Safety, Effectiveness, Experience & Leadership), designed to track the performance and improve quality.



4.2 Q-SEEL Group

Provides advice and assurance to the Divisional Directors in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of mental health and learning disability services. It ensures that the quality and safety of patient care is in accordance with corporate and divisional goals and the principle of continuous quality improvement including organisational learning. There is an agreed cycle of business with Assurance reports being received from the Chair of each sub-group, with items for escalation or decision and onward identification of issues for escalation to Divisional Directors.

The Divisional QSEEL group has a number of sub-groups reporting to it during its cycle of business as demonstrated in the diagram above.

BCUHB Internal Audit undertook an audit into the Governance Arrangements (18/19) within MHLD with the final report being received on 19.03.19.

Separately, a Risk Management Audit report was undertaken by the BCUHB Risk Management Department with the report being received by the Division on 01.03.19. The objective of this audit was to provide an opinion as to the adequacy and effectiveness of the system of risk management and controls and that this is consistent with the BCUHB Risk Management Strategy RM01.The review was conducted through interview with the Head of Governance and Compliance, interrogation of the Datix system Incident and Risk Register modules, risk management documentation and divisional intranet pages. The overall assurance rating was provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The MHLD Division's overall assurance rating has improved from 'moderate' in February 2018 to the current 'substantial' rating in February 2019. This reflects improvements to the risk management arrangements, structure and the provision of a risk management procedure.

4.3 Welsh Government Reportable Incidents

The Division has reported frequently on the breach position for Welsh Government reported incidents. Over the past 6 months, intensive support provided to the Areas within the MHLD Division by the Risk and Governance Team to achieve the breach trajectory within the specified timeframe. Progress continues and remains a priority across the Division with further work to do to be within real time closure.

The Divisional Governance Team are introducing weekly Serious Incident Huddles attended by the Quality and Safety Leads and Head of Nursing for each locality to ensure that Serious Incidents progress according to the Putting Things Right (PTR) timescales and quality outlined by Welsh Government. The expected impact is:

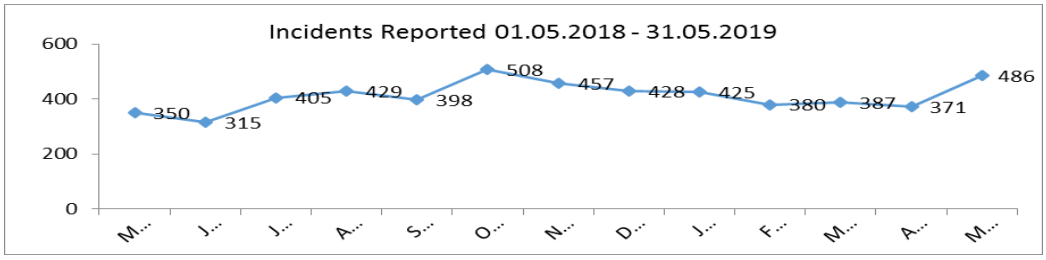
- Timely investigations
- Improvement in quality
- Ownership by localities
- Influencing the procurement of specialist panels relevant to the context of the Serious Untoward Incidents
- Learning relevant to current practice
- Improved assurance

The Division manages all incidents, concerns and risks through the Datix system, which is embedded across all sites and teams. Incidents for wards and community teams are reviewed and investigated directly by the managers and deputy managers for those areas. This is overseen by matrons and service managers, and all incidents are considered at the Division's weekly Today We Can (TWC) meetings to identify any issues, trends or patterns which require action and

escalation. Quality assurance for all Datix reports is provided through the local TWC meetings, through training and during individual supervision sessions with staff. Heads of Nursing maintain overall responsibility for ensuring all incidents within their areas are fully and appropriately addressed.

The Quality & Safety team provides overview of all incidents reported within the Division, providing support to staff where required and highlighting issues which may require more information. Serious incidents which require additional investigation or reporting to external bodies are managed with extensive support from the Quality & Safety team. During the last 12 months, the Division has significantly reduced the timescale for investigating incidents which do not require a comprehensive review (moderate, minor or negligible-severity incidents).

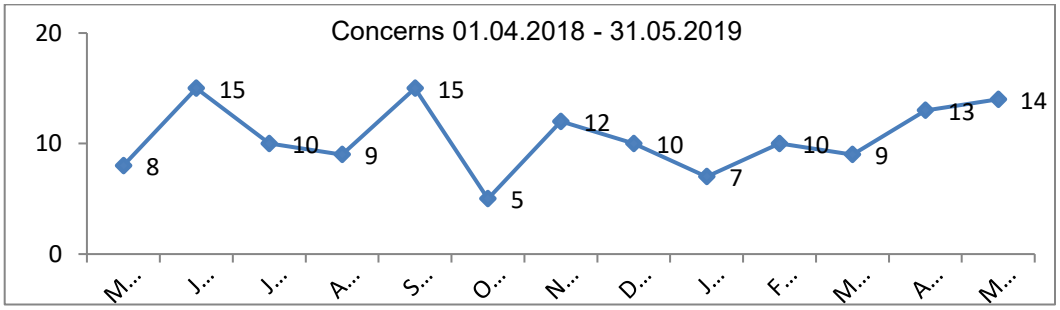
The Division continues to show a downward trend in the number of incidents reported until the last reporting month of May 2019. Of the 486 incidents reported in May, 475 were graded as minor incidents or below with the greatest proportion, 342 being reported as negligible in severity of harm.



The Division places the safety of our patients at the heart of all it does. Divisional rates of self-harm incidents appear to be reducing with an increase in incidents reported in January and February 2019.

Each locality with the division is undertaking a thematic review of cases of suspected suicide in order to enable learning within and across the Division. The Division has recently established a Coroners Board round on a weekly basis to prepare for coronial activity.

4.4 Complaints

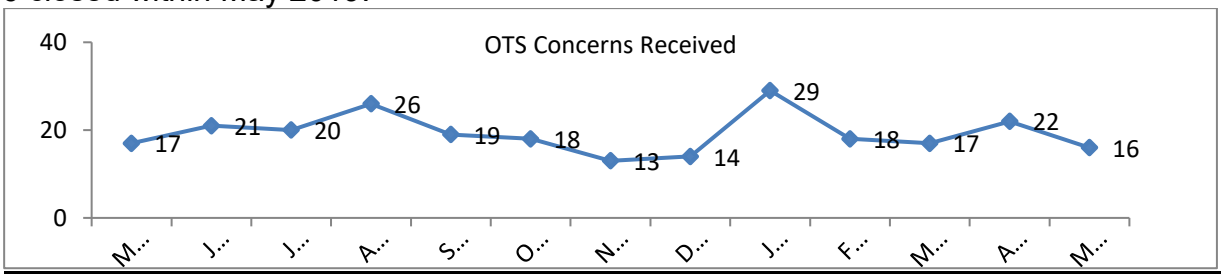


Between May 18 and May 2019 consent, confidentiality or communication remains the most received theme to date for the year.

As of the 26 June 2019, there are 7 formal complaints currently open and none >30 days and the division is working hard to maintain this position.

4.5 On The Spot Concerns [OTS]

OTS remains within variation with 16 'OTS' concerns opened in May 2019 and also 16 closed within May 2019.



4.6 Public Service Ombudsman for Wales [PSOW]

For the period 01/06/2018 – 31/05/2019 there were 17 concerns received/opened from the Ombudsman.

Of the 17 concerns from the PSOW, 5 were listed as enquiry only, 5 were listed as full investigation, 2 were listed as not to investigate and 5 were listed as proposal. Of the 17 PSOW concerns received 1 final report has been received back from the ombudsman (February 2019). For the period 01/06/2019 – 31/05/2019 there were 11 concerns closed by the Ombudsman

4.7 Learning from Concerns (Incidents and Complaints).

Serious incident reviews, both comprehensive investigations and rapid reviews are shared with the coroner and the patient's family (where applicable). Once an investigation is complete the lessons learned are captured and circulated across the Division and are also available on the Health Board Intranet site. To ensure learning is shared the bulletins are received at locality QSEEL meetings with the expectation that team and ward managers disseminate the learning.

Since 1 June 2018 the Division has circulated six lessons learned bulletins. In October 2018 the title was changed to Today We Can to reflect the Division's commitment to the TWC agenda and in 2019 decision made to align the lessons learned bulletins with the Risk and Governance Group discussion. The Risk and Governance sub-group is the forum where themes are discussed and importantly addressed to ensure improvement are made. A learning event will be held during Autumn 2019 that will provide further opportunity and focus on the important lessons being learned and to move forward with implementing changes that result in improved patient care.

4.8 Patient Experience

The MHLD Division continues to strongly advocate and show sustained embedding of co-production in the patient experience feedback. To quote Tony Carr (2019), Caniad *"co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice it involves individuals,*

humans being consulted, included and working together from the start to the end of a project that affects them".

As a division we have seen and continue to see this relationship mature, growing from strength to strength, with our most recent success being jointly shortlisted for a Nursing Times award 2019, our finalist interview is in September.

4.9 External Regulation: Healthcare Inspectorate Wales Reports and Actions

The most recent HIW inspection was at the Ablett Unit on 16-18 January 2019. However, the All Wales Thematic Review of CMHTs was reported in February 2019 with a number of actions to be undertaken.

There are 21 outstanding actions of the total 168 (including All Wales HIW actions) that require work and these will be progressed by each of the area triumvirates. It is important to reflect the recent inspectorate visits that have determined a clear improvement year on year of the services delivered, whilst there is always room for improvement.

4.10 Mortality Review

The Mortality sub-group continues to meet on a bi-monthly basis chaired by the Divisional Medical Director. Cases referred to Mortality Group are identified through local TWC (PTR) and the outcome of review is reported within Divisional Q-SEEL (QSG) and Risk and Governance. The Group continues to use the 2 stage mortality process piloted in 2017.

4.11 Prevention of Future Deaths (PFD) Report (Regulation 28)

Mental Health and Learning Disability services within BCUHB have not received a PFD report since December 2017. There are a number of upcoming inquests for the MHLD Division and the recently introduced Inquest Board round strengthens support and our response to coronial process.

4.12 Safety Alerts

Safety Alerts and alerts for action and response received via the Office of the Medical Director reviewed, disseminated and monitored for action completion by the Divisional Solution Lead. The table below identifies Safety Alert activity for the Division in 2019.

4.13 Infection Prevention Notifications

The Division has engaged well with the Safe Clean Care campaign within the Health Board. Compliance with hand hygiene audits remains slightly below BCU standard although in March 2019 reached 100%

The MHLD has a low rate of infection for the 6 infections monitored by WG and the last Welsh Government recordable infection was MSSA in August 2018. There was one confirmed index case of Influenza on Gwanwyn ward in April 2019. Our Divisional response to the flu campaign has concluded which led to 844 doses given.

4.14 Health Care Acquired Pressure Ulcer [HAPU]

The MHLD Division has low rates of HAPU and the table below shows the numbers recorded at stage 1-4 over a 12-month period up until June 2019.

	Grade 1	Grade 2	Grade 3	Grade 4	Unstageable/Unclassified	TOTAL
Aneurin, Hergest	0	1	0	0	0	1
CHC Commissioned Location (MH&LDS)	0	0	2	1	1	4
Cynan, Hergest	0	1	1	0	0	2
Gwanwyn Ward	1	1	0	0	1	3
Hydref Ward	0	3	3	0	0	6
Tegid Ward - Ablett	0	1	1	0	0	2
TOTAL	1	7	7	1	2	**18**

4.15 Use of Positive Interventions (RPI)

The Division has a dedicated team who have carried out remarkable work in conjunction with fully adopting and embracing the TODAY ICAN methodology, this has seen about a positive response to restraint. Less people are being restrained. All Physical Restraints as indicated by the Physical Restraint Reporting Guide (MHLD 0047 Physical Restraint policy) are recorded on Datix and are independently scrutinised by the Positive Interventions Clinical Support Service (PICSS) leads who collate, analyse and synthesise RPI data, support safeguarding procedures, monitor and review RPI incidents and promote a restrictive intervention reduction programme.

RPI data is provided on a monthly basis for each area QSEEL meeting, data includes the number and duration for prone restraints, compliance of recording vital signs and compliance for having Person Centred Behavioural Support Plans (PCBSP) in place. There has been a significant drive over the last 12 months (both during training and clinical reviews) to assert the importance of taking a patients vital signs during and after a restraint (PSN 023)

- 86% staff are trained in preventing Violence and Aggression, 90% risk assess Violence and Aggression
- 28% use the Person Centred Support Plans - Training plan in place led by our PICCS team in conjunction with the corporate V&A trainers.
- 7% use Violence checklist - The Dynamic Appraisal of Situational Aggression is now included in the reviewed Restraint Policy MHLD0047 and the new

Proactive Reduction & Therapeutic Management of Behaviours which Challenge Policy MHLD0049

4.16 Safeguarding Activity: Adult at Risk Referral, Multi Agency Public Protection Arrangements [MAPPA], Safeguarding Training

The Division has engaged well with the corporate safeguarding team to build a new level 3 training day, the first held in May 2019 with 100 staff attending. These training days are held monthly alternating east, centre and west.

Our attendance at MAPPA meetings is good and this serves to enhance our reputation for engagement with partners and the probation service. This ultimately provide a safer North Wales with our partner agencies.

The Division has participated in desktop review of adult at risk referrals for Cefni Hospital and the report shows good practice and learning applied.

The Division has worked hard to ensure safeguarding practice has been embedded across our teams and staff. This close attention to safeguarding activity has been facilitated by a weekly tracker of all adult at risk records; importantly those that remain active cases. The Division is now much more assured about safeguarding cases, supported by corporate safeguarding colleagues who attend weekly meetings in our area teams. The weekly tracker mentioned above also contains safeguarding training compliance, therefore teams are able to target those areas of low compliance.

4.17 Medicines Management Including Medicines Errors

The MHLD Division places scrutiny to medicines management reporting through to the Safer Medicines Sub Group. There were no reports of a moderate or major medication incident up until April 2019.

4.18 MHLD Divisional Falls Management

In November 2016 the new Executive Director of Nursing made the management of in-patient falls a patient safety priority for every division within BCUHB. In December 2016 the Health Board launched a new falls policy and pathway. A two year divisional falls management plan was developed with specific aims to reduce the number of falls, reduce harm from falls and, improve post falls management. During the two years every in-patient fall was reviewed and a management bundle introduced to older person's services where more than 85% of falls occurred.

The MHLD Division has also examined learning from other Health Board Regulation 28 concerns related to falls. Staff awareness of falls management has significantly improved over the past two years. This is evidenced through the analysis of case note entries which is one aspect of the falls review. Those entries show a lower threshold towards responding to unwitnessed events in which a patient is found lying, sitting or kneeling on the floor as a possible fall with possible head injury. Intelligence gathered during the two-year programme reports staff

undertaking immediate physical examination in 100% of cases and escalating for medical in 100% with examination occurring in 99% of cases.

Whilst the MHLD Division should be proud of the innovative visual guide it has developed (the big red wall) it must also be acknowledged that successful completion of a clinical intervention takes more than a guide. The divisional fall management bundle includes a detailed visual guide which sets out the observation schedules required post falls. The early warning signs assessment (NEWS) is embedded in practice within this MHLD Division. It is used daily and the new physical health guidance has been built around it and that guidance approved by the Rapid Response Acute Illness lead. During Q3 2017/18 all registered nurses in older person's wards were individually trained and competency assessed in their use of the NEWS.

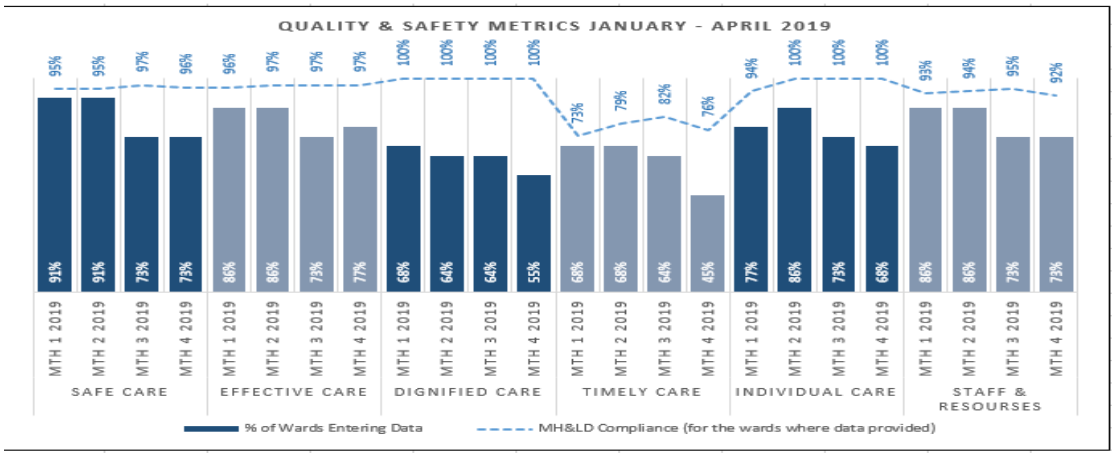
4.19 MHLD Policy and Procedure Position

Following the publication of the OBS1 (Policy for management of Health Board Wide Policies, Procedures and other Written Control Documents) in September 2018 the MHLD Division revised the process for ratification and management of tracking documents as per the policy.

The MHLD division starting position in September 2018 was 43 policies were published on the intranet with 20 (47%) being out of date. New policies have been developed and a number of policies have been reviewed and ratified following the new process and procedures and placed within the correct area on the intranet. The current position following the most recent MHLD Policy Implementation sub-group meeting (4th June) is that 59 policies are published on the MHLD intranet page. 11 (19%) are currently out of date, with 4 of these due to be ready for ratification in July and 10 new policies are currently under development.

4.20 Healthcare Management Solutions (HCMS) Quality & Safety Audits & Ward Accreditation

The MHLD Division complete the HCMS audit very well for individual care. Efforts will be directed towards higher levels of compliance in the next reporting period and area teams have been reminded to do this. The MHLD Division is awaiting the start of the new metrics and some modification has been made to the questions to be asked. The Division will also report on Matron monthly ward reviews as part of its quality and safety monitoring.



The MHLD Division are fully involved with the BCUHB ward accreditation process and this improvement journey will feature within the Divisional Action Plan (DAP). Managers from across the division have attended sessions on the ward accreditation process, monthly metrics and Quality improvement methods. We are working closely with the Quality Improvement Team to ensure that the metric questions are adapted to meet the needs of the division. So far, two wards Taliesin and Bryn Hesketh have been accredited from the division with Silver awards.

4.21 Memory Services National Accreditation Programme (MSNAP)

All Memory Assessment Services provided by the MHLD Division are accredited by the Royal College of Psychiatrists under the Memory Services National Accreditation Programme (MSNAP). The purpose of this programme is to assure that such services are provided in a way that meets National Quality Standards. Accreditation can assure the public that services function effectively, in an evidence based way and, are sensitive to the needs of people who are referred. Accreditation is rooted in independent peer review and appraisal by those who use the service. Accreditation through MSNAP is common in England but in Wales the only accredited services are those provided by the MHLD Division. All three locality based services have been successfully accredited twice and those covering Anglesey and Gwynedd have just re-accredited for a third time.

4.22 Electroconvulsive Therapy (ECT) in North Wales

ECT was centralised to the Ablett Unit, Ysbyty Glan Clwyd and we have been involved with ECTAS (ECT Accreditation Service) for approximately the past 15 years, being amongst the first departments to engage with their ideal of core standards that are intended to provide staff with a clear and comprehensive description of best practice in the administration of ECT. The department was first accredited in 2005, followed with gaining Excellence in 2008 and have continued with this high Accreditation standard since then. Although the ECTAS committee has altered the wording to just being ‘Accredited’ the Accreditation remains the same. The Ablett Unit was last ‘Accredited’ in June 2018 and is next due for renewal in October 2020.

4.23 Hospital Ward Kitchen Checklist

The Catering Department prepares and supplies all food in accordance with good practice and the food hygiene regulations. However, there are situations where food is prepared by others for consumption by patients and residents e.g. relatives or friends bringing food in, patients self-catering and Occupational Therapy (OT) kitchens. Kitchen environments must be monitored on a monthly basis by Matrons for each ward using the approved audit tool. Monthly audit results must then be sent electronically to the Senior Nurse for Infection Prevention by the 25th of each month. Audit results and resulting action plans are scrutinised by the Strategic Food Safety Group. The audit comprises a self-assessment checklist of 54 questions relating to the refrigerator, freezer, trolleys, cupboards, sinks, dishwashers, toasters, microwaves and general points.

Divisional response rate for completion of checklists has fluctuated over the past year, however, it also indicates a consistent improvement with submission rates reaching 97% in February, March and April 2019. Data is discussed in Q-SEEL meetings on a monthly basis.

4.24 Anti-ligature Risk Assessment

The Health Board received an alert WG EFA 2018 005 on anti-ligature responses for each health organisation across the UK. A MHLD action plan was developed and distributed to the Division and a refreshed review of the inpatient settings is currently underway. A key action from the alert was to have in place a controls document setting out the standards for the completion of anti-ligature assessment. An anti-ligature policy is currently under consultation and this will provide further assurance over quality control of the process of assessment and highlight of the risks for mitigation.

4.25 Risk Training

The MHLD Division will be investing further in train the trainer for Wales Applied Risk Reduction Network (WARRN) risk assessment and the areas of focus will be adult and older adult specialty. Registered nursing is currently showing as 65% trained in WARRN as a proportion of the workforce, an annual increase noted.

4.26 Perinatal Mental Health Services

Welsh Government have indicated that the aim for Perinatal Mental Health Services across the whole of Wales is to turn the map for services ‘green’, with particular attention being focused on staff composition laid down in recognised guidance. Based on data provided by the Maternal Mental Health Alliance (2018), BCUHB are currently amber. Welsh Government are currently looking at ways in which to turn Wales green on the map by 2021 whilst working towards meeting CCQI standards by March 2020, indicating there is still a vast amount of development work to be undertaken whilst remaining clinically active as a team. The team have established links with the North Wales Neonatal unit situated on the Glan Clwyd site. They provide inpatient care for premature babies delivered before

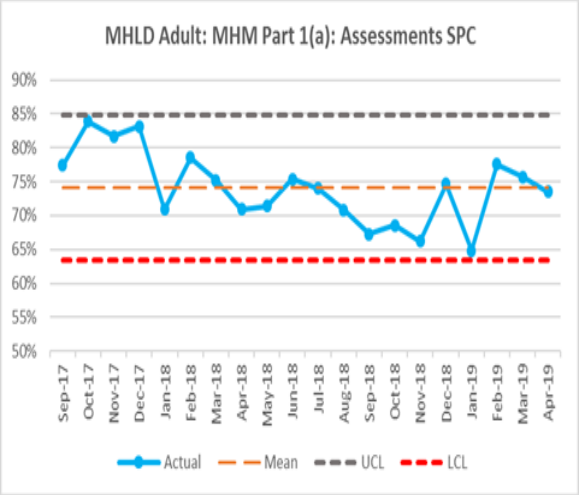
28 weeks' gestation from across the whole of North Wales. With mums spending most days at the centrally based unit, it allows any of the practitioners from any locality the option to assess mums on the unit. Historically this has proven to be a barrier as mums did not engage as they did not want to leave baby. Neonatal allows the team to book a room in the Neonatal Unit to assess these mums. The team are also going to provide a monthly education session for parents on the Neonatal Unit as part of their rolling education programme and are also in the process of compiling a training package for all of the Neonatal Units across North Wales.

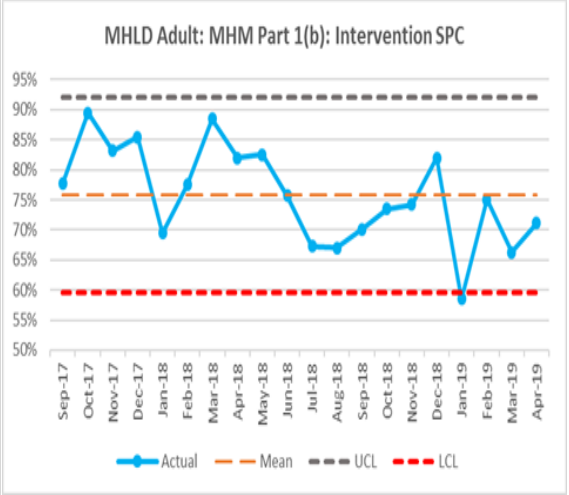
The team have also established a number of central clinics in the GP out of hours' rooms located within the emergency department in Ysbyty Glan Clwyd. The team's specialist mental health Midwife devised and conducted a perinatal mental health training package for all Midwives across North Wales via mandatory training during 2018.

5. Performance

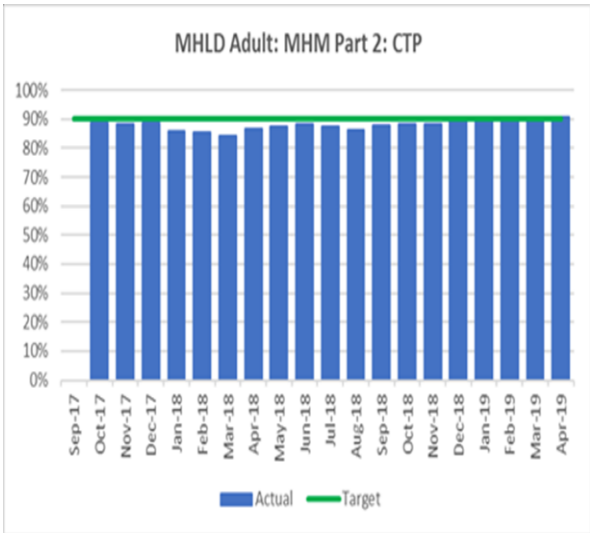
5.1 Mental Health Measure

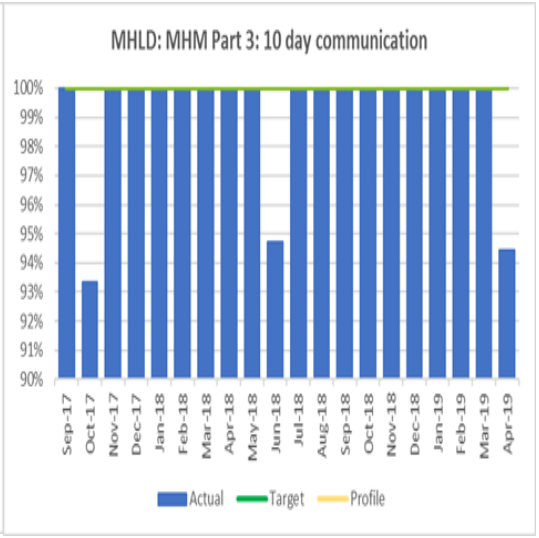
Our ability to perform Part 1a assessments and assessments sits below the target of 80% with a downward trend for assessment but an upward trend for intervention.





We are able to sustain Part 2 compliance with a Care & Treatment Plan (CTP) in place and this is at 90%.



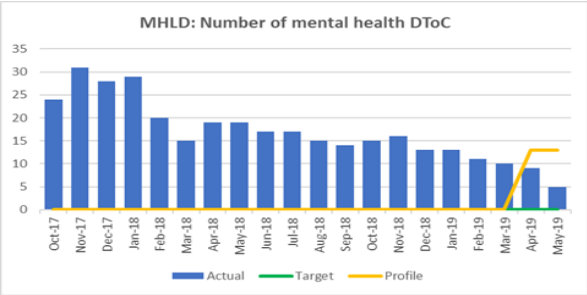


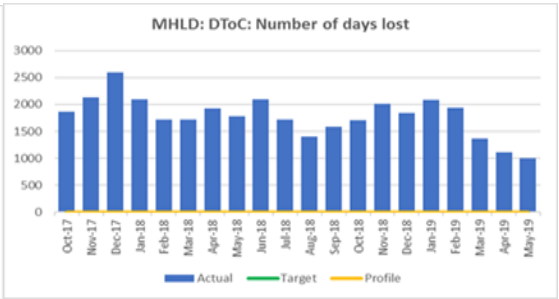
5.2 Out of Area Admissions

Our ability to reduce out of area placements has been sustained over many months with zero up to and including April 2019.

5.3 Delayed Transfer of Care (DTOC)

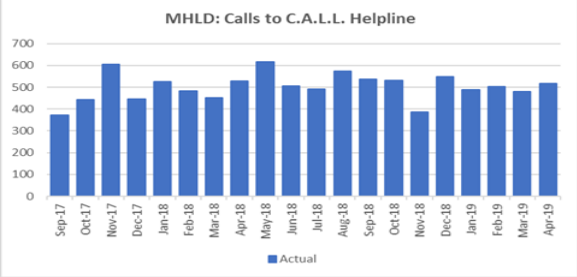
The MHLD Division continues to show improvement in the overall number of patients' subject to a DTOC and bed days lost.

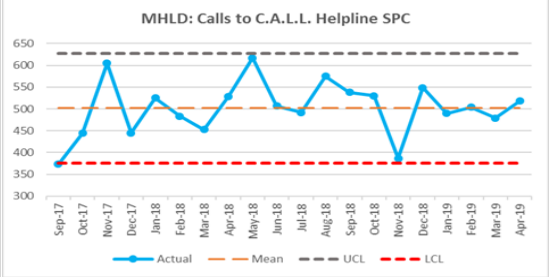




5.4 CALL Helpline

Our use of the call helpline remains strong which is positive for supporting our wider health and social care economy.

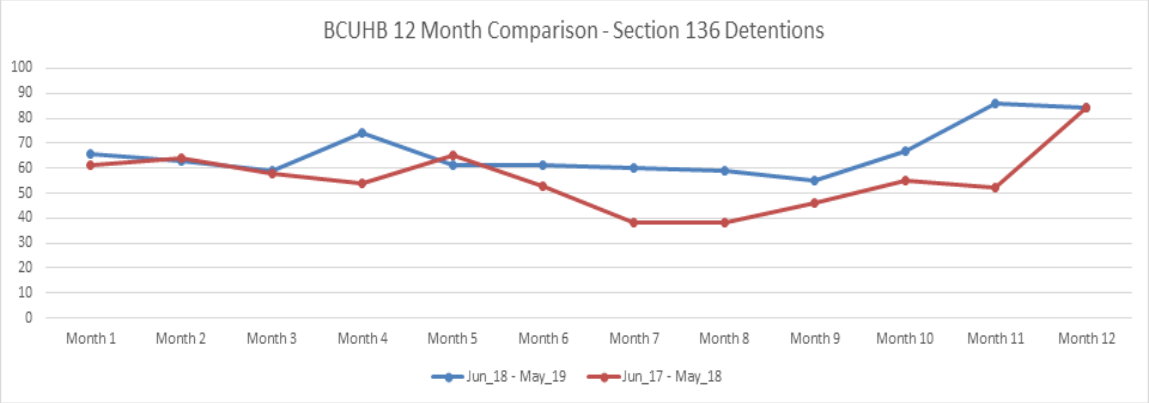




5.5 Mental Health Act – Section 136 Mental Health Act

The S136 multi-agency Protocol is led by North Wales Police and has been agreed in principle, as a draft, and this has been placed on the Health Board's Intranet as an interim working position whilst the document progresses through the respective organisations policy groups and is finalised.

The graph below shows the comparison for the previous 12 months to include most recent data.



5.6 S136 Assessments for Under 18's and Admission to Adult Beds

A total of 25 under 18s were brought to hospital places of safety for assessment during the financial year (2018-19) this is a 50% decrease on the last financial year's figures. (n50). Figures have demonstrated a steady decease of <18 detentions during the past 12 months.

5.7 Commissioned Care Activity

The Continuing Health Care (CHC) improvement programme embodies the Today ICAN Framework with the strategic foundations of the programme as set against four key improvement areas:

1. Standardisation of CHC processes & consistency of approach
2. Sustainable Care Planning
3. Right Care, Right Place, Right Size
4. Care Closer to Home

A revised commissioning framework developed and implemented across all Divisional clinical areas and provides clear processes for the commissioning of services for individuals who are eligible for CHC, 117aftercare and specialist bespoke packages of care.

In November 2018, the Right Care Project was launched, Right Care Assurance Programme (RCAP); this is an intensive review project that ensures BCUHB patients are cared for in the right environment and that timely discharge or transfer to appropriate local services is facilitated wherever clinically appropriate to do so.

In the last 9 months via this project, 15 patients have been repatriated back into North Wales and are now receiving services closer to their home area. With a further 12 patients identified for repatriation in the next 4-6months. In addition to repatriation, the project is quickly identifying gaps in local provision that is preventing repatriation or discharges from hospital, valuable data which will inform a wider commissioning strategy for the Division.

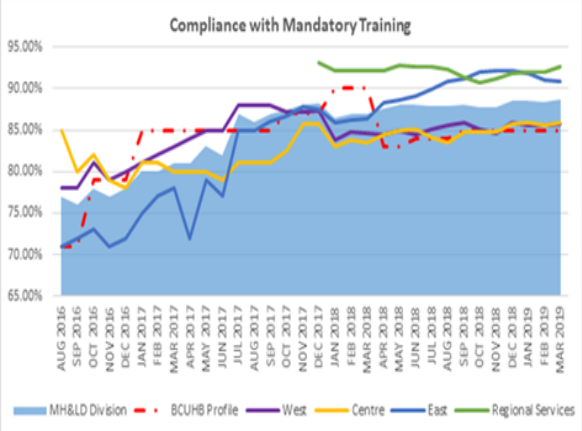
5.8 Workforce Establishment

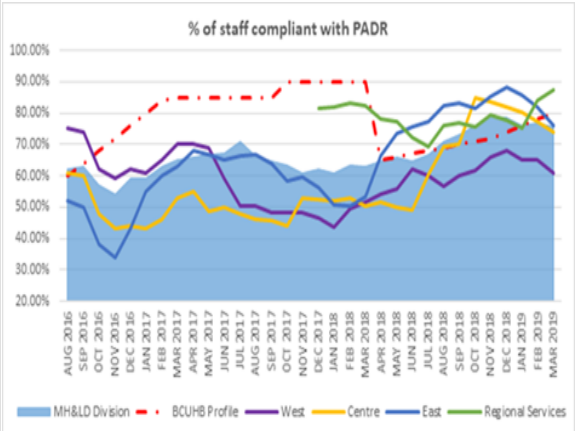
5.8.1 Substantive Workforce

Divisional workforce remains stable with a slight improvement in vacancy for the band 6 registered nursing workforce but a slight deterioration for the band 5 registered nursing workforce. This will be offset by the 30 graduates recruited and to start September 2019 subject to Nursing and Midwifery Council (NMC) registration.

MHLD Absence for the 12 months April 2018 to April 2019 shows an improving position for long term sickness compared to the BCU average. The links between staff training and Performance Appraisal Development Review (PADR) and productivity is established. Our Division is showing an upward trend in PADR compliance with the central area showing the sharpest increase for the Division.

Similarly, our compliance with mandatory training is also above BCU trend with the east area and regional services being the highest for the Division.





The MHLD Division have responded to the HIW Inspection report carried out in Abertawe Bro Morgannwg University Health Board in relation to a Learning Disability service. A key area of learning relating to Disclosure Barring Service (DBS) checks. This work has entailed examining Electronic Staff Record (ESR) for those staff assignment without a DBS or a DBS below their assignment. This has now progressed for action by each Head of Operations and monitored through accountability meetings.

The MHLD Division has carried out an establishment review on all inpatient wards approved by Divisional Directors and the Executive Team. Further small changes subsequently made to the proposed model to fit the alignment principles. An assessment of the actual staff worked for April 2018-April 2019 shows that the MHLD Division will experience a challenge to meet the agreed establishment for some of the wards.

6. Connecting the Mental Health Strategy and Quality Improvement Governance Plan

Progress in North Wales has been guided by the values of co-production and prudent health care. This has meant that the changes taken place become meaningful for the people we serve. The practice of involving people with lived experience has radically changed across North Wales.

The Mental Health Strategy has matured in both the structure and clarity of intent but also the level of integration with our partner agencies. Central to this success has been the work of the Local Implementation Teams linking both local and regional partnerships.

Work has continued with the QIGP with three actions outstanding from the report produced in May 2019, these being; implementation of the Local Delivery Plans, development of an improvement strategy, production of a report for Welsh Government on the progress today.

The Local Delivery Plan is focussed on the 10 key themes for improvement and these are centred on the regulatory reports and other external reviews. Considerable work has been reported to the Health Board, PAC and Welsh Government on these new initiatives.

One of the final actions on the QIGP is to produce a quality improvement strategy. This will seek to provide a context for how the MHLD Division has changed through a TODAY ICAN approach and provide the foundation for the 4 key transformation projects. This Quality Improvement Strategy will provide a summary of the Phase 1 achievements as examples of achievement and the context for Phase 2. The Quality Improvement Strategy will be launched in October 2019.

The MHLD Division has utilised the energy of TODAY ICAN, the Local Implementation Teams (LITs) and Quality Workforce Groups over the past year to arrive at a number of focused theme areas. Phase 2 will be to focus the improvement journey into key transformation projects interfaced through the LITS and the Quality & Workforce Groups and these include:

- Improvement to the Mental Health Measure Part 1 and 2
- Bed flow and capacity within 3 acute care hubs
- Response to unscheduled care in Emergency Department and Section 136

Our multi agency partners focused on local priorities using local resources to meet needs of the local population with a key focus on reducing unscheduled care demand. Key initiatives will include ICAN Unscheduled Care Centre; ICAN Step

Up – Step Down; ICAN Community Hub, ICAN Primary Care, The Barbers Initiative, First 1000 days, Post intervention.

The services redesign and models of care have been developed in-line with the principals of prevention and early intervention, continuity of care, care closer to home, and offering a continuum of interventions from primary to tertiary care. The attachment theory forms the theoretical and philosophical framework to shape services. The models of care proposed have been discussed with patients and carers and experts in the field and are all evidence based or in-line with National and International recommendations.

The most important aspect that has emerged throughout the discussions is that the current workforce needs to be developed and in many cases has to work differently. It is envisaged that senior clinicians will work across a number of services offering advice, with high level of flexibility embedded within their working week, to comply with service and patient needs, rather than having a number of fixed commitments that impedes rapid interventions and consultancy. This is particularly applicable to consultant psychiatrists and consultant psychologists but can be extended to nurse consultants, which will progressively form an important part of the senior clinical input. To enable such a model of care and usage of expertise from senior clinicians, some of the tasks and clinical functions have to be delegated to other colleagues such as pharmacists, occupational therapists and nurses. Hence, the service re-design has to be in parallel with a strategy to develop the workforce with the appropriate training and competencies.

Another important change is the Partnership work, in particular with the voluntary sector. The Division has recently developed the I CAN Centres for unscheduled care in the A&E Department but this will extend further into the community to the level of primary care. The interface with statutory services will form part of specific pathways and the voluntary sector will also receive training to enable them to practice safely. In some parts of the Division, this partnership work is developed and developing but in others is at a premature stage that requires further attention

Phase 2 of the improvement journey can be subdivided into 4 parts that follows the idea of the square model:

1. Primary
2. Community
3. Acute
4. Rehabilitation Care

6.1 Primary Care

Following an exercise of mapping of the current situation of the Primary Care Services in North Wales, it is envisaged that the mental health part will be delivered through Community Care Hubs. It is envisaged that Senior Clinicians (Band 7) will be based in GP surgeries to deal with a degree of emergencies and first assessment to enable a large number of people to be either signposted or referred appropriately.

The Division have agreed to twin with Cardiff and Vale Health Board that have piloted and evaluated this model which appears to be rather successful. In North Wales we had a similar concept developed for people who are homeless, that again has been successful and evaluated. We have an opportunity of piloting the model in the Wrexham Cluster. It is planned that I CAN Centre will form a strong partnership with the Community Care Hubs. It has also been discussed as to the development of community I CAN + (known commonly as crisis centers) that will offer a valid alternative to admissions.

6.2 Acute Care

The major proposed cultural change is that acute care becomes a resource of the community rather than a standalone, separate service. In practice this means that for each acute care episode it is envisaged that the community care teams will remain integral to a person's care. This is to maintain continuity and to be able to plan the discharge in a safe and more appropriate manner. This will also avoid problems with communication.

The pathway needs to be very clear. It has also been discussed that the unit needs to have the input of senior clinicians on a daily basis to continue to deliver care that is safe, efficient and of high quality. The senior clinician will include a number of consultant nurses that will also facilitate early discharge. Detailed discussions have highlighted the need of developing specific pathways for the interface between Liaison, Acute Care, Home Treatment Team and Crisis Homes. Crisis homes are considered an independent resource of the community. Emphasis has been put into creating the right therapeutic environment within the units. In the development of the Ablett environment, emphasis will be placed on trying to differentiate and create a more therapeutic environment (Milieu Therapy).

There have been a lot of discussions in regards to an Admission Unit associated with a Section 136 suite and a group of clinicians have been visiting such units across the UK. The views on an Admission Unit varied substantially and the current evidence is not strong, therefore it has been agreed that this development will wait until the community care and the I CAN centers are in place, as it will inform the need and functions of the Admission Unit.

6.3 Community

Community care in North Wales needs to be developed further to offer a more comprehensive therapeutic service. The advances in psychiatry research has led to a more comprehensive nosology and inclusion in services of other conditions historically not served, such as Autism, Attention Deficit Hyperactivity Disorder (ADHD) and Personality Disorders.

Due to the geography, in some parts of North Wales models of care have developed where specialist teams are co-located with the CMHTs and have been very successful. This is also in-line with the idea of continuity of care and care closer to home. There is no specific research or evidence that favours one model of care versus another, but there is cumulative evidence that fragmentation has worse clinical outcomes.

The model of community care that suits the population and geographical needs in North Wales seems to be the above, as long as the functions of the specialist teams is protected and maintained with a high degree of fidelity to the original model.

In line with the principle described and following a lot of discussions and reviewing the current evidence, it has been agreed to develop a standalone Early Intervention Psychosis Team that initially will deal with first episodes of psychosis and subsequently will include the “at risk” population. The Hub and spoke model does not have enough evidence to be supported and due to the geography of North Wales, the Early Intervention in Psychosis Team needs to be County based and co-located with the community services. The Early Intervention in Psychosis Teams, although co-located, need to be completely protected in their function and they will assume care coordination. The Medical and Psychology input needs to be provided locally as having a Hub is too expensive and a potential waste of resources, mainly due to travelling. We have agreed to start appointing the team leader that will act as project manager.

The Academic Partnership Board will provide the appropriate training for the staff and the Project Management Team will coordinate a Task and Finish Group to design pathways in-line with the National Institute for Health and Care Excellence (NICE) Guidelines on Early Intervention in Psychosis.

There has been a lot of emphasis on extending the remit of community care to 7 days a week. However, it is not clear what functions need to be extended longer than is currently, although crisis interventions will be embedded in the main community care function. Again, the collaboration with the voluntary sector will be paramount. The Community Care Centre requires the most change and development for workforce as they interface with a wider community and more specialist services, but also because they will absorb a higher number of functions. Over the years, the remit of Mental Health Services has also increased, for example, in regards to ADHD, autism and personality disorders. The attachment theory will be totally embedded in the ways of working and the emphasis on the multi-disciplinary team work will be a priority. The referral system will decrease and possibly be eliminated to avoid fragmentation.

6.4 Older Peoples’ Mental Health

The Older Peoples’ Mental Health Services have planned to increase their presence through the Community Care Hub. As for the other services, some of the function will be delivered directly in the primary care surgeries such as medicine management and psychological interventions.

Memory clinics are run directly in the primary care surgeries and this model is currently being evaluated. In the East this model will be introduced shortly. The main development that requires immediate attention is about the Home Treatment Services for Older People. This function is not fulfilled across North Wales and needs extra resources. There is also emphasis on a Care Home Liaison Service to avoid unnecessary admissions to acute care.

6.5 Rehabilitation

The rehabilitation services have undergone a change in regards to out of area placements. The National Collaborative have produced a document in regards to the ICAN plus centres that can be a step up or down facilities in North Wales.

The Quality and Workforce group has also reviewed the needs for modernising services and the current estate situation. The decisions made are:

- The outreach team for out of area placements working closely with the community forensic team has to be defined and established. A task and finish group is going to be put together to give details of the above, including pathways

A commissioning strategy is in development and will set out the detailed plans to achieve the service improvements set out from the Quality and Workforce Group.

7. Conclusion

The Health Board has urgently focused on reviewing the mental health and learning disabilities division and the development and implementation of a strategy for the division that will deliver sustainable services for the future. This has included significantly improving operational planning including co-production, partnership working, and a transformational review of the service model.

BCUHB has focused on strategy and service change for people who require support for their mental health and wellbeing. Our direction of travel has been supported by Special Measures and it has led to a fundamental shift in the way services are planned and provided.

The priority in developing the Mental Health Strategy in conjunction with the Quality Improvement methodology (TODAY I CAN) has been to ensure ownership and commitment from all stakeholders. Our aim is to develop age inclusive services which deliver person centred care for the population of North Wales.

Quality Safety Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Children's Services
Report Author:	Mrs Alison Cowell
Responsible Director:	Dr Chris Stockport, Executive Director of Primary & Community Services
Public or In Committee	Public
Purpose of Report:	To provide an update on Children's Services
Approval / Scrutiny Route Prior to Presentation:	Updates on Children's Services are provided to the Children's Transformation Group, Area Teams and the Regional Partnership Board
Governance issues / risks:	Risks highlighted in this report include: • The waiting times for a neuro-development assessment are lengthy and increasing for families, resulting in deterioration in wellbeing and difficulties managing behaviour. • Number of children who are Looked After is increasing with limited resources and children being placed outside North Wales and within from Local Authorities across the UK. • Recruitment of experienced neonatal nurses • Health Visiting and School Nursing Teams are small and carry vacancies while not enough student placements are being commissioned by Welsh Government (WG) to fully deliver the Healthy Child Wales Programme. • Breast feeding uptake needs to increase • Immunisation uptake is not consistently ensuring herd immunity/public protection. • Obesity prevalence of 12.3% at health board level is higher than the Wales average of 11.9%. • Self-harm assessments undertaken on the paediatric wards were 23% higher from 2017/18 to 2018/19 • Referral to Child & Adolescent Mental Health Services (CAMHS) continue to rise with capacity not matching the demand. • The Tier 4 inpatient unit is not able to provide emergency urgent admissions out of hours or a service for acutely ill high risk young people. • CAMHS Psychiatry provision is 7 days a week 9 – 5pm then an out of hours telephone on call rota
Financial Implications:	The service is striving to deliver on its objectives within the core

	budget, supported by new additional Welsh Government (WG) funding
Recommendations:	The Committee is asked to note: 1. The progress that is being made to services for children, young people and their families. 2. The risks that are identified and being managed through the Area Teams. 3. The external reviews of CAMHS during 2018-19 with a fuller report to be provided

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Strategic and service planning			
Equality Impact Assessment Equality Impact assessments exist for specific elements of this report associated with business cases and projects.			

Children's Services

1. Purpose of report

To provide the committee members with an update on the quality improvement and risk management measures in place within Children's Services to progress our partnership priorities.

2. Children's Partnership Priorities

Children's services has embedded the 'windscreen' continuum of care ensuring that Children's Rights approach with choice and partnership at its core.
The agreed Partnership Priorities are;

1. Children with Complex Needs
2. Prevention and mitigation of Adverse Childhood experiences (ACEs)
3. Improving outcomes in the first 1000 days
4. Improving emotional Health, mental wellbeing and resilience of children
5. Promotion of healthy weight and prevention of childhood obesity
6. Review of crisis intervention services for children and young people who are experiencing an urgent perceived mental health crisis

These priorities were developed through two interagency workshops and agreed by the Regional Partnership Board (RPB) in 2017 and are operationally implemented and monitored within the 3 year BCUHB delivery plan via the Children's Transformation Group.

2.1 Children with Complex Needs

The 2015 Population Needs Assessment identified an increasing Looked After population. In 2015 there were 1000 Looked After Children (LAC) in North Wales compared to 910 in 2011. It also identifies that as at 2015 the number of disabled children in North Wales had increased steadily over the previous 5 years and it was estimated that at that point there were approximately 5,000 children in North Wales with a disability that has a substantial and long-term adverse impact on their ability to carry out normal day-to-day activities.

Families who are caring and supporting children with complex needs require our support, be that from Health, Education, Social Services, or Voluntary sector; at times from all of us and at other times just one agency. The breadth of complex needs includes chronic conditions (diabetes, epilepsy, allergies, cystic fibrosis), severe disability, life limiting conditions, palliative care, prematurity needing neonatal care, challenging behaviour, mental health difficulties, children who are Looked After, require joint packages of care, or Continuing Care; who will find themselves receiving care at home, on the paediatric wards, in psychiatric inpatient care and in Local Authority care at times and are supported by a number of practitioners within children's services across the agencies.

As a consequence this has been a high priority for the Children's Transformation Group and will continue to be a partnership priority. If we can get our services meeting the needs of children with complex needs then this will be a measure of what good looks like for all children.

2.1.1 Neuro-development needs

A cohort of children who can be described as having complex needs are children with neurodevelopment needs. Over the last decade, there has been a shift in understanding of Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD), with increased acknowledgement that many of these children and young people have co-morbid conditions (e.g. dyspraxia, additional learning needs, complex social backgrounds). This awareness by families and professionals; and the rising numbers of children affected by Adverse Childhood Experiences; or who have not had their neurodevelopment needs attended to in the 1st 1000 days has impacted on demand which is rising year on year and outstripping capacity. Further work is required locally and nationally to understand this growing demand.

At the end of April 2019 there were 1730 children and young people waiting for a neurodevelopmental assessment of which 1103 had waited over 26 weeks. The longest wait is 111 weeks and the longest average wait is 47 weeks – both in the East area. The capacity requirements are understood by the Area Teams however there has been no additional funding to address this need. A deep dive exercise was undertaken in January to explore whether there were inefficiencies and inequities in the services across North Wales and to start to understand the reasons for the significantly increasing demand. Each Area has developed an action plan with an overarching regional plan to improve our efficiency, effectiveness and partnership working. A key element of this is work with partners to ensure that families are supported, parenting programmes and Team around the Family are accessed and 1st 1000 days is prioritised.

A survey of parents to identify what they wanted to achieve from the neuro-development pathway, found most (77%) believed that they need a diagnosis to access support in school.

- Want to better understand my child's behaviour **100%**
- Need behaviour support at home **53%**
- Need **behaviour support at school 75%**
- Need **additional educational support at school 64%**
- Need financial support (universal credit now needs diagnosis) **21%**
- Parenting support / Groups 43%
- Do you believe that you need a diagnosis to get the help you need - yes **77%**

It is hoped that the Additional Learning Needs Act may provide the opportunity to address this with the focus on function and need rather than a diagnosis to access support in schools.

Quality Assurance and Risk Management

Measures in place

- All Wales Neuro development pathway being implemented
- Clinical supervision framework in place
- Job planning and performance management system in place
- Concerns investigated and responded to

Identified risks:

- The waiting times for a neuro development assessment are lengthy for families resulting in a deterioration in wellbeing and difficulties managing behaviour.
- AXIA (the independent provider for Neuro-development assessments) – there has been a view that they over diagnose, this is being addressed by a Consultant Psychiatrist attending the Multi-Disciplinary reviews.
- Intervention and support provision is limited.

Improvement actions being undertaken

- Action plans in place per Area to ensure no duplications, streamlining of assessments and recruitment to vacant posts.
- Bid to be submitted for new Welsh Government (WG) Mental Health Service Improvement funding to increase capacity.
- Business cases being discussed at Area level.
- Renewal of contract with independent provider - tendering process commenced
- Partnership working with Local Authorities and 3rd sector to provide support to families.

2.1.2 Neonatal Care

The new Sub Regional Neonatal Intensive Care Centre (SuRNICC) was officially opened in September 2018. The Neonatal Service now provides care for babies 26 weeks gestation and above. It is supported by the two Special Care Baby Units in Wrexham and Bangor. The North Wales Neonatal Transport Service is based in the SuRNICC and operates from 8am to 8pm. The remaining 12hrs of service is commissioned from CONNECT now based in Liverpool Women's Hospital. This ensures a full 24hrs service for Neonatal Transport.

Quality Assurance and Risk Management

Key quality achievements

- The unit has recently achieved a Silver ward accreditation.
- The unit was the first Neonatal Unit in the UK to achieve a national Aseptic No Touch Technique (ANTT) Silver award.
- Kangaroo care (skin to skin) global award, 1st out of 137 units worldwide.
- Family integrated care (FiCare) launched in May 2019
- Transitional Care has been developed and implemented across BCUHB.
- Neonates support group for families meetings on the unit provides support for families from peers and staff once their baby has been discharged home.
- Neonates Facebook page to help parents connect and support one another.

- The Neonatal Qualified in Specialty course is in place. 10 staff have undertaken this course in the last two years. This ensures competent trained nursing staff to care for babies requiring Intensive and High Dependency Care. It also ensures that shifts are British Association of Perinatal Medicine (BAPM) compliant for Neonatal Qualified nurses.

Risks identified:
- Recruitment of experienced neonatal nurses
- Ensuring effective interface and communication between maternity services and neonates.

Improvement actions being undertaken
- Daily multidisciplinary huddles take place. This ensures all members of the team are aware of any safety briefings, safeguarding issues, transfers and expected deliveries. This is in addition to the Nurse and Medical handovers at the beginning of each shift**.**
- To assist staff with reporting of Datix a Neonatal clinical reportable incidences list has been compiled.
- All neonatal deaths are reviewed and reported.
- All Full-Term admissions to the unit are reviewed and reported by the Neonatal manager and Midwifery manager. This helps to ensure good quality of care of mothers and babies and is considered good practice by MBRRACE-UK.
- The Neonatal Service Manager and Clinical Lead attend the Women's Directorate North Wales Group to ensure good communication and information exchange between the two services.
- Neonatal Service Manager attends the North West Neonatal Clinical Effectiveness Group (CEG), to link in with our commissioned service providers from the North West.
- The Neonatal Steering Group is held monthly and attended by representatives from all three neonatal units, women's services and the Wales neonatal Network.

2.1.3 Children who are Looked After or on the Edge of Care

During 2018-19 there were 490 children living in North Wales who became Looked After and required an initial health assessment. Of these 374 were North Wales children resident in N Wales. In addition a further 116 children from out of area required an initial medical as they became looked after and became resident in North Wales.

BCU is a net receiver of Looked After Children from all over the UK. As at 31 March 2019, there were 325 Looked After Children placed within the six North Wales Local Authorities from 83 Clinical Commissioning Groups from outside of North Wales. This is an increase of 14% on the previous year's figure of 285. There are currently 172 North Wales children being looked after in England.

Many of these children and families require CAMHS and Neuro-development support, joint packages and continuing care.

Quality Assurance and Risk Management

Identified Risks:

- The NHS Wales Notification Pathway for Looked After Children states that a notification must be sent from the placing Local Authority within 5 working days of a child being placed; this also applies to those changing placement or ceasing to be looked after.

- During 2018-19 a total of 1333 notifications for a review medical were received equating to an average of 26 per week. Only 59% were received within the statutory target from Local Authorities (LA) impacting on the timeliness of health assessments. However this is an improving position as a consequence of task and finish work with each LA.

- The capacity within the LAC team is lean, one LAC nurse per county supported by Health Visitors, School nurses and Community Paediatricians to undertake the assessments and support the children, young people and the foster parents.

- Many children who are Looked After need CAMHS and Neuro-development assessments and support in a timely flexible manner which can be difficult to achieve particularly if placements change frequently.

- Financial cost of joint packages and continuing care is unpredictable. The WG guidance is not clear resulting in disagreements about financial responsibility between Health, Education and Social Services.

Improvement actions being undertaken

- The six Local Authorities with the Health Board have been successful in gaining £3million Parliamentary Review Transformation funding which supports a focussed early intervention multi-disciplinary model with residential assessment beds for those children and young people who are on the Edge of Care or who are Looked After. The children and young people are often unable to be discharged from paediatric wards when medically fit and many would have benefited from an alternative option to a hospital. This model has been built on the Conwy LAC pathway and the early help hub in Flintshire.

  Key elements of the pathway include consistent emotional health screening, joint formulation and care planning and open up access to the range of assessments and interventions available from both services on a needs led basis. It is recognised that the needs of Looked After Children and carers may change over time and the pathway aims to provide the flexibility to respond to these changes by removing interagency barriers.

- A review of our governance systems including quality monitoring of placements and financial contracting is under way.

- Task and finish work continues with individual Local Authorities to improve efficiency specifically timeliness of notifications.

2.2 Prevention and mitigation of Adverse Childhood experiences

Quality Assurance and Risk Management

Adverse Childhood Experiences are traumatic experiences that occur before the age of 18 and are remembered throughout adulthood. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. Evidence shows children who experience stressful and poor quality childhoods are more likely to develop health-harming and anti-social behaviours, more likely to perform poorly in school, more likely to be involved in crime and ultimately less likely to be a productive member of society.

Identified Risks

- A Public Health Wales study of Adverse Childhood Experiences (ACEs) found almost half (47%) of adults in Wales have suffered at least one ACE. 14% of adults in Wales have suffered four or more ACEs. Forty-one percent (41%) of adults in Wales who suffered four or more adverse experiences in childhood are now living with low mental well-being.

- Raising awareness of ACEs and their lifelong impact is relevant to all staff working in health, social care, the police and other public services, particularly those working with parents where parenting is compromised.

Improvement actions being undertaken

- Healthy Child Wales Programme has increased the number of contacts that families have universally and when either enhanced or intensive support is required; this is dependent on recruiting and training enough Health Visitors to fill the vacancies and reduce the caseloads to the recommended 250 families per 1 whole time equivalent (WTE).

- We now have the findings from a pilot study by BCU health visitors in Anglesey, in which health visitors have routinely asked new mothers about the ACEs they suffered as children. The routine ACE enquiry aims to better prepare individuals for parenting through providing opportunities to discuss and reflect on what impacted the mother's own experiences of childhood. Whilst this is only an initial evaluation, the findings by Public Health Wales are very promising.

2.3 Improving outcomes in the first 1000 days

The first 1000 days, during pregnancy and up to a child's second birthday, represent a critical part of childhood when we form attachments to our caregivers, learn how to safely explore and trust the world around us, and start to communicate. It is when we see the most rapid phase of brain growth and development and where the foundations are laid down for our future health and wellbeing.

This critical period has a long lasting impact on individuals and families. They shape the destiny for children as they grow up: their educational achievements, their ability to secure an income, their influences on their own children, and their health in older age.

Quality Assurance and Risk Management

Identified Risks

- The United Kingdom has the lowest breastfeeding rate at 12 months in the world and only 1% of babies are breastfed exclusively at 6 months. Wales has the lowest initiation and continuation rates in the United Kingdom, and this is reflected within North Wales. Statistics from Public Health Wales (2016) indicate that 54.9% of women intend to breastfeed at birth in North Wales and 25.3% were breastfeeding at 6 weeks following birth. Recent data suggests, 33.8% of babies born in North Wales are breastfed at 10 days. (Public Health Observatory, 2017).

- The World Health Organization (WHO) says “The 2 public health interventions that have had the greatest impact on the world’s health are clean water and vaccines”. Immunisation uptake is not consistently ensuring herd immunity or public protection.

- In order to ensure the ongoing delivery of a high quality, safe and effective immunisation programme that achieves high uptake, it is important that all practitioners involved in immunisation have a high level of knowledge and are competent. The Children’s immunisation schedule is complex and increasing in number, cohorts eligible for Flu has increased and in 2019-20 will see the introduction of Human Papillomavirus (HPV) for boys in year 8.

- The capacity in the School nurse is limited, it is small and addressing the Safeguarding and health needs of this large group of children, caseloads are approximately 3,000 per 1 WTE.

Improvement actions being undertaken

- The infant feeding strategy was launched earlier this year with clear expectations for the health board to take forward.

- All the maternity units, neonatal units, community midwives and health visitors are continually striving for or maintaining level 3 UNICEF baby friendly accreditation

- As above the Healthy Child Wales Programme is a key vehicle with the additional health visiting capacity for supporting families in the 1st 1000 days.

- Area and Cluster immunisation action plans being developed

2.4 Improving Emotional Health, mental wellbeing and resilience of children

Quality Assurance and Risk Management

As a result of on-going performance concerns, specifically not meeting the Mental Health Measure targets for assessment and therapy the Board requested a deep dive into Community CAMHS to understand whether there were inefficiencies and inequities in the services across North Wales and to start to understand the reasons for the significantly increasing demand on both CAMHS and Neuro-development services.

The deep dives found that we have consistent access pathways through the Single Point of Access established in the teams, and in CAMHS we have the CAPA - Choice & Partnership Approach (the WG demand and capacity model) embedded, which ensures we are as efficient as possible, and the services across all three geographical areas are deficit of good clinical and managerial IT systems to support efficient use of resources. It was noted that the unscheduled demand draws available capacity away from the scheduled care demand, which has a direct impact on achieving the performance targets.

Identified Risks

- In North Wales the demand continues to rise, with an average of 581 per month compared with 534 in 2017/18. 2018-19 saw a 9% increase of referrals compared with 2017-18 with a 23% increase of self-harm risk assessments being undertaken on the paediatric wards.
- WG require all Health Boards to achieve 28 day access for GP referrals to assessment and then intervention, the target is 80%. The end of March position saw BCUHB achieve 82% for assessments and 75% for intervention with Centre Area experiencing the biggest challenge due to vacancies, serious illness in the team and maternity leave.
- Average wait for assessment in May was 5 weeks. Longest waiting time was 18 weeks for one young person in Central Area.
- Average wait for intervention was 3 weeks. Longest waiting time was 18 weeks in West Area.
- Self-harm assessments undertaken on the paediatric wards were 23% higher from 2017/18 to 2018/19

Improvement actions being undertaken

- To reduce the demand the specialist CAMHS has a key role in promoting good mental health for children and young people by supporting partners in Primary Care, Health Visitors, School Nurses, Education and Social Services. Early interventions in place:
  5 Ways to Well-being, Self-harm pathway with schools, LAC pathway, ADTRAC and particularly the Health and Wellbeing practitioner in the North Denbighshire GP cluster pilot which his reducing referrals to specialist CAMHS.

- Scheduled referrals to CAMHS is managed by Single Point of Access (SPoA) per county, five days a week. The SPOA's provide consultation and support to non-CAMHS practitioners and triage referrals to specialist CAMHS. Those who do not meet the criteria for a mental health assessment or require consultation are signposted to other services, which is approximately 30% of the total.

- All referrals are triaged with urgent referrals being prioritised and children and young people are seen within 48 hours as required under the Mental Health Measure (MHM), and much sooner in most cases.

- The paediatric wards are supported 7 days a week by a CAMHS practitioner based on the ward.

- Successful recruitment day in May. The team with Workforce & Organisational Development (WOD) organised a well-publicised event by flooding social media, on a Saturday when all interested candidates could meet the teams, submit applications for vacancies and be interviewed. Our workforce plan includes development posts to bring practitioners into the organisation with the opportunity to increase their skill set enabling them to move into more senior posts. There was very good interest and appointments have been made to vacancies with others being progressed.

- Weekly performance management of job plans to meet demand.

- Bids being submitted to Welsh Government for Mental Health Improvement funding

2.4.1 Tier 4 CAMHS Services

Quality Assurance and Risk Management

Over the past year there have been a number of external reviews of the CAMHS service particularly inpatient services. These reviews have scrutinised our care and leadership, and whether our provision is meeting the needs of the population. In July 2017 the Welsh Health Specialised Services Committee (WHSSC) wrote to the Health Board concerned about a number of performance issues resulting in the service being put into escalation level 3. Since then WHSSC have paid a number of visits to North Wales Adolescent Service (NWAS) and the senior team, de-escalation has been discussed due to the significant improvement in the number of out of area placements during the past year, this was held off due to the ongoing difficulties in accessing an age appropriate bed in adult services and the Together for Children & Young People (T4CYP) peer review.

Importantly HIW undertook an unannounced inspection in June 2018. It found that the ward provided safe and effective care in a pleasant environment that was suitable to the patient group. Patients they spoke with, were positive about their experiences within the hospital and staff commented favourably upon working within the service.

In December 2018 the T4CYP Team undertook a peer review, as a consequence of the concerns raised by the T4CYP Team. The senior management team have requested a quality assurance visit from WHSSC, this is being scheduled. There are 12 beds commissioned by WHSSC for planned care at NWAS which appear to meet the current need. Throughout this year the number of young people placed out of area has been on average three at any time compared with an average of six during 2017-18. These young people have in the main required psychiatric intensive care or low secure which is not provided in North Wales.

During 2017 and early part of 2018 we had many nursing vacancies, recruitment has been challenging and use of experienced agency has been required to ensure that care has not been compromised. We are pleased to report that recruitment to the vacancies has now been successful, with all posts appointed to.

We now have a stable nursing workforce and since February 2018 have had a new clinical leadership and medical model, this was endorsed and supported by WHSCC. The model has been transformational, and was as a consequence of our inability to recruit to the substantive Consultant Psychiatrist post within NWAS. The Consultant Psychiatry time is now provided by the Tier 3 Psychiatrists and the leadership is from a Consultant Psychologist.

The clear benefits of this model include integration between Tier 3 and Tier 4 CAMHS in managing care and risk, and a safer provision of Psychiatry moving away from reliance on one individual which has its own challenges and risks, to three Psychiatrists providing a team approach. The three Psychiatrists have dedicated sessions for NWAS, covering the full working week. At the weekends the unit is supported by the on-call Psychiatrist

Risks Identified:

- The Tier 4 inpatient unit is not able to provide emergency urgent service out of hours or a service for acutely ill high risk young people in hours. It would not be safe to do this as a consequence of lack of resident medical (Junior Doctor) presence on site and the geographical location of the unit. This is not the current service specification commissioned by WHSSC.
- CAMHS Psychiatry provision is 7 days a week 9 – 5pm then an out of hours telephone on call rota, consequently the inpatient unit is dependent on competent nurses managing the care and risks. Emergencies are managed by the nurses and calling the emergency services, Police and WAST.

Improvement actions being undertaken

- A focus on reducing length of stay
- Intensive outreach team working closely with community CAMHS to manage risk safely, preventing admissions and enabling earlier discharge
- Young people who are placed out of area for Psychiatric Intensive Care Units (PICU) or low secure have a care co-ordinator who visits them and assists with discharge home or to step down.
- The Health Board will be submitting a bid for the new improvement funding to address this unscheduled care need. In addition the Parliamentary Review Transformation fund will assist in implementing a multi-agency partnership of

care to address the needs of children and young people who are on the Edge of Care or who are Looked After.
- Escalation protocol in place.

2.5	Promotion of healthy weight and prevention of childhood obesity

Quality Assurance and Risk Management

Identified Risks

- The rising levels of obesity at population level have to be addressed to avoid the wide range of health issues that this stores up later in life. The key focus for children's services has been around prevention and addressing this in the early years. This starts with supporting mum's in pregnancy to keep within healthy weight gain parameters, through weaning, the first thousand days and then on through the school years. Whilst prevention is crucial, there are already significant numbers of children who are overweight and obese. When data is combined across five years (2013/14 to 2017/18) obesity prevalence at health board level is statistically significantly higher than the Wales average of 11.9% in three health boards – Betsi Cadwaladr UHB (12.3%); Hywel Dda UHB (12.5%) and Cwm Taf UHB (13.5%). It is lowest in Cardiff and Vale UHB at 9.5% and the difference is significant.
- North Wales does not have a tier 3 service for children already overweight and obese and this requires a level of investment.

Improvement actions being undertaken

- A pilot in the West has been developed to offer first line support for children identified as being overweight and obese via the Child Measurement program to help inform future service intervention. This runs until July 2019 and will be evaluated after that time. Training has been delivered to School Nursing teams in December 2018 to support them with this advice and letters will be sent to families of children to offer support.

- A business case will be developed in 2019 and presented for consideration.

2.6	Review of crisis intervention services for children and young people who are experiencing an urgent perceived mental health crisis.

Quality Assurance and Risk Management

Identified Risks

- We are experiencing an epidemic of self-harm amongst young people with the number of young people being admitted for self-harming continuing to rise. We are also experiencing an increase in presentation of Young People in severe urgent distress.

- The BCUHB all age designated 'Places of Safety' are within the three adult mental health facilities across North Wales, within the Acute Hospital Sites. Attendances at the s136 suite appear to be changing with a significant decrease in attendances this year, 49 in 2017-18; to 25 in 2018-19, this may be due the changes in the Police and Crime Act, the prevention and early intervention work and the focus on ACEs.

- The crisis demand that we are not meeting adequately with our partners in the Local Authorities is for those young people in distress, who are self-harming or have complex behaviour and attend our Emergency Departments resulting in an admission to the Paediatric wards. These young people are not waiting for a psychiatric bed, they frequently need a multi-agency care package however, there are risks associated with these paediatric admissions and delayed discharges occur.

- Risks associated with the provision of care for those young people attending the s136 suite or for those young people requiring an age appropriate bed, a requirement of all Health boards, continues to be challenging to mitigate and are on the risk register.

Quality Improvement Measures implemented

- Seven day 9am – 5pm CAMHS service (nursing and psychiatry), supporting the paediatric wards and s136 suite.
- 24 hour telephone on call rota for CAMHS Psychiatry.
- Paediatricians undertake a holistic assessment of young people under the age of 16 years who attend the s136, and review the Safeguarding risks.
- All admissions to paediatric wards are risk assessed including the impact of the environment and effect on other patients.

Additional Quality Improvement Measures required

- Resolve the estates issues preventing the use of the designated age appropriate bed in the Heddfan unit Wrexham, for 16 – 18 year olds
- Finalise the s136 protocol between the Police, Mental Health & Learning Disability (MHLD) Division and Children's Services.
- Progress Parliamentary Review Transformation project with Local Authorities to enable alternative pathways for young people in crisis who are on the Edge of Care or who are Looked After.
- Develop bids for newly announced mental health improvement funding for crisis interventions.
- Progress the transition work with adult mental health to ensure that early planning is the norm and all are respectful of the UN Rights of the Child.

3.	**Assessment of risk and key impacts**

Risks highlighted in this report include:

- The waiting times for a neuro-development assessment are lengthy and increasing for families, resulting in deterioration in wellbeing and difficulties managing behaviour.
- Number of children who are Looked After is increasing with limited resources and children being placed outside North Wales and within from Local Authorities across the UK.
- Recruitment of experienced neonatal nurses
- Health Visiting and School Nursing Teams are small and carry vacancies while not enough student placements are being commissioned by WG to fully deliver the Healthy Child Wales Programme.
- Breast feeding uptake needs to increase
- Immunisation uptake is not consistently ensuring herd immunity/public protection.
- Obesity prevalence of 12.3% at health board level is higher than the Wales average of 11.9%.
- Self-harm assessments undertaken on the paediatric wards were 23% higher from 2017/18 to 2018/19
- Referral to CAMHS continue to rise with capacity not matching the demand.
- The Tier 4 inpatient unit is not able to provide emergency urgent admissions out of hours or a service for acutely ill high risk young people.
- CAMHS Psychiatry provision is 7 days a week 9 – 5pm then an out of hours telephone on call rota
- The crisis demand that we with our partners in the Local Authorities are not meeting adequately is for those young people in distress, who are self-harming or have complex behaviour and attend our Emergency Departments resulting in an admission to the Paediatric wards.

4. Equality Impact Assessment

Equality Impact assessments exist for specific elements of this report associated with business cases and projects eg ADTRAC, Obesity.

5. Conclusions / Next Steps

These priorities have supporting work streams and quarterly actions monitored through the BCUHB 3 delivery plan and the Regional Partnership Board.

The risks are registered, with monitoring through the Area Quality and Safety Groups reporting to the QSG.

6. Recommendations

The Committee is asked to note:

1. The progress that is being made to services for children, young people and their families.
2. The risks that are identified and being managed through the Area Teams.
3. The external reviews of CAMHS during 2018-19 with a fuller report to be provided

Quality, Safety & Experience (QSE) Committee

16.7.19

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

To improve health and provide excellent care

Report Title:	Update paper following National audit of Handover of Care at Emergency Departments - Health Board Related Recommendations
Report Author:	Mr Trevor Hubbard, Deputy Executive Director of Nursing
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	The purpose of the report is to provide assurance following the improvements made in reducing ambulance handover within BCUHB and the impact of the improvements to overcrowding within Emergency Departments across North Wales and the Health Board response and management of this
Approval / Scrutiny Route Prior to Presentation:	This report was discussed at the Unscheduled Care Improvement Group on 9th July 2019
Governance issues / risks:	The report provides assurance that the improvements identified as part of the National Audit have been implemented and that the impact of reducing ambulance handover delay is not impacting on the care of patients within the Emergency Departments and that there is adequate monitoring and mitigation in place to prevent or identify harm early.
Financial Implications:	No financial implications from the recommendations of the paper – for assurance only
Recommendation:	The Committee are asked to note the report which provides assurance that: 1. regular review of the ambulance handover performance and actions are embedded within existing process. 2. structures are in place to effectively monitor patient safety within the Emergency Departments particularly in times of escalation. 3. systems are supporting data capture to identify harm and recording performance impact

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership & Governance Strategic and Service Planning (sustainable improvement in unscheduled care performance)			
Equality Impact Assessment No EQIA completed as paper is for assurance purposes and an update from the National Audit Review of Ambulance Handover			

Disclosure:

Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Update paper following National audit of Handover of Care at Emergency Departments - Health Board Related Recommendations.

Situation

Ambulance Handover across Wales has been a significant issue with patients remaining in the back of ambulances outside of Emergency Departments (EDs) for considerable lengths of time.

A National audit was undertaken by NHS Wales Audit and Assurance Service to review the impact of recommendations to improve this position and the implementation of policy and practice to deliver this across Wales.

Following the improvements made in reducing ambulance handover within BCUHB concern was raised at QSE Committee over the impact of the improvements to overcrowding within Emergency Departments across North Wales and the Health Board response and management of this. Are we keeping patients safe?

Background

Within BCUHB and in particular in the East area there have been a number of historical incidents resulting in patient harm which were also the focus of the Coroner who identified that harms were not only due to the care within the ED but also the delays either for the patient in the ambulance outside the department and the patients in the community where an ambulance has not been able to respond for significant periods of time resulting in poor clinical outcomes and in certain cases is thought to have contributed to patient death.

Most of the recommendations identified by the audit were for Wales Ambulance Services NHS Trust (WAST) to implement alongside Health Boards. BCUHB participated in the response to the audit and there was a mixed impact from BCUHB at the time on the improvements required. However, since the implementation of the Building Better Care programme, there has been a focus on Ambulance Handover and in particular the measurement of patients waiting over 60 minutes (in England this is referred to as an Ambulance Black Breach). This has concentrated the minds of ED staff on preventing long delays in ambulances, providing early assessment and clinical intervention in order to facilitate the release of ambulances to manage the community demand where the highest risk lies due to patients not having had any clinical assessment.

Whilst the WAST performance has improved in North Wales and the delays caused by queuing at hospitals has decreased there has been an impact on the number of patients within our Emergency Departments. Concern was raised that although the risk had been moved from outside to inside the department which was a positive outcome, the ability of the teams to effectively manage these patients in a timely way and within the existing environment was having an impact on the safety of patients. It was requested that a report is provided to QSE to give assurance that the care of patients was not being compromised and that mitigation was in place to ensure that patients had a good experience and safe care.

Assessment

The following assessment is an update on the recommendations from the audit and the current experience of patients within ED in BCUHB and the mitigation to ensure safety.

Recommendation 1

1. *All health boards should ensure that their Emergency Department Standard Operating Procedures are current and reflect actual practices regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.*

   All Emergency Departments have a Rounding process in place for patient safety and comfort. This includes assessing nutritional, hydration needs, pain management, pressure area care and clinical observations. The triage process has been moved away from the back of ambulances to being undertaken within the ED in a majority of cases. This only occurs when sites are operating at a level 4 escalation and the department is completely full. During Winter NHS Wales implemented the Red Cross scheme to support patients within the ED and Red Cross volunteers do regular hydration and nutrition rounds for patients. This scheme has continued with NHS Wales funding.

2. *All health boards should undertake compliance checks to confirm that Emergency Department staff are acting in accordance with Standard Operating Procedures regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.*

   Implementation of patient focussed rounding which aligns to the Bristol model developed in association with an ambulance trust in England is being piloted at Ysbyty Glan Clwyd (YGC). The ED Matrons will undertake audits to ensure that there is compliance with the rounding process and identify if harm has been caused that can be associated with long delays within the department and patients waiting on trolleys.

Recommendation 2

1. *Health boards, in conjunction with WAST, should evaluate the results of the trials in ultimately reducing conveyance to Emergency Departments, and where found successful, extend the trials across Wales, where appropriate.*

   BCUHB currently has 3 trials which impact on patient handover and ambulance conveyance.

   1. SICAT – Single Integrated Clinical Assessment Triage has been working alongside the WAST control room to provide clinical support to decision making, telephone triage and clinical advice by a GP. They currently field

600 calls a month with ¾ being managed with a different pathway and preventing an ambulance conveyance to ED.

2. 24 hour Alltwen – Expansion of the community Minor Injuries Unit (MIU) at Alltwen to 24 hours to provide local community support, prevent transport to Ysbyty Gwynedd (YG) and provide local treatment plans for patients preventing admission.

3. Llandudno Ambulatory Emergency Care Unit – Primary care focussed alternative to ED providing point of care testing and treatment for ambulatory conditions – identified as a site of best practice by the Delivery Unit

2. *Health boards should work closely with primary care service providers to ensure that patients are being referred appropriately and in line with the health boards' demand and capacity.*

   BCUHB have successfully piloted a GP at ED front door in YG to identify how much of the current walk in demand could be seen in primary care or by an alternative practitioner to reduce ED demand

   SICAT will challenge calls by Health Care practitioners to identify alternative pathways or treatments that could prevent admission and will be undertaking a pilot to take calls from community hospitals, particularly out of hours and at weekends to prevent transfers back to acute sites

3. *The health boards in collaboration with WAST should assess the impact of any pilot to reduce the number of patients being conveyed to the ED by a WAST vehicle on the demand and capacity of the hospital.*

   There is ongoing monthly reporting of the impact of the demand elements as part of the Health Board performance reporting and the demand element of Building Better Care programme. The is currently further development of SICAT to include Health Visitors and other AHP / Nurse triaging alongside the GP in the Ambulance control room

Recommendation 3

1. *Each health board, in conjunction with WAST, should proactively assess whether pathways are being correctly applied*.

   SICAT have developed a Directory of Services which can be applied by WAST and are testing these on a daily basis. A recent review of the Every Day Counts initiative by the NHS Wales Delivery Unit has reviewed the processes in place for discharge to assess and recover models and pathways and the safety netting of patients to ensure that they remain safe at home with appropriate support reducing the reliance on emergency care, in particular for patients with long term conditions and palliative care. Groups already exist with multi-disciplinary review of Frequent Attenders or users of services to manage these patients better clinically.

2. Where the application of an incorrect pathways is identified, the reasons should be investigated and corrective action taken to ensure that such errors are not repeated and that WAST are always provided with up to date pathway documentation.

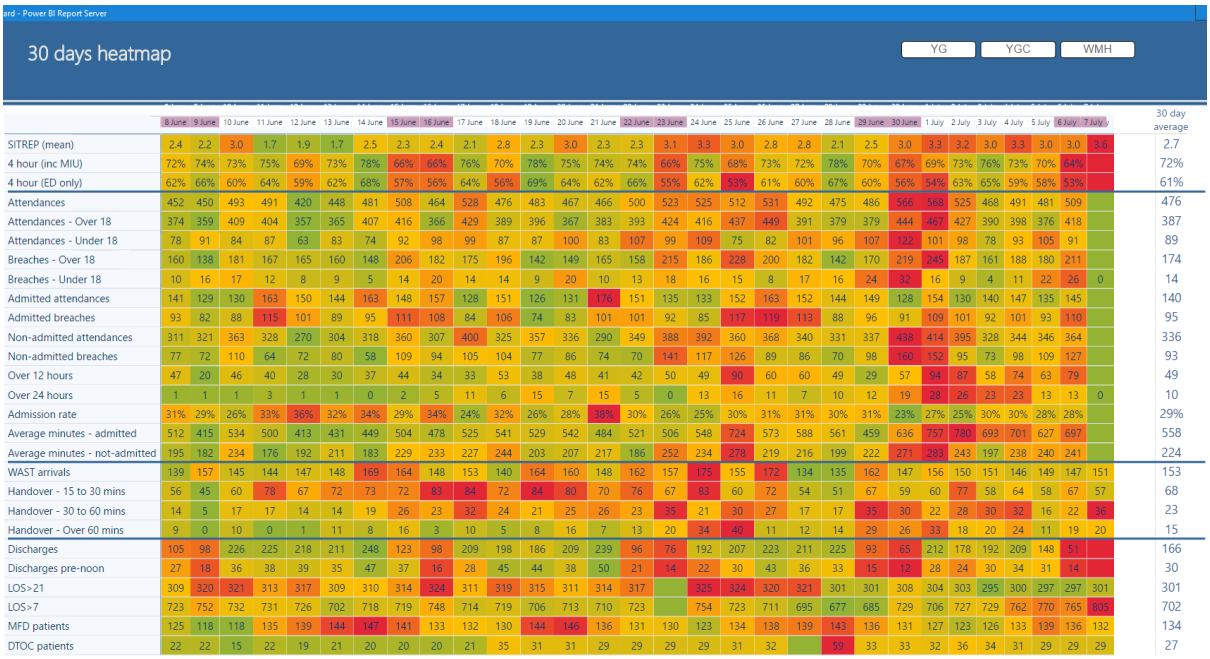
This is undertaken as part of the processes above.

Recommendation 4

1. *Health boards should continue to review their handover performance via published Ambulance Quality Indicators (AQIs) and evaluate how changes in performance achieved over time are a direct result of individual changes in processes and practices implemented.*

As part of the Building Better Care programme a Zero tolerance of 60 minute breaches, paediatric breaches and 24 hour delays was introduced with implementation from September. Datix reporting is already undertaken for any patient wait over 24 hours with indications of harm reported and investigated.

Daily reporting is available via the critical success factors dashboard which is broken down to site level (Chart 1)



	8 June	9 June	10 June	11 June	12 June	13 June	14 June	15 June	16 June	17 June	18 June	19 June	20 June	21 June	22 June	23 June	24 June	25 June	26 June	27 June	28 June	29 June	30 June	1 July	2 July	3 July	4 July	5 July	6 July	7 July	30 day average
SITREP (mean)	2.4	2.2	3.0	1.7	1.9	1.7	2.5	2.3	2.4	2.1	2.8	2.3	3.0	2.3	2.3	3.1	3.3	3.0	2.8	2.8	2.1	2.5	3.0	3.3	3.2	3.0	3.3	3.0	3.0	3.6	2.7
4 hour (inc MIU)	72%	74%	73%	75%	69%	73%	78%	66%	66%	76%	70%	78%	75%	74%	74%	66%	75%	68%	73%	72%	78%	70%	67%	69%	73%	76%	73%	70%	64%		72%
4 hour (ED only)	62%	66%	60%	64%	59%	62%	68%	57%	56%	64%	56%	69%	64%	62%	66%	55%	62%	53%	61%	60%	67%	60%	56%	54%	63%	65%	59%	58%	53%		61%
Attendances	452	450	493	491	420	448	481	508	464	528	476	483	467	466	500	523	525	512	531	492	475	486	566	568	525	468	491	481	509		476
Attendances - Over 18	374	359	409	404	357	365	407	416	366	429	389	396	367	383	393	424	416	437	449	391	379	379	444	467	427	390	398	376	418		387
Attendances - Under 18	78	91	84	87	63	83	74	92	98	99	87	87	100	83	107	99	109	75	82	101	96	107	122	101	98	78	93	105	91		89
Breaches - Over 18	160	138	181	167	165	160	148	206	182	175	196	142	149	165	158	215	186	228	200	182	142	170	219	245	187	161	188	180	211		174
Breaches - Under 18	10	16	17	12	8	9	5	14	20	14	14	9	20	10	13	18	16	15	8	17	16	24	32	16	9	4	11	22	26	0	14
Admitted attendances	141	129	130	163	150	144	163	148	157	128	151	126	131	176	151	135	133	152	163	152	144	149	128	154	130	140	147	135	145		140
Admitted breaches	93	82	88	115	101	89	95	111	108	84	106	74	83	101	101	92	85	117	119	113	88	96	91	109	101	92	101	93	110		95
Non-admitted attendances	311	321	363	328	270	304	318	360	307	400	325	357	336	290	349	388	392	360	368	340	331	337	438	414	395	328	344	346	364		336
Non-admitted breaches	77	72	110	64	72	80	58	109	94	105	104	77	86	74	70	141	117	126	89	86	70	98	160	152	95	73	98	109	127		93
Over 12 hours	47	20	46	40	28	30	37	44	34	33	53	38	48	41	42	50	49	90	60	60	49	29	57	94	87	58	74	63	79		49
Over 24 hours	1	1	1	3	1	1	0	2	5	11	6	15	7	15	5	0	13	16	11	7	10	12	19	28	26	23	23	13	13	0	10
Admission rate	31%	29%	26%	33%	36%	32%	34%	29%	34%	24%	32%	26%	28%	38%	30%	26%	25%	30%	31%	31%	30%	31%	23%	27%	25%	30%	30%	28%	28%		29%
Average minutes - admitted	512	415	534	500	413	431	449	504	478	525	541	529	542	484	521	506	548	724	573	588	561	459	636	757	780	693	701	627	697		558
Average minutes - not-admitted	195	182	234	176	192	211	183	229	233	227	244	203	207	217	186	252	234	278	219	216	199	222	271	283	243	197	238	240	241		224
WAST arrivals	139	157	145	144	147	148	169	164	148	153	140	164	160	148	162	157	175	155	172	134	135	162	147	156	150	151	146	149	147	151	153
Handover - 15 to 30 mins	56	45	60	78	67	72	73	72	83	84	72	84	80	70	76	67	83	60	72	54	51	67	59	60	77	58	64	58	67	57	68
Handover - 30 to 60 mins	14	5	17	17	14	14	19	26	23	32	24	21	25	26	23	35	21	30	27	17	17	35	30	22	28	30	32	16	22	36	23
Handover - Over 60 mins	9	0	10	0	1	11	8	16	3	10	5	8	16	7	13	20	34	40	11	12	14	29	26	33	18	20	24	11	19	20	15
Discharges	105	98	226	225	218	211	248	123	98	209	198	186	209	239	96	76	192	207	223	211	225	93	65	212	178	192	209	148	51		166
Discharges pre-noon	27	18	36	38	39	35	47	37	16	28	45	44	38	50	21	14	22	30	43	36	33	15	12	28	24	30	34	31	14		30
LOS>21	309	320	321	313	317	309	310	314	324	311	319	315	311	314	317		325	324	320	321	301	301	308	304	303	295	300	297	297	301	301
LOS>7	723	752	732	731	726	702	718	719	748	714	719	706	713	710	723		754	723	711	695	677	685	729	706	727	729	762	770	765	805	702
MFD patients	125	118	118	135	139	144	147	141	133	132	130	144	146	136	131	130	123	134	138	139	143	136	131	127	123	126	133	139	136	132	134
DTOC patients	22	22	15	22	19	21	20	20	20	21	35	31	31	29	29	29	29	31	32		59	33	33	32	36	34	31	29	29	29	27

[Chart 1 – Critical Success Factors (CSF) screen shot]

IRIS also reports monthly data on key metrics which is used to inform the Finance & Performance reporting internally and the Integrated Quality Performance Report (IQPR) slides which are used in the board reports and reported to NHS Wales. (Chart 2)

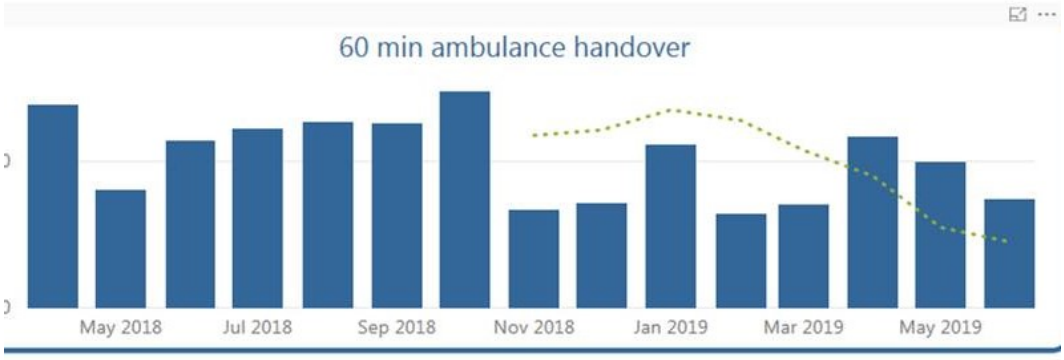


Chart 2 – IRIS screen shot of Ambulance Handover by month

2. *Health boards should support and develop successful processes and practices, whilst those deemed unsuccessful should be reviewed and reversed where appropriate.*

   The Building Better Care programme includes ambulance handover as a key work stream with weekly local review, reporting at the monthly Unscheduled Care board and using 90 day cycles of change to review and implement best practice across BCUHB. In addition the Health Board is an early implementer of the EDQDF (Emergency Department Quality and Delivery Framework) Programme of which ambulance handover is a specific deliverable with targeted intervention from the National Collaborative Commissioning Unit.

Recommendation 5

1. *Health boards should ensure that all Emergency Department staff are provided with consistent and updated HAS operational documentation and learning by WAST, including any proposed dual pin role out.*

   The Hospital Arrival Screen (HAS) is available on all sites and provides information on expected ambulances en route to the department and the ambulances waiting outside. There is a requirement for the WAST crews to log off of the HAS screen at handover. Implementation of dual pin will require BCUHB staff to do this alongside the crew. Dual pin was rolled out in June – early impact indicates success in reducing post-handover delays attributable to WAST staff

2. *Health boards should ensure that delayed handover reasons are always entered on HAS and are used to inform discussions with WAST colleagues and develop operating models.*

   This remains work in progress and reporting from WAST to the Health Board will be through the Unscheduled Care (USC) Improvement Group.

3. *Health boards should consider whether the current option of pre-listed delayed handover reasons on HAS are able to usefully inform health boards' management decision making processes.*

   As above.

Recommendations

The Committee are asked to note the report which provides assurance that:

1. regular review of the ambulance handover performance and actions are embedded within existing process.
2. structures are in place to effectively monitor patient safety within the Emergency Departments particularly in times of escalation.
3. systems are supporting data capture to identify harm and recording performance impact

Quality, Safety & Experience Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Policies, Procedures or Other Written Control Documents for Approval
Report Author:	Authors are detailed on the respective title page
Responsible Director:	Responsible directors are detailed on the respective title page
Public or In Committee	Public
Purpose of Report:	To seek Committee level approval for the following new or revised policies and written control documents: • Community Treatment Order Policy MHLD0051 • Seclusion Policy • Consent to Examination or Treatment Policy MD01 • Restricted Items Policy
Approval / Scrutiny Route Prior to Presentation:	In accordance with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, authors are responsible for ensuring that appropriate consultation has taken place with the relevant individuals and groups. Each policy was considered by the Quality Safety Group (QSG) at the meetings held on 11th June and 2nd July 2019 with detail of prior scrutiny being set out on the respective title pages. The QSG was supportive of recommending each of the written control documents to the QSE Committee for approval.
Governance issues / risks:	BCUHB has a statutory duty to ensure that appropriate written control documents are in place to comply with legislation, enabling staff to fulfil their roles safely and competently. Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees and the Health Board. They help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance. This ensures the Health Board provides a robust and clear governance framework within which service delivery and operational activity can occur.
Financial Implications:	Authors have a responsibility to consider any training and resource implications that are identified as a result of implementation of the policy and to set out who is responsible for the training programme as documented within the Health Board's Policy on Policies.

Recommendation:	The Committee is asked to approve the attached written control documents for implementation within BCUHB.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	**X**	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	**X**	2.Working together with other partners to deliver objectives	**X**
3.To support children to have the best start in life	**X**	3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	**X**	4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	**X**	5.Considering impact on all well-being goals together and on other bodies	**X**
6.To respect people and their dignity	**X**		
7.To listen to people and learn from their experiences	**X**		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Policy development will support the special measures theme of Leadership & Governance

Equality Impact Assessment

Each of the attached written control documents have been subject to EQIA screening – copies of which are appended.

Version: 0.1

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

MHLD 0051

COMMUNITY TREATMENT ORDER POLICY MENTAL HEALTH ACT, 1983

Date to be reviewed:	May 2022	**No of pages:**	30
Author(s):	Wendy Lappin All Wales MHA Policy Group	**Author(s) title:**	Mental Health Act Manager Mental Health Act Managers
Responsible dept / director:	Director of Mental Health & Learning Disabilities Division		
Approved by:	MHLD Policy Implementation Group 07.05.2019 MHLD Q-SEEL 16.05.2019 PAG 04.06.2019 QSG 11.06.2019 QSE		
Date approved:	16.05.2019 as draft whilst progressing through the Health Board approval system		
Date activated (live):	May 2019 as draft		

Date EQIA completed:	April 2019
Documents to be read alongside this policy:	The Mental Health Act 1983 (as amended by the Mental Health Act 2007) The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) The respective Codes of Practice of the above Acts of Parliament The Human Rights Act 1998 (and the European Convention on Human Rights) Domestic Violence, Crime and Victims Act, 2004 All BCUHB policies on the Mental Health Act 1983 as appropriate
Purpose of Issue/Description of current changes: Changes in relation to Code of Practice Wales revised 2016	

First operational:	December 2011				
Previously reviewed:	Date	date	date	date	Date
Changes made yes/no:	Yes/no	Yes/no	Yes/no	Yes/no	Yes/no

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GLOSSARY OF TERMS

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
AMHP	Approved Mental Health Professional - A professional with training in the use of the Act, approved by a local authority to carry out a number of functions under the Act.
AWOL	Absent without leave - when CTO patients and conditionally discharged restricted patients don't return to hospital when recalled
CTO	Community Treatment Order – Written authorisation on a prescribed form for the discharge of a patient from detention in a Hospital onto supervised community treatment
HIW	Healthcare Inspectorate Wales – The independent body which is responsible for monitoring the operation of the Act in Wales.
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
MDT	Multi Disciplinary Team
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Part 4A treatment	The Part of the Act which deals with the medical treatment for mental disorder of CTO patients when they have not been recalled to hospital.

RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case.
SOAD	Second Opinion Approved Doctor – An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Section 5	The powers in Section 5 allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.
Section 25	Restrictions on discharge by nearest relatives
Section 62	Urgent treatment given to detained patients
Section 20A	Community treatment period
Section 23	Discharge of patients
Section 58 treatment	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply, which means medication for mental disorder for detained patients after an initial three-monthperiod.
Section 117	Aftercare - Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients, as well as those who have been absolutely discharged.
Keywords	CTO, Mental Health Act, Section, Supervised Community Treatment, Community Treatment Order

1 INTRODUCTION

This policy sets out to describe the process of using Community Treatment Orders (CTO). Those on CTO will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTO.

CTO provides a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion.

2 POLICY STATEMENT

This policy has been developed to guide staff on the implementation and management of Community Treatment Orders (CTOs) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (“the Code of Practice”).

CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others. It is one of a range of options for mental health treatment in the community and is implemented through the making of a CTO.

3 SCOPE

This policy is applicable to employees within All Mental Health inpatient settings, community settings and general hospital settings where patients are subject to Community Treatment Orders.

4 AIM

Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs

Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Ensure that statutory requirements under the Mental Health Act 1983 are met.

5 OBJECTIVES

Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Whenever mental capacity is to be considered the following practice must be adopted:-

"In particular, they will need to be familiar with the principles of the MCA to understand what it means to lack capacity and to know when decisions can be taken
in the best interest of people who lack capacity to take those decisions themselves, the steps to be taken before doing so, and the principles to be applied".
(MCA 2005 Code of Practice, Introduction, para X1VIII).

6 MATTERS FOR CONSIDERATION FOR CARE IN THE COMMUNITY

To support and deliver care in the community for a patient detained on a treatment order, the options include:

- Section 17 leave of absence. This can be short term or for extended leave of absence (Section 17);
- Section 117 aftercare;
- Transfer onto guardianship; or
- Community treatment order.

7 WHO IS ELIGIBLE FOR CTO

To be considered for CTO a patient must be currently detained under section 3 of the Mental Health Act (MHA) or an unrestricted Part 3 patient (section 37, section 45A, section 47 or section 48). Those detained for assessment on section 2 are not eligible. Furthermore, CTO can only be used for patients whose treatment needs have already been assessed in hospital under one of the above-mentioned detention orders and if they meet the eligibility criteria.

8 ELIGIBILITY CRITERIA

The patient's treatment needs have already been fully assessed under section 3 or as an unrestricted Part 3 patient and the patient is still liable to be detained. An individual patient can be discharged onto CTO if s/he satisfies the eligibility criteria, which are that:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of other persons that they should receive such treatment;
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital;
- It is necessary that the responsible clinician should be able to exercise the power under s17E(1) of the Act to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

9 Recommendations by the Mental Health Review Tribunal (MHRT)

The MHRT may decide not to discharge a patient who has made such an application to them. The MHRT may decide, instead, to recommend that the RC should consider whether the patient should go onto CTO (qualifying patients only). The RC will carry out the assessment of the patient's suitability for CTO in the usual way.

However, it will be for the RC to decide whether or not CTO is appropriate for that patient. The assessment may have to be carried out within a period of time as allowed for by the MHRT.

10 Assessment for CTO

The Responsible Clinician and the Approved Mental Health Professional (AMHP) will need to consider whether the objectives of CTO could safely and effectively be achieved in a less restrictive way. The RC will decide whether CTO is the right option for any patient and requires the agreement of the AMHP. The RC must be satisfied that appropriate treatment is, or would be, available for the CTO patient in the community. The key factor is whether the patient can safely be treated for mental disorder in the community with the RC's power to recall the patient to hospital for treatment if necessary. The RC would also assess the risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

11 Consultation

When the RC considers that a patient may be suitable for CTO, then the first step would be to consult with those involved in the care of the patient including the care coordinator and, where applicable, a different RC who will take over the responsibility for the patient in the community. The AMHP for the patient's area must also be consulted in the early stages to ensure that they will be in agreement.

Consultation is necessary when a CTO is first considered but it should also take place on any review of CTO, when a change of condition is considered and prior to recall of a community patient unless the need for recall is too urgent.

The patient does not have to consent formally to CTO. However, in practice patients need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

The RC must be fully aware of the diverse needs of the patient when considering a CTO and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

12 Who to Consult

- The patient, who may be supported by the Independent Mental Health Advocate (IMHA);

- The AMHP for the patient's local area.
- The care coordinator;
- A different RC (if applicable) who will take over responsibility for the CTO patient;
- The nearest relative/carers (unless the patient objects or it is not reasonably practical)
- The multi-disciplinary team involved in the care of the patient;
- Anyone with authority to act on behalf of the patient under the MCA 2005, such as an attorney or a deputy;
- The GP; it is important for the GP to be aware that the patient is to go onto CTO. A patient without a GP should be encouraged and helped to register with a practice; and
- Other relevant professionals.

13 Who makes the decision

The RC and the AMHP make the decision as to whether a CTO is the right option for the patient. They would also have considered whether there is a less restrictive way to achieve the same objectives. The RC must be satisfied that the relevant criteria are met. An AMHP must state in writing that they agree with that opinion and that it is appropriate to make the order. This will be done by completing the appropriate part of Form CP 1.

14 THE ROLE OF THE APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

The AMHP must reach an independent professional view. The AMHP should ensure that they consider the patient's wider social circumstances including any cultural issues. They should also consider any support networks the patient may have, the potential impact on the patient's family, employment and educational circumstances.

If the AMHP does not agree that a CTO should be made or does not agree to the conditions, the CTO cannot proceed. It would not be appropriate for the RC to approach another AMHP in the absence of changes to the plan. Where such disagreement occurs, an alternative plan should be developed by the relevant professionals.

When an AMHP disagrees to the making of a CTO, s/he should make a written entry to that effect in the patient's clinical record.

15 CARE AND TREATMENT PLANNING MEETING

CTO patients are entitled to aftercare services under section 117 of the Act. The care and treatment plan will reflect the needs to be met by the services from the Health Board and the Local Social Services Authority (LSSA). Such care plan, coherent with CTO, must be in line with the requirements of care and treatment planning and a care coordinator will need to be identified. Good care planning will be essential to the success of CTO. This would include an appropriate package of treatment and support services and the identification of a care coordinator. There

would be a record of the patient having an attorney if applicable and also of any advance decisions.

As part of the pre-discharge arrangement, the team should identify the statutory consultees who will have to meet the second opinion approved doctor (SOAD) in person during their forthcoming visit for the purpose of providing a Part 4A Certificate. Again the local venue where the patient must attend to be examined by the SOAD must be agreed with the patient.

Before giving a Part 4A certificate, the SOAD will need to consult two other persons who have been professionally concerned with the patient's medical treatment. At least one must not be a doctor and neither must be the patient's RC or the Approved Clinician (AC) in charge of the patient's treatment in question (see s64(H)(3)(a)(b)).

16 CONDITIONS

A CTO will specify the conditions to which the patient is to be subject whilst on a CTO. All CTOs must include the ''mandatory conditions'':

- For the patient to make themselves available for medical examination where an extension of the CTO is being considered or
- Where necessary to allow a second opinion approved doctor (SOAD) to provide a Part 4A certificate authorising the patient's treatment in the community.

The MHA Code of Practice for Wales suggests that the RC with the agreement of the AMHP may also set other conditions that are necessary or appropriate to ensure one or more of the following purposes:

- Ensuring that the patient receives medical treatment;
- Preventing risk of harm to the patient's health or safety;
- The protection of other persons.

With the exception of the two mandatory conditions, other conditions are in themselves not enforceable. The reasons for any conditions should be explained to the patient and others and be recorded in the patient's notes.

The conditions should:

- Be kept to a minimum number consistent with achieving their purpose
- Not amount to a deprivation of liberty for the patient
- Have a clear rationale
- Be clearly and precisely expressed, so that the patient can readily understand what is expected
- SMART – Specific, Measurable, Achievable, Realistic, Time framed.

Where applicable the RC should take account of any representation from a victim or their family, where the provisions of the Domestic Violence, Crime and Victims Act 2004 apply.

The conditions might include stipulating:

- Where a community patient is to live;
- The arrangements for receiving treatment in the community;
- The avoidance of the use of illegal drugs and/or alcohol where their use has led to relapse in their mental disorder.

17 COMPLETING A COMMUNITY TREATMENT ORDER

The RC is responsible for initiating the process. The patient is entitled to ask the (IMHA) to support them at this point. Staff should assist the patient in contacting the IMHA if requested. The decision to go ahead is a joint one by the RC and the AMHP (who may be a member of the multidisciplinary team).

- The RC completes Part 1 of the Statutory Form CP1;
- The AMHP completes Part 2 of the Form CP1;
- The RC completes Part 3 of the above Form CP1;
- As soon as reasonably practical the RC shall furnish the Mental Health Act Administrator (on behalf of the managers of the responsible hospital) with the duly completed Form CP 1 together with an up-to-date risk assessment and care and treatment plan;
- The Mental Health Act Administrator will ensure that a copy of the Form CP1 is copied for the patient's notes and the original kept in the patients legal file;
- The date on which the patient is discharged on CTO shall be the date on Part 3 of the duly completed Form CP1;
- The community patient is informed of the effect of CTO by the care coordinator / Mental Health Act Administrator;
- A copy of the CP1 is sent to the patients GP

18 COMMENCEMENT OF CTO

The day on which the CTO is made is determined by the date on the duly completed Part 3 of Form CP1. Hence, that will be the date on which the patient shall be discharged onto CTO. Similarly, for patients who are already on s17 leave, they will instead be 'transferred' onto CTO from that date. This date may be a short period after the date on which the form is signed, to allow for arrangements to be put in place for the patient's discharge.

When the CTO is in force, the patient becomes a 'community patient' and the treatment order they are subject to does not expire and the hospital managers' authority to detain is suspended.

19 DURATION OF CTO

The CTO will be in force, until:

- The community treatment period expires;
- The patient is discharged by the Responsible Clinician or Hospital Managers under s23 or under a direction by the MHRT under s72 (1)(c);
- (For Part 2 Patients) the nearest relative applies for discharge and it is not barred by the RC;
- The patient no longer satisfies all the criteria for CTO;
- The CTO is revoked under s17F.

20 COMMUNITY TREATMENT PERIOD

The community treatment period shall cease to be in force on expiry of the period of six months beginning with the day on which it was made. The day it was made is arrived at by the date on the duly completed Part 3 of Form CP1. Unless the CTO has previously ceased to be in force, it can be extended for a period of six months and thereafter for a period of one year at a time.

21 GIVING INFORMATION TO THE PATIENT

Following the decision to make the CTO, the RC should inform the patient and others consulted of:

- The decision;
- The conditions to be applied to the CTO; and
- The services which will be available for the patient in the community.

Unless the patient objects, the nearest relative should be informed where practicable of the conditions to be applied and of their right to apply for the discharge of the patient from CTO.

22 GIVING INFORMATION ABOUT THE IMHA TO CTO PATIENTS

CTO Patients are qualifying patients for the purpose of accessing the services of the Independent Mental Health Advocate (IMHA). The care coordinator will give CTO patients information both orally and in writing as soon as practicable after the patient goes onto CTO about the availability of the IMHA service. This may be done as soon as practicable when the CTO is being considered.

The Mental Health Act Administrator will send such information to the Nearest Relative, unless the patient requests otherwise (or does not have a Nearest Relative).

23 VARIATIONS IN / SUSPENSION OF ANY CONDITIONS OF A CTO

With exception of the two mandatory conditions, the RC may vary or suspend any of the above conditions applied to a community patient. There is no requirement for the RC to obtain an AMHP's agreement before doing so. Unless there is an urgent need to vary, it would be good practice to obtain an AMHP agreement before doing so. Any variation of the conditions by the RC shall be recorded on Form CP2. The RC

may by order in writing vary the conditions of the CTO from time to time. Additionally, the RC may suspend any condition specified in the CTO. The RC may consider any failure to comply with the conditions for the purpose of recalling the patient. However, the power to recall is not restricted to cases where there is such a failure. The RC should record any decision to suspend conditions in the patient's notes, with reasons.

The RC shall furnish the Mental Health Act Administrator with a duly completed Form CP2. The Mental Health Act Administrator will ensure that the information about any such changes is brought to the attention of the patient and anyone affected by the changes. They must understand the reasons for the changes and how to comply with them. The original Form CP2 will be filed with the Form CP1 in the patient's legal file and a copy in the patient's notes

24 CHANGE OF RESPONSIBLE CLINICIAN

In certain circumstances, the RC for an inpatient may not be the RC for the CTO patient. In such cases, at an early stage of planning for the CTO the RC must liaise with the different RC to take over responsibility for the patient. Hence, as part of the CTP review, on the inpatient unit both the community team and the different RC who will take over the responsibility for the CTO patient must attend such reviews. Alternatively, transfer can take place during a CTP review and the CTO patient informed accordingly.

To ensure that the correct RC is known Appendix 2 Notification of change of Responsible Clinician for patients subject to CTO to be completed and forwarded to the Mental Health Act Office on a change of RC.

25 MEDICAL TREATMENT FOR MENTAL DISORDER IN THE COMMUNITY

The provision of medical treatment for mental disorder is governed by the new Part 4A of the Act. There are two types of requirements in Part 4A, namely authority and certification. In all cases, the person giving the treatment must have the authority to do so and the certificate requirement must be met for section 58 and 58A type treatment.

To a negligible extent, those on CTO who are under the age of 16 may have the competence to consent to the treatment. The MCA 2005 is not directly relevant. The child's own consent will provide the authority. However, the Act also requires a SOAD or the AC in charge of their treatment to certify this on a Part 4A certificate. Under 16 year olds, who do not have competence, can be treated by the AC in charge of the treatment or someone acting under the AC's direction provided certain conditions are satisfied.

CTO patients with capacity to consent cannot be treated in the community against their wishes. A CTO patient will be recalled to hospital when treatment for the patient's mental disorder is clinically necessary and the patient is not consenting. There are no exceptions to this rule, even in emergencies.

The authority to treat patients who lack capacity to consent to a treatment may come from an attorney, a deputy or the Court of Protection. The AC in charge of the treatment or someone acting under that AC's direction would be able to provide treatment to the person who lacks capacity provided certain conditions are met (see ch 24.17of the Code). The only exceptions will be in emergencies where patients lack the capacity to consent to treatment which is immediately necessary to prevent harm to the patient and is a proportionate response to that harm.

26 AGREEING LOCATION FOR CTO PATIENT TO BE EXAMINED BY THE SOAD

As part of the above 'mandatory conditions' the RC will inform the patient of the exact location where the patient would be examined by the SOAD with regard to the provision of a Part 4A certificate. The location would normally be a local outpatient facility, day hospital or somewhere that the patient might visit regularly such as a drop-in centre. In some circumstances a local inpatient facility may be used should the patient be required to attend the facility as part of the care plan. Prior to using such non-NHS locations the care coordinator would have obtained the agreement of the centre in question. The location will have a facility for the SOAD to interview the patient in private unless agreed otherwise.

27 CTO – PRIOR ARRANGEMENT AND PREPARATION FOR A SOAD'S VISIT

The Mental Health Act Administrator will be aware whenever a patient is discharged onto CTO.

Healthcare Inspectorate Wales (HIW) will be contacted to request a SOAD for a patient discharged on a CTO. The RC/care coordinator would also identify the location where the patient will attend for reviews and hence to be examined by the SOAD.

HIW or the SOAD will contact the care coordinator and/or Mental Health Act Administrator to confirm a date and time and a mutually agreed venue for the SOAD's visit. The patient's notes must be present for a SOAD review this may require planning by the care coordinator.

28 ARRANGING FOR A SOAD VISIT

If a SOAD is required to provide for treatment under Part 4A, arrangements should be made prior to the CTO patient leaving the inpatient facility. The Community Responsible Clinician should complete HIW SOAD Request Form (CTO only) and identify the two consultees. In this instance, the care coordinator is ideally placed to be one of the consultees. The care coordinator may be a nurse, an Occupational Therapist (OT) or an AMHP but not a registered medical practitioner. The second consultee can be a registered staff member who has been professionally concerned with the patient's medical treatment such as a doctor, OT or AMHP, but not the patient's RC or the Approved Clinician in charge of the treatment in question.

In circumstances whereby the care coordinator would be on leave s/he will make the necessary arrangements for another registered staff member who has been

professionally concerned with the patient's medical treatment to take his/her place as the lead professional. The patient's health record should be made available to the SOAD on the day of the visit.

29 CTO PATIENT – IDENTIFYING ATTORNEY / ADVANCE DECISIONS

If the patient lacks capacity to consent to treatment, the care coordinator will remind the RC/AC to inform the SOAD if the patient has an attorney or deputy and details of any advance decisions or any expressed views, wishes or feelings, both past and present.

30 SOAD VISIT – PLANNED VISIT TO A COMMUNITY FACILITY

The care coordinator will contact the patient to inform him/her of the venue, date and time s/he must attend for an examination by the SOAD. The care coordinator will remind the patient of the above and make suitable transport arrangements if necessary.

The following should be made available on the day of the visit:

- The treatment proposal for the patient completed by the RC;
- The clinical records of the patient containing the MDT meeting notes on which it was based (can be given before or at the time of the visit);
- The relevant CTO papers;
- The statutory consultees;
- Any other relevant people, including the IMHA or any attorney/deputy of the patient;
- The treatment proposed to be authorised in case the patient is recalled to hospital completed by the RC/AC in charge of the treatment.

Wherever possible the SOAD will discuss the case with the RC/AC in charge of the treatment in question face to face and also the two statutory consultees. If this is not possible at the time of the visit the SOAD will make telephone contact with them.

The care coordinator may take copies of the Part 4A certificate to keep in the patient's record. The original must be posted to the Mental Health Act Administrator.

31 EFFECT OF CTO

The application for treatment will not cease to have effect because the patient has become a 'CTO patient'. However, whilst the patient remains on a CTO:

- The authority of the managers to detain him (section 6(2)) with regard to that application shall be suspended; and
- Any reference however expressed in this or any other legislation to patients liable to be detained or detained under this Act shall not include that patient on a CTO.
- Furthermore, whilst the patient remains on CTO, section 20 shall not apply to the patient, however, section 20A will apply.

The authority for the detention of the patient shall not expire during any period in which that authority is suspended.

32 APPLICATION FOR DISCHARGE FROM CTO

CTO patients are entitled to request the hospital managers to consider their discharge from CTO. Additionally, their nearest relative can apply for their discharge from CTO giving 72 hours' notice, unless the RC issues a barring certificate. They are also entitled to apply to the MHRT during each period of detention or renewal of detention. The hospital managers shall refer them, should they not have applied to a Tribunal, to a MHRT after six months and three years.

The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for both referrals to the MHRT and treatment under Part 4 of the Act. Such a period will only be broken should the patient be received onto guardianship or when they are discharged by the MHRT or under section 23 of the Act.

The effect of discharge is to end the CTO and liability to detention. The patient can no longer be recalled to hospital or required to stay in hospital.

33 INFORMING CTO PATIENT OF LOCATION OF A MHRT HEARING/HOSPITAL MANAGERS HEARING

CTO patients will be entitled to ask for a tribunal hearing. As they would be community patients the hearing need not necessarily take place in the hospital. When a CTO patient applies to the MHRT the care coordinator will inform the patient of the agreed location of the tribunal hearing. The Mental Health Act Office should identify a community setting where such hearings can take place for CTO patients being treated in the community.

34 ACCESS TO PATIENTS' CLINICAL RECORDS

The medical member of the Tribunal may want to examine the patient before the hearing takes place. Hospital Managers must ensure that the medical member can see the patient in private and any records relating to the patient's detention or treatment, to be produced for their inspection. The patient should be told of the visit in advance so that they can be available to meet the medical member.

Medical records should be available on the day for Hospital Managers Hearings preferably in advance of the hearing taking place.

35 LEGAL REPRESENTATION

Patients should be informed that they are entitled to free legal advice and representation. Hospital Managers and local social services authorities should inform patients of their rights to present their own case to the Tribunal or to be represented by someone else. A list of solicitors who undertake tribunal work should be available for use by patients – this is especially important for CTO patients who may not have daily contact with professionals.

36 ATTENDANCE AT HEARINGS

It is important that the Responsible Clinician and other relevant staff involved in the patient's care should attend for the full hearing, as their evidence will be crucial in the decision reached by the Tribunal as to whether the patient still meets the criteria for CTO under the Act.

Patients do not need to attend the hearing but should be encouraged to do so, unless it would be detrimental to their health or wellbeing. Wherever possible the RC and other relevant staff should attend the full hearing so they are aware of all the evidence and the tribunal's decision and reasons.

37 MONITORING CTO PATIENTS

CTO should form a part of the patient's care and treatment plan, in accordance with section 8 of the Mental Health (Wales) Measure 2010 and regulations pursuant to it.

It will be important to maintain close contact with a patient on CTO and to monitor their mental health and wellbeing. The care coordinator will normally be responsible for coordinating the care and treatment plan, working with the RC, the team responsible for the patient's care and any others with an interest. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and would include access to services provided locally. Appropriate action will need to be taken if the patient becomes unwell, engages in high risk behaviour as a result of mental disorder, or withdraws consent to treatment or begins to object to it. The reasons for a failure to comply with any condition must be considered and if necessary reviewed. The patient's compliance with the conditions will be a key indication of how CTO is working in practice.

If the patient refuses crucial treatment, an urgent review of the situation will be needed. If suitable alternative treatment is available which would allow CTO to continue safely and which the patient would accept, the RC should consider such treatment if this can be offered.

A failure to comply with a condition is not in itself enough to justify recall. Each case should be considered on its own merits and any actions are proportionate to the level of risk posed by the patient's non-compliance.

38 RESPONDING TO CONCERNS RAISED BY CARERS AND OTHERS

The care coordinator / community team must give due weight to any concerns raised that the patient is not complying with any conditions and/or that their mental health is deteriorating. The care coordinator / Community Mental Health Team (CMHT) / out-of-hours services will deal with any such concern as an urgent referral. The practitioner concerned will access the CTO patient's records including the care plan and risk assessment.

The practitioner concerned will also obtain all the relevant details of the concerns to make a decision as to whether to meet with the person who raised the concerns and/or the CTO patient. Depending on the risk, the practitioner concerned / care coordinator will discuss the concerns with the RC / on-call consultant so that the RC / on-call consultant can decide whether to recall the CTO patient or not.

39 RISK ASSESSMENT

Whilst determining whether the criteria to recall the patient is met, the RC shall consider, having regard to the patient's history of mental disorder and any other relevant factors, what risks there would be of a deterioration of the patient's condition if s/he were not detained in a hospital. The following must be assessed:

- Failure to follow a treatment plan;
- Patient's insight and attitude to treatment;
- The risk of patient's condition deteriorating after discharge;
- The risk of harm arising from the patient's disorder is sufficiently serious to justify the power of recall;
- The co-operation of the patient in consenting to the proposed treatment.

40 ADMISSION TO HOSPITAL OF CTO PATIENTS ON A VOLUNTARY BASIS

CTO patients may agree to be admitted to hospital on a voluntary basis. Clearly, on such occasions the CTO patient would not have been recalled to hospital by their RC. Such patients may be referred to as 'Part 4A patients'. CTO patients who are in hospital on a voluntary basis can be recalled if there is a need to. However, as Part 4A 'patients' the medical treatment they may receive is governed by the rules applied to CTO patient as in Chapter 25 of the Code.

The Mental Health Act Administrator will send a reminder to the RC to undertake a review to determine if the patient still satisfies all the criteria for CTO, whilst the patient remains on the ward.

41 PROCEDURE FOR RECALL OF CTO PATIENTS TO HOSPITAL

The power to recall includes circumstances when the community patient is already in hospital at the time the power of recall is exercised. The RC may recall a community patient if s/he is of the opinion that:

- The patient requires medical treatment for his mental disorder in hospital; and
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient was not recalled to hospital for that purpose.

Failure to comply with the conditions of attending for medical examination as required will result in the RC recalling a community patient. The notice in writing to recall the community patient to a named hospital shall be sufficient authority for the managers of that hospital to detain the patient in hospital.

All patients on CTO have a hospital which is responsible for oversight of their case while they are in the community. The Act referred to this hospital as the "responsible hospital''. There is no special procedure to follow if the CTO patient is re-assigned to another hospital which is under the same managers.

The RC may recall a patient to a hospital other than the responsible hospital. In such instances, the RC has responsibility for coordinating the recall process, unless agreed with someone else. The power of recall will be carried out by notice in writing to the patient. The RC will complete Form CP5 to recall a community patient. Two copies of the completed Form CP5 must be taken. One copy is to be kept on the patient's records and the original faxed and forwarded to the Mental Health Act administrator.

It will not usually be appropriate to post a notice of recall to the CTO patient. It is important that, whenever possible, the notice should be handed to the patient personally. When the need for recall is urgent, it will be important that there is certainty as to the timing of the delivery of the notice. When such a notice of recall is handed to the patient, it is effective immediately. This may not be possible if the patient's whereabouts are unknown, or if the patient is unavailable or simply refuses to accept the notice.

Regulation 3 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 states that a notice of recall may be served by delivery to the patient's usual or last known address. Delivery of the recall notice relating to CTO is secured by delivery in person or by pre-paid post.

SERVING THE NOTICE – WHEN NOT HANDED TO CTO PATIENT

- If it is urgent, the notice should be delivered **by hand** to the patient's usual or last known address. The notice is then **deemed to be served** (even though it may not actually be received by the patient) on the **day after it is delivered**. That is, the day beginning immediately after midnight following delivery.
- First class post can be used. The notice is deemed to be served on the second working day after posting. Sufficient time must be allowed, as detailed above, for the patient to receive the notice before any action is taken to ensure compliance.

Once the notice of recall is duly served the patient can be treated as absent without leave if that is necessary and taken and conveyed to hospital. Should the police be informed, the care coordinator would inform the police that the CTO patient has been duly recalled and is now absent without leave.

There may be cases whereby the patient's whereabouts are known but access to the patient cannot be obtained. In such cases, it may be necessary to consider whether a warrant issued under section 135 (2) is needed.

42 COMMUNITY PATIENTS WHO ARE ABSENT WITHOUT LEAVE

Patients on CTO are considered to be absent without leave (AWOL) if:

- They fail to return to hospital when they are recalled; or
- They abscond from hospital following recall.

Hence, such a patient, who is AWOL, may be taken into custody by an AMHP, an officer on the staff of the responsible hospital, a constable or anyone authorised in

writing by the RC or the Hospital Managers, and returned to the hospital to which they were recalled.

That may only be done before:

- The time at which the CTO is due to expire (assuming it were not to be extended); or
- The end of the six months beginning with the first day of the absence without leave, if that is later.

If patients are taken into custody, or come to the hospital voluntarily, before the end of the period during which they could be taken into custody, the 72 hours for which they can be detained effectively starts again on their arrival at the hospital, even if they had already been detained for part of that period before they went AWOL.

Special arrangements apply if a patient is AWOL at any point during the week which ends on the day their CTO is due to expire, and an extension report has yet to be made. The arrangements are equivalent to those of Part 2 detained patients.

If a patient is taken into custody, or comes to the hospital voluntarily, within 28 days, an examination and the report under section 20A may be furnished to the managers to extend the CTO.

If patients are taken into custody, or come to the hospital voluntarily, after being absent for more than 28 days, their CTO expires at the end of the week starting on the day of their arrival at the hospital unless the relevant practitioner furnishes a report to the managers within that time to extend the CTO using Form CP 4. The CTO may also be revoked under section 21B(4)(a).

43 POWERS IN RESPECT OF RECALLED PATIENTS

The community patient may be recalled to a hospital other than the responsible hospital.

- The recalled patient may be transferred to another hospital.
- Subject to meeting the necessary conditions and written agreement of an AMHP, the RC may by order in writing revoke the CTO.
- The RC may at any time release the patient but not after the CTO has been revoked.
- If the CTO has not been revoked or the recalled patient released at the end of 72 hours, the patient shall be released from hospital. However, a released patient remains subject to the CTO. The ‘‘holding powers’’ of section 5 may not be used to keep the patient in hospital after the end of the 72-hour period.

The period of 72 hours begins at the time the detention in hospital begins by virtue of the notice of recall.

Section 5(6) makes it clear that a patient subject to CTO is not to be held on either section 5(2) or section 5(4) of the Act.

44 POWER OF RECALL TO A HOSPITAL OTHER THAN THE RESPONSIBLE HOSPITAL

The hospital managers (or a person authorised by them) from the hospital from which the patient is to transferred must use Form TC6 to authorise the transfer to the managers of the hospital to which the patient is being transferred.

A copy of the duly completed Form CP5 to recall the patient will be provided to the managers of the hospital to which the patient is recalled as soon as possible after it is served to the patient. This will provide sufficient authority for the managers of the named hospital to detain the patient. The legislation allows a recalled patient to be transferred to another hospital provided it is done within the 72-hour period.

A transfer between hospitals while a patient is recalled does not change the responsible hospital.

45 TRANSFER OF A RECALLED PATIENT

A CTO patient who has been duly recalled may be transferred to another hospital managed by the same hospital managers. There is only the transfer arrangement, as an internal issue, to be carried out so as not to negatively affect the continuity of care. This can only be done within the same 72-hour period. The nurse in charge of the receiving unit must know the time at which the 72 hours started and must ensure that the Form CP5 is duly completed and returned to the MHA Administrator.

46 TRANSFER OF A RECALLED CTO PATIENT TO A HOSPITAL UNDER DIFFERENT MANAGERS

A recalled CTO patient may also be transferred to another hospital under different managers. In such cases the transfer must be effectuated within the 72-hour period. A nominated senior manager on behalf of the hospital managers, must complete Part 1 of Form TC5. Part 2 of the form must be completed by someone authorised by the managers of the receiving hospital.

When Part 2 is duly completed, a photocopy of the completed Form TC5 must be obtained and sent to the MHA Administrator.

47 ASSIGNMENT OF RESPONSIBILITY FOR CTO PATIENTS

Responsibility for a CTO patient may be assigned to another hospital managed by different hospital managers other than Betsi Cadwaladr University Health Board.

If the hospital is satisfied that arrangements have been made for the assignment of responsibility of the CTO patient to the hospital to which responsibility for the CTO patient is being assigned, the appropriate person as identified under the BCU Scheme of Delegation, on behalf of the managers, must complete Part 1 of Form TC5.

On assignment the managers of the hospital to which responsibility for the CTO patient is being assigned must record the assignment in the form set out in Part 2 of Form TC5. When Part 2 is duly completed, a photocopy of the completed Form TC5 must be obtained and sent to our MHA Administrator.

In the event of assignment, the MHA Administrator on behalf of the hospital managers of the hospital to which responsibility has been assigned must notify:

- The patient, in writing, of the name and address of the responsible hospital and the details of the hospital managers; and
- The patient's nearest relative of the name and address of the responsible hospital and the details of the hospital managers of that hospital (if the patient does not object).

48 RECORDS TO BE KEPT FOR RECALLED PATIENT

The MHA Administrator, on behalf of the hospital managers, will keep a record of the time and date of the patient's detention as a result of the notice of recall given by the RC. The start time and date will be the time and date of the patient's arrival on the inpatient unit.

The nurse in charge must record the start date and time of the recall and also the release of the recalled patient using Form CP6 to and also record this in the patient's clinical record.

When completed the Form CP6 must be faxed and the original sent to the MHA Administrator who will keep a record of these times and dates on behalf of managers of the responsible hospital. A copy will be retained on the ward to be filed in the patient's notes.

Prior to the release, the care coordinator and anyone else involved must be informed of the CTO patient's release.

49 MEDICAL TREATMENT FOR MENTAL DISORDER – RECALLED PATIENTS

Though the CTO patient has been recalled to a hospital, the required treatment may be given on an outpatient basis when appropriate. CTO patients who have been recalled to hospital are subject to the same rules on medical treatment (with certain exceptions) as other detained patients and are subject to Part 4 of the Act.

Part 4A does not apply to the treatment of CTO patients who have been recalled to hospital, unless or until they are released from detention in hospital.

Part 4 applies to such patients instead, but with three differences.

First, treatment which would otherwise require a certificate under section 58 or 58A can be given without such a certificate if it is expressly approved instead by the patient's Part 4A certificate (if the patient has one). It is expressly approved if the SOAD states in the certificate that the treatment in question may be given to a patient who has been recalled. The certificate may contain conditions. The conditions may, for example, be different for the patient who is not recalled. However, the Part 4A certificate cannot authorise section 58A treatment for which there would be no authority under Part 4A itself.

Second, medication which would otherwise require a certificate under section 58 can be given without such a certificate if the certificate requirement in Part 4A would not yet apply to the treatment because less than one month has passed since the

making of the patient's CTO. In other words, no certificate is required for the administration of most medications to a patient who has been a CTO patient for less than a month.

Third, treatment that was already being given on the basis of a Part 4A certificate before the patient was recalled to hospital may be continued temporarily, even though it is not authorised for administration on recall on the Part 4A certificate, if the person in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. However, this exception only applies pending a new certificate being obtained.

SOADs providing Part 4A certificates need to consider what treatments (if any) to approve, should the patient be recalled to hospital.

These exceptions also apply to CTO patients who's CTOs have been revoked except that, for section 58 type treatments, continuance with medication will continue pending compliance with section 58 requirements.

Part 4A does apply to CTO patients who are in hospital, either voluntarily or when complying with a condition of their CTO without having been recalled.

HIW may at any time notify the AC in charge of the treatment in question that a Part 4A certificate will cease to apply from a certain date.

50 REVOKING A COMMUNITY TREATMENT ORDER

A CTO may only be revoked while the patient is detained in a hospital as a result of being recalled. The RC may by order revoke the CTO if:

- In their opinion the patient again needs to be admitted to hospital for medical treatment under the Act; and
- The AMHP agrees in writing with the RC and that it is appropriate to revoke the CTO.

The RC's order revoking the CTO will be in the form of a duly completed Form CP7. The RC will complete Part 1 and the AMHP will complete Part 2 of the Form CP7. Again, as soon as practicable the RC will furnish the MHA Administrator with that form. The original Form CP7 will be sent by post to the MHA Administrator. The nurse in charge at the time will have a photocopy made and the copy will be filed in the patient's notes.

The MHA Administrator, on behalf of the managers of the hospital, must refer the patient's case to the MHRT as soon as practicable after the revocation of the CTO. As soon as practicable, the care coordinator and the relevant CMHT must be informed of the revocation of the CTO.

If the AMHP does not agree that the CTO should be revoked then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will remain on CTO. The AMHP's decision and full reasons should be recorded in the patient's notes.

51 EFFECT OF REVOKING A COMMUNITY TREATMENT ORDER

Below is the effect of revoking the CTO in respect of the patient.

- Section 6(2) shall have effect as if the patient has never been discharged from hospital on a CTO. The patient's detention under their original treatment order will be re-instated from the date of revocation.
- The provision of this or any other Act relating to patients being liable to be detained (or detained) in pursuance to an application for admission for treatment shall apply to the patient as was prior to the CTO being made.
- When the patient is being detained in a hospital other than the responsible hospital, the provisions of this Act will have the effect as if the application for admission for treatment were made to that other hospital and he had been admitted to that other hospital at the time when the patient was originally admitted in pursuance of that application.

In any case of a patient being revoked, section 20 shall have the effect as if the patient had been admitted to hospital in pursuance of the application for admission for treatment on the day on which the order is revoked. The detention will last for six months and the RC will be able to renew the detention order, if appropriate, two months prior to the last day of the detention order.

Where the CTO patient has been recalled to a hospital which is not the responsible hospital, the RC / MHA Administrator must furnish the managers of that hospital with a copy of the order.

52 MEDICAL TREATMENT FOR MENTAL DISORDER – ON REVOCATION OF A CTO

Upon revocation of the CTO, the patient would be detained on a treatment order. As such the patient will be subject to Part 4 of the Act as far as medical treatment for mental disorder is concerned. The period of time spent receiving treatment on section 2 and section 3 and CTO will count as being continuous.

53 DUTY TO INFORM NEAREST RELATIVE

The MHA Administrator on behalf of the hospital managers will inform the nearest relative that a detained patient is to be discharged from hospital, unless that patient or the relative has asked that such information should not be given. This duty applies equally where patients are to be discharged from hospital by means of a CTO.

54 EXTENSION OF COMMUNITY TREATMENT PERIOD

Within two months ending on the day on which the CTO would cease to be in force, it shall be the duty of the RC to examine the patient and, if it appears to him that the conditions are satisfied and that the AMHP has agreed in writing, the RC must furnish the managers of the responsible hospital a report on the prescribed Form CP3. However, before providing the report the RC must consult one or more other persons who have been professionally involved with the patient's medical treatment.

The report, duly furnished, would extend the CTO for the prescribed period. Unless the hospital managers discharge the patient under section 23, the care coordinator as delegated by the hospital managers would inform the community patient of the renewal.

55 CONSULTATION BY RC PRIOR TO EXTENSION OF COMMUNITY TREATMENT PERIOD

Before furnishing the above CTO Form to the hospital managers, the RC must consult one or more other persons who have been professionally concerned with the patient's medical treatment. The RC will need to complete Part 3 of Form CP3 with details such as the name and profession of the person consulted. Ideally, it may be the care coordinator, an Occupational Therapist, a Community Psychiatric Nurse (CPN) or a chartered psychologist who has been professionally concerned with the patient's medical treatment.

56 HOW CAN A COMMUNITY PATIENT BE DISCHARGED FROM CTO?

A community patient ought to be discharged from a CTO if the patient no longer meets the grounds for CTO. Such a patient can be discharged from CTO in the following ways:

- Discharge by the RC at any time;
- By the hospital managers under section 23 of the Act;
- For Part 2 patients following application by their Nearest Relative (NR) giving 72 hours' notice;
- By the MHRT;
- Following the patient's reception under guardianship.

57 EFFECT OF EXPIRY OF A COMMUNITY TREATMENT ORDER

A patient will be absolutely discharged from CTO and liability to be recalled to hospital and the application for admission for treatment will similarly cease to have any effect when the CTO expires.

58 SAFEGUARDS FOR CTO PATIENTS

Patients on CTO will be entitled to similar safeguards to patients detained in hospital including nearest relative rights and the right to apply to an MHRT. All patients on CTO will also have their treatment (if it involves giving medicines) reviewed and certified by a second opinion appointed doctor after three months from when medication was first given or one month from discharge from hospital onto CTO, whichever is later. CTO patients will have their case reviewed regularly and will be discharged when they no longer meet the criteria.

59 TRAINING

The Health Board will provide ongoing training for staff who are involved with the care and treatment of patients subject to Community Treatment Orders. Details of training available can be found by contacting the Mental Health Act Department.

It is the responsibility of all clinical managers to:

- Ensure that this policy is brought to the attention of all their staff, and that they understand and adhere to the guidance/procedure contained within.
- Ensure that all staff involved in the care and treatment of CTO patients have received adequate training and are competent to carry out these guidelines.

60 IMPLEMENTATION

This document will be widely disseminated to staff across Betsi Cadwaladr University Health Board. It will be published on the organisations intranet site and referred to during training relevant to the Act.

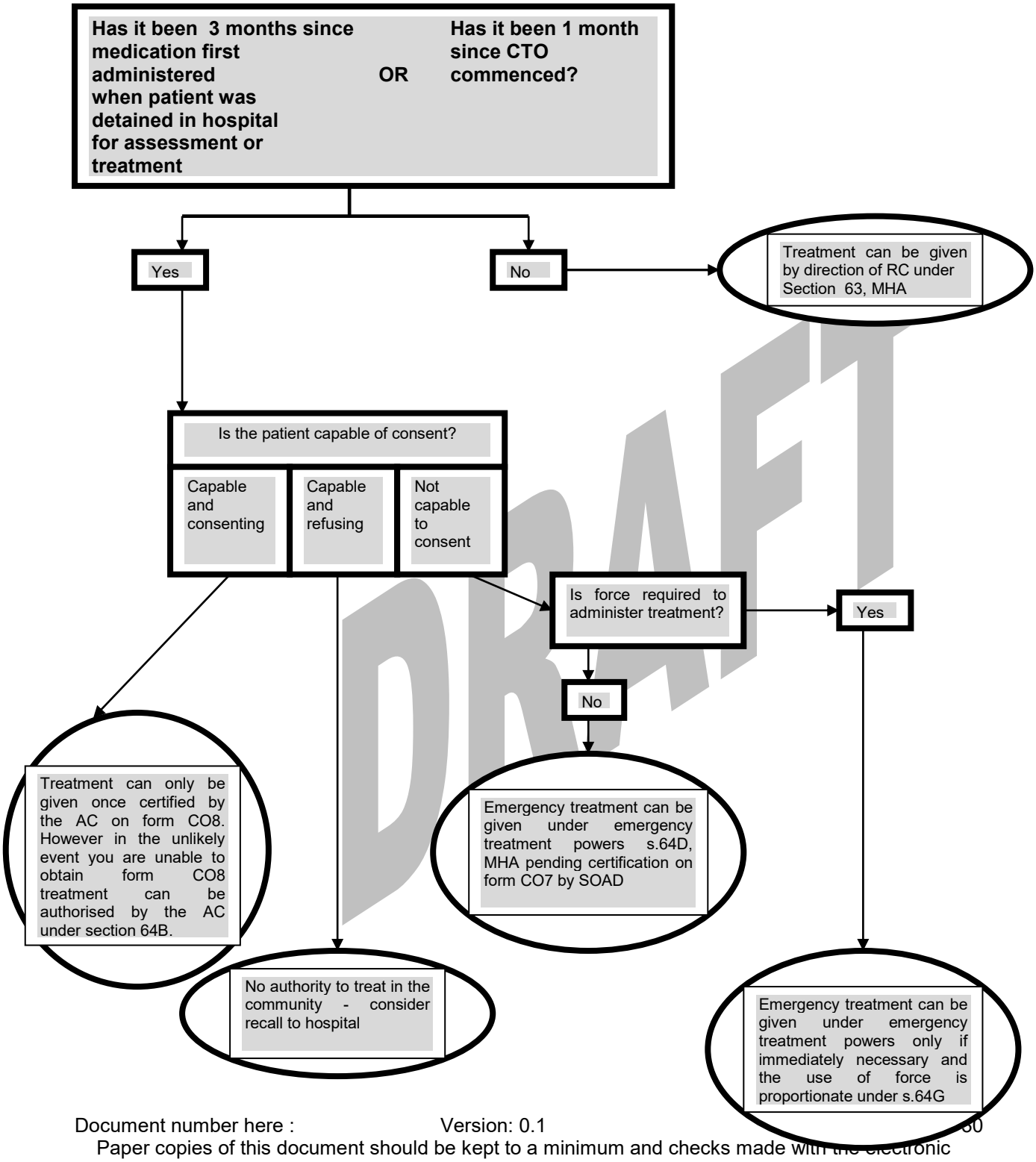
All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

61 REFERENCES

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Domestic Violence, Crime and Victims Act 2004
Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008

Appendix 1

TREATMENT WITH MEDICATION FOR PATIENTS IN COMMUNITY SUBJECT TO A CTO



KEY:	
s.63, MHA	Treatment not requiring consent
s.64B, MHA	Adult community patients
s.64D, MHA	Adult community patients lacking capacity
s.64G, MHA	Emergency treatment for patients lacking capacity or competence
CO7	Certificate of appropriateness of treatment to be given to a community patient (Part 4A certificate)
CO8	Certificate of consent to treatment for community patient (Approved Clinician Part 4A certificate)

Appendix 2

NOTIFICATION OF CHANGE OF RESPONSIBLE CLINICIAN FOR PATIENTS SUBJECT TO A COMMUNITY TREATMENT ORDER

Name of Patient: _____

Date of Birth: _____

NHS No: _____

Hospital Identifier: _____

Inpatient Hospital: _____

_____

_____

To be completed by Inpatient Consultant

I _____, am the Responsible Clinician for the above named patient, I am transferring the care of this patient to _____ Who is an Approved Clinician.

Signed: _____ Date: _____

To be completed by the Community Consultant

I _____, have agreed to take over the care of this patient who is now subject to a CTO and will act in the capacity of Responsible Clinician with effect from _____

I will ensure that:

- The transfer of care is recorded in the patient's medical notes
- The patient is informed of the transfer of care
- The community team are informed of the transfer of care
- The Nearest Relative is informed of the transfer of care (if Applicable)
- This form is sent to the MH Act Administrator for retention in the legal file.

Signed: _____ Date: _____

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

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Community Treatment Order Policy Mental Health Act 1983
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy sets out to describe the process of using Community Treatment Orders (CTO). Those on CTO will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTO. CTO provides a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion. The aims are: Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. The Objectives are: To support and deliver care in the community for a patient detained on a treatment order, Practitioners should have due regard to the Mental Health Act Code of Practice generally and

		specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	MHLD Policy Implementation Group MHLD Divisional Directors QSG and QSE Groups for BCUHB
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	The Mental Health Act 1983 (as amended by the Mental Health Act 2007) The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) The respective Codes of Practice of the above Acts of Parliament The Human Rights Act 1998 (and the European Convention on Human Rights) Domestic Violence, Crime and Victims Act, 2004 All BCUHB policies on the Mental Health Act 1983 as appropriate
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Service Users, Responsible Clinicians, Nursing Staff, Approved clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Training for all Mental Health Staff Communication to staff Workflow chart. Cooperation of staff Time constraints

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:- Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
Age	N/a		Mental health issues can affect anyone among the population at any stage of life. However national statistics show that there are higher incidences of mental health issues among certain protected groups. 20% of children have a mental health problem in any given year and about 10% at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increased to 40% of care home residents (mind, "Our communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds 2016). There are currently 48 patients subject to community treatment orders across BCUHB. The Mental Health Act related to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age, this also applied to CTO criteria.
Disability	N/a		Physical illness more than doubles the risk of depression, and between 30% and 50% of adults with learning disability in the UK have mental health problems. (Mind "Our communities, our mental health". The proposed policy will apply to all patients detained regardless of disability. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity

			Act, DoLS and the Mental Health Wales Measure.
Gender Reassignment	N/a		This policy will apply regardless of whether patients have transitioned or not.
Marriage & Civil Partnership	N/a		This policy will apply regardless of whether a patient is married or within a civil partnership
Pregnancy & Maternity	N/a		This policy will apply regardless of whether patients are pregnant at the time of being subject to a community treatment order.
Race / Ethnicity	N/a		This policy will apply regardless of the race/ethnicity of patients or staff.
Religion or Belief	N/a		Spiritual awareness, practices and beliefs is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). The policy will apply regardless of the religion or belief of patients or staff.
Sex	N/a		This policy will apply regardless of the sex of the patient or staff.
Sexual Orientation	N/a		The policy will apply regardless of the sexual orientation of the patients or staff.
Welsh Language	Positive	High	There is no evidence of disproportional representation to date, but a proportion of service users will be Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by the Welsh Government. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language. Welsh Language Act is a consideration. For those patients who live in rural areas which are predominantly Welsh speaking this enables them to receive information within their primary language.
Human Rights	Positive	High	The proposed policy promotes human rights in ensuring that all patients are detained within the least restrictive method, the consideration of a CTO rather than hospital detention upholds a patient's rights.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	This policy is conducted in line with the Mental Health Act and the legal requirements for detention under a CTO. The policy and MHA considers the least restrictive method for ensuring the safety of a patient and others.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Better communication Joint working across the Health Board in the best interests of the patients.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Community Treatment Order Policy

2. Brief Aims and Objectives: (Copy from Form 1)	This policy sets out to describe the process of using Community Treatment Orders (CTO). Those on CTO will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTO. CTO provides a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion. The aims are: Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. The Objectives are: To support and deliver care in the community for a patient detained on a treatment order, Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No x
3b. Could any of the protected groups be negatively affected?	Yes	No x
3c. Is your decision or policy of high significance?	Yes x	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	x
	Record Details:	

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement	Yes x	No
	How is it being monitored?	The use of Community Treatment Orders are monitored by the Mental Health Act Committee and benchmarked against the rest of Wales. The policy is monitored for changes via the MHLD policy implementation group and identified progress through ratification.
	Who is responsible?	Mental Health Act Committee / BCUHB

your document or proposal?	What information is being used?	The number of patients subject to a CTO
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Three yearly or sooner if legislation changes

7. Where will your decision or policy be forwarded for approval?	As a statute document this policy must progress through the HB full ratification process as identified within the Policy on Policies OBS1: MHLD Policy Implementation Group, Divisional Directors, PAG, QSG and QSE

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	There was an existing policy which has been incorporated into this All Wales MHA CTO policy. The policy was reviewed and developed by the All Wales MHA policy Group and has been through a process of consultation via all the Health Boards in Wales.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Wendy Lappin	Mental Health Act Manager
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

MHLD 0002

SECLUSION POLICY

Date to be reviewed:	14th January 2021	**No of pages:**	36
Author(s):	Lisa Jones Ian Jones Gareth Owen	**Author(s) title:**	Modern Matron Practice Development Nurse Clinical Nurse Specialist V&A
Responsible dept / director:	Mental Health & Learning Disability Division		
Approved by:	Quality & Safety Committee MHLD Policy Implementation Group 5th February 2019 MHLD Q-SEEL 21st February 2019 PAG 4th June 2019 QSG 11th June 2019		
Date approved:	21st February 2019 Approved as a draft policy whilst progressing through the Health Board approval process.		
Date activated (live):	February 2019 as a Draft document		

Date EQIA completed:	27 March 15 updated February 2019
Documents to be read alongside this policy:	This procedure must be read in conjunction with the following policies: Observation and Therapeutic Engagement Policy (MHLD AC002) Searching Patients and their Property Policy (MHLD 0013) Mental Capacity Act Code of Practice for Wales MHA Code of Practice for Wales (Revised 2016) Physical Restraint Guidelines (SCH016) Rapid Tranquillisation Protocol (MHLD 0004) MH02 Protocol for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit. Safeguarding Adult at Risk Procedure (SA01)

Purpose of Issue/Description of current changes:

The statutory scheme, while providing for the Secretary of State to give guidance, deliberately left the power and responsibility of final decision to those who bear the legal and practical responsibility for detaining, treating, nursing and caring for patients.

The Board's policy defines a procedure for seclusion which does not permit arbitrary or random decision-making and the rules are accessible, foreseeable and predictable.

Previously Reviewed:	Date	Date	Date	Date	Date
Changes Made Yes/No:	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

1. Introduction & Aims

The purpose of this policy is to guide staff in the appropriate implementation of seclusion in designated in-patient settings within the MHLD division and to ensure that patient care is delivered to a high standard in line with current national guidelines.

2. Policy Statement

The Board recognises the importance of the Mental Health Act 1983 Code of Practice for Wales (revised 2016) and has incorporated its principles into this policy. It is the responsibility of all members of the Patient Care Team and their managers to ensure that seclusion is used as described within this policy. They are also responsible for ensuring that they record, monitor and review their use of seclusion and collaborate with the managerial arrangements for monitoring seclusion in their service.

3. Objectives

This policy will enable staff to safely, legally and ethically implement seclusion as a last resort in managing extreme behaviours which challenge.

4. Scope

This document is relevant to all staff working in areas within Betsi Cadwaladr University Health Board where patients may be subject to seclusion.

5. Roles & Responsibilities

All staff within the Health Board have an individual responsibility to ensure that the Health Board policies and standards, including Health Care Standards are adhered to and that health and safety arrangements set out in this guidance are appropriately followed

The Health Board recognises and accepts its responsibility as an employer for providing a safe and healthy workplace and working environment for its employees, and a safe environment for persons, visitors and other members of the public. It will discharge these

responsibilities through its managers and will expect its staff to comply with procedures and to act at all times in a responsible manner.

6. Principles

The Mental Health Act 1983 Code of Practice for Wales (revised 2016) defines seclusion as:

"…the supervised confinement of a patient in a room, which may be locked".

It is recognised that in extreme circumstances where a patient is being violent or aggressive and all other options have been considered, as a last resort, seclusion may be the option that presents the least risk and is likely to be of most benefit to the patient concerned.

There are currently three designated seclusion rooms within the BCUHB Mental Health and Learning Disability Division. At all times seclusion must be:

- Based on individual need
- Used as a last resort.
- Employed for the shortest possible time.
- Never used as a punishment or threat.
- Never used as a routine part of a treatment program
- Must not be used due to staff shortages.

Any patient confinement, even if agreed or requested by themselves, does not change the fact that the patient has been secluded and the same processes must be followed - it is essential that they are afforded the procedural safeguards of the code.

NICE Guidelines recommend that seclusion be considered as an alternative to prolonged restrictive physical intervention.

7. Sensitivity to Cultural and Spiritual Needs

Betsi Cadwaladr University Health Board provides care for patients of various ethnic groups with diverse cultural and spiritual needs, treating people with dignity and respect at all times.

The Board has the Equality, Diversity and Human Rights Policy (WP8) which the seclusion policy will take into account.

Consideration must always be given to involving patients in their normal routine at the earliest opportunity and of ensuring that individual cultural and spiritual needs are identified and met throughout the episode of seclusion where practicable.

Further consideration must be given to liaising and consulting with external agencies for advice and support if appropriate.

8. Human Rights

Betsi Cadwaladr University Health Board is aware of and compliant with its legal duties under the Human Rights Act 1998.

9. Dignity, Respect, and Privacy

Design and function of seclusion facilities within the Division must take into account need for privacy and dignity of the patient at all times. All clinical interventions during episodes of seclusion must also uphold these principles.

10. Hydration, Nutrition and Hygiene

Patients in seclusion must be offered their normal diet, served at regular intervals. Regular fluids must also be provided as required, particularly during periods of hot weather, when on certain medications or when situations dictate. There may be occasions where a patient will require menu changes depending on risk factors which will be care planned and continuously reviewed for that patient. In such circumstances consideration must be given to placing the patient on a fluid monitoring chart to ensure basic hydration needs are met. Nursing staff are expected to make a note of times of planned and actual meals, clothing, and bedding and patient's ability to attend to their own hygiene and the patient's participation in the decision making process.

11. Resources

A purposely designed and designated seclusion room is required which must meet the following criteria:

The whole interior of the room can be observed by staff from outside – observation must be continual during the period of seclusion.

To ensure effective communication during the seclusion period, the patient must be able to see staff and hear them.

Ideally the door of the room must open outwards. Where this is not the case, it is the responsibility of the ward manager to discuss refurbishment with the Estates Department.

The door of the room is lockable and entry can be gained easily and quickly in an emergency. The seclusion door key will be held by a designated qualified nurse and a second key will be kept in secure storage on that ward.

Any furnishings and fittings in the room have been checked for possible risk (to self and others).

A bed/mattress is available for the patient to rest on.

The patient is appropriately clothed and the room is heated or ventilated or both, as dictated by the external and internal temperature variations and the clothing worn by the patient. Ideally, the regulating mechanisms must be outside the room.

The patient being secluded has access to appropriate toilet facilities.

The patient being secluded must be encouraged to communicate by which ever means is suitable or through an interpreter if necessary, with the observing nurse.

There must be a clearly visible display showing the time, day and date to assist with patient orientation. The time display must be 24 hour or clearly state whether it is daytime (a.m.) or night time (p.m.) and must be inside the room if safe and practicable or alternatively clearly visible outside.

The seclusion facility must be maintained in adherence to national standards

12. Seclusion practice

The decision to seclude a patient will be made by the nurse in charge of the ward or the patients RC. The nurse in charge at any point directs the procedure and assumes responsibility for ensuring the policy is followed. If the nurse in charge has been assaulted by the patient concerned, this role may be delegated to another suitably experienced registered nurse if available. The nurse in charge will inform the patient of the rationale for the seclusion, as soon as

is practicably possible. Once seclusion has commenced then an exit plan must be devised and considered throughout the seclusion process.

The ward doctor or duty doctor (outside of office hours) must be informed of the decision to implement seclusion and must attend immediately. An entry must be made in the patient's notes and on the Seclusion Recording form, detailing the doctor's attendance.

The nurse bleep holder (or equivalent) on duty for the unit/clinical area must be informed immediately and patient's Consultant/ Responsible Clinician (RC) or nominated deputy, must be informed as soon as is practicable. The nurse bleep holder (or equivalent) will, in consultation with ward staff, inform other staff i.e. modern matron or service manager or head of nursing. Outside of office hours the bronze on-call (mental health /learning disability directorate) must be informed.

If the Doctor fails to attend within 1 hour from when Seclusion commenced then a DATIX form must be completed.

The Department of Health publication 'Positive and Proactive Care: reducing the need for restrictive interventions' (April 2014) provides clear guidance relating to the seclusion of informal patients and staff must familiarize themselves with this document (Para's 88 & 89). If during an emergency, an informal patient is secluded then an assessment must be undertaken promptly to determine whether the person will be detained under the MHA. The patient's valuables or any other belongings considered to be potentially harmful must be removed from the patient in accordance with: Searching Patients and their Property Policy (MHLD 0013)

Any potentially harmful or dangerous items must be removed from the person and pockets and clothing checked - where possible this will be in accordance with advance directives and will always take account of the effects of removing items that minimise any sensory disability e.g. hearing aid, spectacles etc.

It is possible that staff may have to use restrictive interventions in order to ensure the safety of all during an episode of seclusion and the requisite practices – staff must therefore refer to BCUHB 'Physical Restraint Guidelines' ref: SCH 016.

When a patient has been medicated under Boards guidelines for Rapid Tranquillisation, the nurse in charge is responsible for checking the patient's vital signs before the seclusion room is vacated. The nurse in charge must also ensure that physical observations monitoring as described in the above policy are carried out where practically possible. If staff are unable to monitor any of these observations, they should record visual vital signs e.g. complexion, respirations etc.

The reasons for not being able to carry out full observations must be clearly documented in the patient's notes.

13. Observation and Recordkeeping

A designated member of staff must be in attendance at all times outside the Seclusion Room and positioned so as to continually and directly observe the patient in accordance with the Boards Observation and Engagement Policy (MHLD AC002). He/she must be relieved at regular intervals not exceeding two hours. The aim of the observation, as well as maintaining the patient's safety, is to ascertain the patient's mental state.

The Seclusion Record documentation must commence immediately and an entry made in the multi-professional notes describing the behaviour and mental state of the patient prior to seclusion and detailing any other interventions that were used.

A written and signed entry will be made at least every 15 minutes, by the observing clinical team member.

The Mental health Act 1983 Code of Practice for Wales (revised 2016) requires that the following reviews of the patient in seclusion must take place:

Two registered members of the nursing team must review the client every two hours – this assessment must be carried out inside the seclusion room where possible. If it is unsafe for staff to enter the seclusion room, this must be clearly documented in the seclusion record documentation. The seclusion record must clearly show when a review has taken place, and the outcome of the review.

A doctor must review the client every four hours – this assessment must be carried out inside the seclusion room where possible. If it is unsafe for staff to enter the seclusion room, this must be clearly documented in the seclusion record documentation. The seclusion record book must clearly show when a medical review has taken place, and the outcome of the review. If the patient is

secluded for 8 hours consecutively, or 12 hours in a period of 48 hours, a multi-disciplinary review should be completed by a senior doctor or a suitably qualified approved clinician, who should consult with nurses and other mental health professionals who were not involved in the incident which led to seclusion. Where an independent multi-disciplinary review takes place it is good practice for those involved in the original decision to be consulted in the review. (Code of Practice for Wales 19.41)

It is essential that the seclusion record documentation provides a clear and accurate record of any use of seclusion.

The decision to terminate seclusion will be taken by the nurse in charge of the ward in consultation with the unit doctor/deputy to the Responsible Clinician. The Senior Nurse on duty for the unit/locality will need to be informed. All data to be appropriately recorded and signed i.e. Record of Seclusion Form / MDT notes.

If a patient needs to be secluded again after termination of the initial seclusion, the seclusion policy must be re-implemented fully.

Any incident of seclusion, the circumstances leading up to it and method of management must be discussed at the next meeting of the clinical team, with the patient present if appropriate. The patient must be offered a de-brief around the events and decisions that led to their seclusion. Following any incident where seclusion has been used, a review of the risk assessment and the care plan must take place.

14. Review Schedule

The purpose of the review is to assess the patient's safety and well-being, reassess mental state and to check for any improvements in their condition which would indicate termination of seclusion.

All reviews must be done by direct contact with the patient wherever possible and safe to do so.

Reviews must be ideally undertaken within the seclusion room but only when it is considered safe to do so.

The review schedule would be:

- Within first hour by a doctor

- Every two hours by two nurses (one of whom was not involved in the decision to seclude) throughout the period of seclusion.
- First day at 4, 8, 12 and 24 hours by a doctor or approved clinician
- Day 2 to Day 6 - twice per day by a doctor or approved clinician.
- Day 7 onwards - three reviews by a doctor or approved clinician in every 7 days (one being by the responsible clinician or deputy)
- Daily by a multi-disciplinary team (to include responsible clinician or deputy)

In addition to these reviews there must also be a layer of objective review:-

- A review by a senior nurse (not involved in the decision to seclude) within an hour of commencement of seclusion
- A daily review by a senior nurse who is not a member of the patient's care team.
- The V&A Clinical /Operational Lead.

15. Reviews During the Night

The Mental Health Act 1983 Code of Practice for Wales (revised 2016) allows for alternative review arrangements during the night. The Health Board recognizes the value in allowing patients uninterrupted sleep and the potentially disturbing nature of reviews during the night.

Where a patient appears to be sleeping, a clinical judgment needs to be made on whether it is appropriate to wake them for a medical review. In such instances the doctor's attendance for the medical review may be replaced by a telephone review with the nurse in charge.

The decision to hold a telephone review needs to be agreed jointly by the doctor and nurse in charge of the ward and will only be agreed on an individual basis subject to the patient being asleep at the time the review is due. In the absence of a positive decision to have a telephone review, the default position will be that the doctor attends for the medical review.

When there are specific concerns around the physical health of the patient, the default position of the doctor attending for medical reviews must continue during the night. If the patient is asleep these reviews must be carried out in such a way that the doctor can satisfy themselves that the patient is safe and that any concerns for physical health and wellbeing can be addressed safely.

When the patient is asleep, the two hour nursing reviews must be carried out in such a way that the registered nurse can satisfy themselves that they are safe whilst causing minimal disturbance.

16. Ending Seclusion

All patients will have an Exit Plan when they are placed into seclusion. The nurse in charge of the ward can end seclusion at any time. When it is ended, all relevant personnel, including the patient's responsible clinician and members of the care team must be informed as soon as possible and a post seclusion care plan formulated to manage the patient in the period following the seclusion.

The ward doctor or duty doctor and any other professionals involved must be informed of the decision to end seclusion. An entry must be made in the patient's clinical notes and on the Seclusion Recording form, detailing the doctor's attendance if necessary.

17. Medication

Regular prescribed medication should be administered as usual unless there are cogent reasons not to, for example, concerns for the safety of staff entering the seclusion room. Any omissions should be documented as per Medicines Code MM02. When Intramuscular/Intravenous medication has been administered staff must follow the Rapid Tranquillisation Protocol (MHLD 0004).

Should any concerns arise regarding the patient's physical health, medical advice should be sought immediately.

18. Children and Young People

Children and Young People's services are generally not expected to utilise seclusion, and do not have provision of designated seclusion facilities within their inpatient units. However in exceptional circumstances, young people (16-18 year olds) who are cared for and treated within adult services, where seclusion facilities are available, may be cared for in "single person wards" or "enforced segregation" . In these occurrences it will be deemed that seclusion is utilised. In the event that seclusion is used, a multidisciplinary team review and discussion will occur within one hour. If the multidisciplinary team cannot convene within one hour, the review will take place between nursing and medical staff. It is expected that there will be nursing and/or medical input to this review from the Children and Young People's service.

All staff to follow the arrangements laid out in – MH02 Protocol for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit.

19. Post Incident Review and Analysis

Once the person has been secluded, the nurse in charge will ensure that a post incident review takes place with any other person or staff affected by the incident.

The post-incident review must address:

- What happened during the incident
- Any trigger factors
- Each person's role in the incident
- How they felt during the incident

- How they feel at the time of the review, How they may feel in the near future
- What can be done to address their concerns (NICE guidance 2005) Patient Outcomes
- The person who was secluded will be provided with a post incident review as described above where practicable and appropriate with account being taken of their individual needs and capacity to retain the information. This is likely to be when seclusion has ended. However, the interactions with the person both whilst they are in seclusion and when seclusion is ending will start to address these issues.

19.1. Service User Support

The patient will be offered contact with advocacy services following all incidents of seclusion.

19.2. Service Analysis by MDT Modern Matron

The MDT in collaboration with the Modern Matron will review, develop and contribute to the analysis of the incident from a service perspective.

19.3. Independent Corporate and Practice Analysis

The Mental Health and Learning Disability Clinical Programme Serious Untoward Incident Review Group will consider all incidents of seclusion from the above information and will initiate further independent review in response to individual or aggregated issues as necessary.

The Service Manager will consider collated information in relation to the use of seclusion and produce a report for the Head of Operations on a monthly basis.

In addition, the Service Manager will present the objective service review and analysis findings to the Matron for their area within their triumvirate group on a bi-monthly review. This will be used to identify and take action in relation to any practice issues, particularly from a Board nursing perspective.

20. Areas to be Included in Seclusion Plan

Where seclusion has been initiated, staff will complete a seclusion plan which will provide details such as:

20.1. Basic Patient Information

This must include name, date of birth, hospital identification number, ward, name of the responsible clinician and Internal Care Co-ordinator

20.2. Information about Seclusion Episode

This must include date and time seclusion commenced and reasons for same It must also make reference to the alternative interventions and strategies taken to prevent seclusion. It must also note any crisis plans in place.

20.3. Assessment of Risk

This must provide details of the perceived risk that gave rise to seclusion and of the continued risks that give rise to the need for its continuation

20.4. Management of Risk

This must specify how identified risks must be managed. It must note access to potential weapons, levels of observation, patterns of association, type of clothing to be worn, bedding to be used, use of toilet/showering facilities, access to reading materials, type of cutlery, number of staff needed to enter the room (min 3) etc.

20.5. Activity

This must identify and prescribe the activities that must be made available to the patient whilst in seclusion and association. This must include such things as access to reading materials, entertainment facilities, rehabilitation input, spiritual and psychological support, access to physical exercise and fresh air, and visits. It must specify the conditions under which these are to be facilitated.

20.6. Working towards Ending Seclusion

This must include the details of interventions and changes needed for seclusion to end (e.g. length of time for a settled mental state, symptom changes, cessation of threats etc). It must also include what pro-active strategies/approaches are to be used to assist this process, and a risk assessment for post seclusion management.

20.7. Basic Patient Wellbeing.

This section must include information about the patient's physical health and needs and any monitoring or interventions required to maintain optimum physical wellbeing throughout the seclusion episode. This section must make specific reference to dietary requirements and food/fluid monitoring, observations or clinical interventions if emergency parenteral medication given, and any reviews of medication required. It must note any specific communication needs and make reference to the patient's view of the seclusion episode.

21. Guidelines for Clinical Reviews during Seclusion.

The purposes of clinical reviews are to:

- Take a fresh look at the situation and to assist in the decision as to whether seclusion must continue or end;

- To make sure that the patient's physical well being has been appropriately looked after;

- To assist in the formulation of a continued management plan or

- To assist in the formulation of a plan for post-seclusion management (e.g. levels of observation) if seclusion is to end. It is good practice to ensure that there is a record of detailed consultation with the nursing staff, who will know what the patient's current needs are. The doctor must make a note of the time they were called, the time they arrived on the ward, any reasons for delay if applicable and record any advice from the approved clinician or nominated deputy (who must be contacted).

The clinical review must encompass:

- Behaviour prior to seclusion, the nature of risks and indicators; aggression and/or threats of physical violence. Potential predictors of physical violence (as shown by past behaviours). Possession of implements without plausible explanation.

- Present behaviour; expression of remorse/apology and general level of cooperation. Explanation given regarding action plans prior to seclusion.

- General physical status; sleep, diet, fluid, BP/pulse and any evidence of trauma that needs escalating. Document when the last medication was given and whether further medication will be required.

- Decision and instructions; a decision will be made as to whether seclusion should continue. This will be recorded in the clinical notes. In the event of seclusion continuing the time of the next review will be indicated.

- Other relevant information.

22. Longer Term Seclusion/ Segregation

There may be a small number of patients who exhibit behaviours that challenge that are most sustained and therefore not amenable to short term seclusion. These patients may benefit from intensive mental health care delivered in a discrete clinical area that minimises their contact with the general ward population.

This group of patients may present a constant risk to others and may not respond to a short period of seclusion in order to safely manage their violence and aggression. The clinical team may judge in these cases that if the patient were to mix freely in the general ward environment other patients or staff would continuously be open to the potential of serious injury or harm (Code of Practice)

Patients subject to longer-term seclusion will have the following reviews:

22.1 Nursing Reviews:

The patient will be seen by the nurse in charge of the ward every 4 hours. The aim of this is to ensure that the patient's health and wellbeing are evaluated and that the current presentation and mental state are assessed to ensure their needs are being met.

22.2 Medical Reviews

A minimum of daily medical reviews must be undertaken every day, unless the clinical presentation of the patient indicates more frequently. The frequency of reviews must be documented in the management plan.

22.3 Care Team Reviews

There must be a daily multi-disciplinary review by the patient's care team. (to include the Responsible Clinician or deputy and Clinical Nurse Specialist, V&A). The care team must see the patient prior to this review.

22.4 Objective Reviews

These must be weekly objective reviews undertaken by the V&A leads. This review will involve seeing the patient to record their views, review the care plan and documentation, and discuss with the care team and provide feedback.

Detail of the review must be recorded in the patient's clinical notes alongside the rationale for continuing longer-term segregation; the review should highlight progress and any relevant care issues.

The review is not a decision making process in that whilst it may offer advice on future management to the care team, it must not unilaterally make a decision regarding the continuation or termination of the seclusion episode. The review must include:

22.5 A review of the documentation

This must include whether the following information is present and completed:

- Seclusion care plan
- Nursing observation sheets
- Nursing and medical reviews
- Note any missing or inaccurate documentation

22.6 A review of seclusion episode

This must include a review of:

- The reason for seclusion
- Alternatives attempted prior to commencement of episode
- The activities available during the episode
- The seclusion care plan to ensure it is comprehensive
- The process by which seclusion will be terminated

22.7 Interview with the Patient

This must include review of patient recollection of reasons for seclusion, concerns or complaints, and assessment of behaviour and mental state

22.8 Interview with Staff

This must include discussion about risk assessment and management issues, reasons for seclusion continuing and issues of concern that may be preventing or delaying termination of the episode.

23. Training

The importance of training cannot be over-emphasised. As well as satisfying legal obligations, training ensures that employees are equipped with the skills necessary to fulfil their duties in a confident and safe manner within a legal and ethical framework.

The BCUHB is committed to providing its employees with an ongoing training programme within this field and is a participant of the '**All Wales NHS Violence and Aggression Training Passport and Information Scheme**' which sets an approved national standard against which NHS employers in

Wales can be judged. Moreover, it signifies the Health Board's willingness to educate and train its staff to a consistent standard. Whilst the Passport Scheme sets out minimum expected standards, the Health Board endeavours to exceed these standards to ensure that staff receive the best possible support in the course of their duties.

The level and frequency in which staff are trained in the use of seclusion will be determined by their area of work and risk assessment. Managers will be responsible for ensuring that staff (including Bank Staff) receive training, which appropriately reduces risk and enhances service provision during the execution of their duties.

Appendix 1 – Seclusion Nursing Care Plan

All Seclusion documentation will be copied, one for the patient notes and one for the Seclusion folder which is on the ward. A copy of the Policy must be included in the patent notes.

SECLUSION NURSING CARE PLAN (example) **Patients will require individual care plans that reflect their needs. This is an example of what may be considered.**
Named Nurse:
Date: Terminated ……hrs

Nursing staff will request that …… either sits or lies on the bed prior to them entering the room.

Nursing staff will maintain a regular programme of visual and verbal communication with …… In order to reduce sensory deprivation.

1. ……'s dignity will be maintained at all times.

EXIT PLAN-
Establish how the patient is presenting by establishing the following:
A minimum of two staff will enter the room and make an assessment of ……'s mental state and level of dangerousness using the following criteria:

a. Likelihood of further serious attack / assault without obvious trigger. b. Likelihood of further serious attack / assault with obvious trigger.
c. Presence of non-verbal indicators of further intent to harm others. d. Presence of verbal indicators of further intent to harm others.
e. Presence of delusional ideation appertaining to intent to harm others.
f. Presence of high levels of over arousal, elations, irritability, disinhibition, anger. A period of

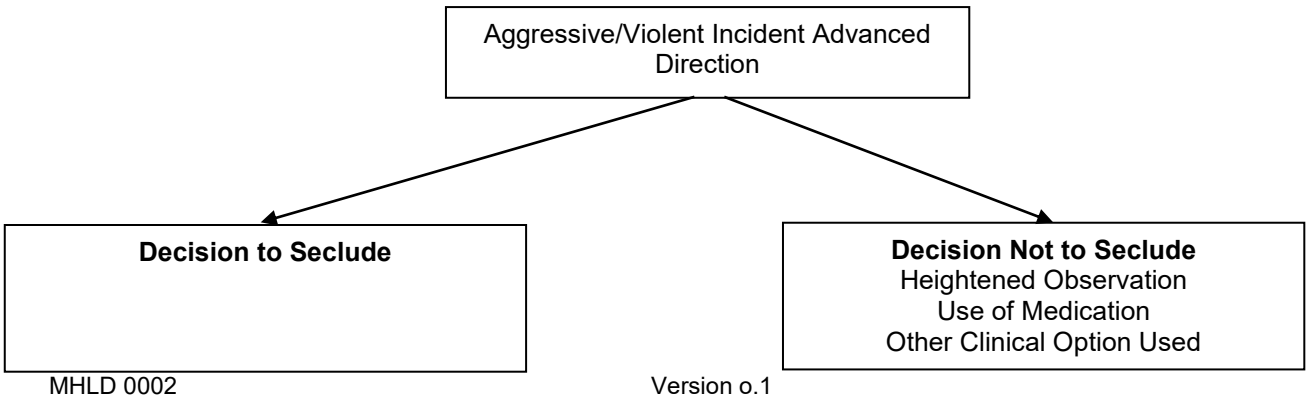
compliance relating to any requests made to ……

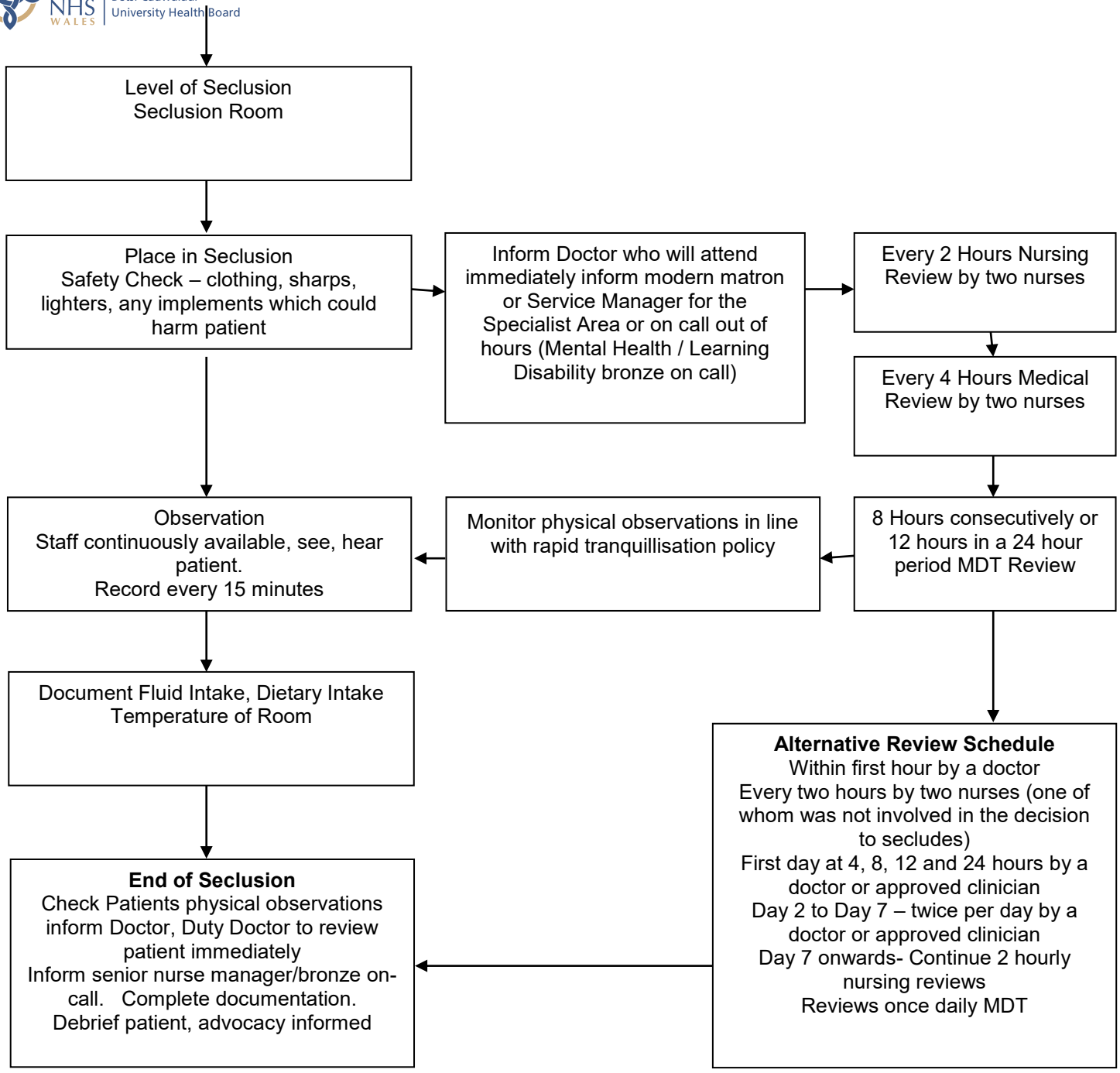
If …….. has reached the optimum level of compliance then Seclusion can be terminated.

SIGNED: …… DAY STAFF

SIGNED: …… NIGHT STAFF

Appendix 2 - Process following decision to seclude





Appendix 3 - Record of Seclusion

Patient details (Use capitals):

Name:…… Status:……..

D.O.A.……Ethnic Origin……Ward:……

REASON FOR SECLUSION:

Datix incident form number:

Authority for Seclusion

	Signature
Nurse in Charge: Print Name	
Doctor Attending Print Name	
Patient's RC: Print Name	

Period of Seclusion

Date and Time STARTED use 24 hour clock	
Date and Time STOPPED use 24 hour clock	

Seclusion Record:

	Yes/ No	Signature
Senior Nurse checked papers		
Report in notes by nursing		
Report in notes by medical		
Report in Seclusion Register		

Appendix 3 - Record of Seclusion - Observation and Review Documentation

Patient's name:……..

Date and Time Seclusion commenced……

2 hours after seclusion commenced:
Nursing Review
(Time……) (to be documented in patient's nursing notes)

Three nurses
(including one registered nurse to sign and print their names below:

1……

2……

3……

Outcome:

4 hours after seclusion commenced:
Nursing and medical review
(Time……) (to be documented in patient's nursing notes)

Doctor and Nurse in charge to sign and print their names below

Doctor……..

Nurse in Charge……...

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's Name……..

Date and Time seclusion commenced…….

6 hours after seclusion commenced Nursing Review
(Time……) (to be documented in patient's nursing notes)

Three nurses (including one registered nurse to sign and print their names below:

1……

2……

3……

Outcome:

8 hours after seclusion commenced (or a total of 12 hours within a 48 hour period)

Team Review
(Time……..) (to be documented in patient's nursing notes)

RC (or deputy), Senior Nurse and Nurse in Charge to sign and print their names below:

Doctor……

Senior Nurse ……..

Nurse in Charge……..

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's name……..

Date and time seclusion commenced……..

10 hours after seclusion commenced:
Nursing review
(Time……..) (to be documented in patient's nursing notes)

Three nurses (including one registered nurse to sign and print their names below:

1……

2……

3……

Outcome:

12 hours after seclusion commenced:

Nursing and medical review
(Time……..) (to be documented in patient's medical and nursing notes)

Doctor and Nurse in Charge to sign and print their names below:

Doctor……

Nurse in charge……..

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's Name……..

Date and Time Seclusion commenced……..

14 hours after seclusion commenced:

Nursing review
(Time……) (to be documented in patient's nursing notes)

Three nurses (including one registered nurse) to sign and print their names below:

1……

2……

3……

Outcome:

16 hours after seclusion commenced
Team Review
(Time……) (to be documented in patient's nursing notes)

RC (or deputy), Senior Nurse and Nurse in Charge to sign and print their names below:

Doctor……

Senior Nurse ……

Nurse in Charge……

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's Name……..

Date and Time seclusion commenced…….

18 hours after seclusion commenced
Nursing Review
(Time……) (to be documented in patient's nursing notes)

Three nurses, including one registered nurse, to sign and print their names below:

1……..

2……..

3……..

Outcome:

20 hours after seclusion commenced:

Nursing and Medical Review

(Time……) (to be documented in patient's nursing notes)

Doctor and Nurse in Charge to sign and print their names below:

Doctor……

Nurse in Charge……

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's Name……..

Date and Time seclusion commenced……

22 hours after seclusion commenced:
Nursing Review
(Time……) (to be documented in patient's nursing notes)

3 nurses, including one registered nurse, to sign and print their names below:

1……..

2…….

3…….

Outcome:

24 hours after seclusion commenced:
Team Review
(Time……..) (to be documented in patient's nursing notes)

RC (or deputy), Senior Nurse and Nurse in Charge to sign and print their Names below:

Doctor…….

Senior ……..

Nurse in Charge…….

Outcome:

Record of Seclusion - Observation and Review Documentation (continued)

Patient's Name…….

Date and Time seclusion commenced…….

……. hours after seclusion commenced: Nursing Review
(Time……..) (to be documented in patient's nursing notes)

3 nurses, including one registered nurse, to sign and print their names below:

1……..

2…….

3…….

Outcome:

…… hours after seclusion commenced:
Team Review
(Time……) (to be documented in patient's nursing notes)

RC (or deputy), Senior Nurse and Nurse in Charge to sign and print their names below:

Doctor…….

Senior ……..

Nurse in Charge…….

Outcome:

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

Appendix 4 - Record of Seclusion Documentation: 15 minute observations

Patient Name…….Date……

Time	Activity	Medical/ Nursing Review	Signature
0700-0715			
0715-0730			
0730-0745			
0745-0800			
0800-0815			
0815-0830			
0830-0845			
0845-0900			
0900-0915			
0915-0930			
0930-0945			
0945-1000			

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name…….Date……			
1000-1015			
1015-1030			
1030-1045			
1045-1100			
1100-1015			
1115-1130			
1130-1145			
1145-1200			
1200-1215			
1215-1230			
1230-1245			
1245-1300			
1300-1315			
1330-1345			

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name……Date……

1345-1400			
1400-1415			
1415-1430			
1430-1445			
1445-1500			
1500-1515			
1515-1530			
1530-1545			
1545-1600			
1600-1615			
1615-1630			
1630-1645			
1645-1700			
1700-1715			

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name……Date……

1715-1730			
1730-1745			
1745-1800			
1800-1815			
1815-1830			
1830-1845			
1845-1900			
1900-1915			
1915-1930			
1930-1945			
1945-2000			
2000-2015			
2015-2030			
2030-2045			

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name…….Date……			
2045-2100			
2100-2115			
2115-2130			
2130-2145			
2145-2200			
2200-2215			
2215-2230			
2230-2245			
2245-2300			
2300-2315			
2315-2330			
2330-2345			
2345-0000			
0000-0015			

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University Health Board

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name…….Date……			
0015-0030			
0030-0045			
0045-0100			
0100-0115			
0115-0130			
0130-0145			
0145-0200			
0200-0215			
0215-0230			
0230-0245			
0245-0300			
0300-0315			
0315-0330			
0330-0345			

Appendix 4
Record of Seclusion Documentation: 15 minute observations

Patient Name…….Date……			
0345-0400			
0400-0415			
0415-0430			
0430-0445			
0445-0500			
0500-0515			
0515-0530			
0530-0545			
0545-0600			
0600-0615			
0615-0630			
0630-0645			
0645-0700			

Name……..Date……

Ensure that all documentation relating to each period of seclusion is kept together until seclusion period has ended.

Members of the Working Group:

Name	Title
Lisa Jones	Modern Matron
Ian Jones	Practice Development Nurse
Gareth Owen	V&A Clinical Lead

Engagement has taken place with:

Name	Title	Date Consulted
MH/LD Divisio		

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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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Betsi Cadwaladr
University Health Board

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Seclusion policy – the process of supervised confinement of a patient in a designated room which is locked.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	It is recognised that the procedure for secluding patients amounts to a form of restrictive practice which will deprive individuals of autonomy. This assessment is being undertaken to ensure that the practice of secluding patients is done so with dignity and respect and that protected characteristics are not impacted upon.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Steve Forsyth MHLD Director of Nursing
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB HS02: Procedures and Guidance Protecting Employees from Violence and Aggression. BCUHB MHLD 0047: Physical Restraint Guidelines. BCUHB Therapeutic Observation Procedure for Inpatients. Former organisational – Rapid Tranquillisation Policy Mental Health Act 1983 – Code of Practice for Wales (Revised 2016). Human Rights Act 1998. Mental Capacity Act 2005 – Code of Practice. Deprivation of Liberty Safeguards – Code of Practice.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Patients. BCUHB Staff.

6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Ensuring that there is an up to date policy in place which reflects current national guidelines. Ensuring that staff are in receipt of training in the use of seclusion. Ensuring that the use of seclusion is closely monitored and reported to appropriate governance structures for review.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005,Healthcare Commission National Audit of Violence 2006-7 Final Report - Older people's services, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Disability	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Gender Reassignment	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Marriage & Civil Partnership	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Pregnancy & Maternity	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Race / Ethnicity	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention

			Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Religion or Belief	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Sex	**Neutral**		NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 201. Equality Act 2010.
Sexual Orientation	**Neutral**		Stonewall Cymru website, NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.
Welsh Language	**Neutral**		WP8: Equality, Diversity & Human Rights Policy
Human Rights			The Human Rights Act 1998,NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	By ensuring that the policy recognises and gives due regard to the impact which secluding and individual and restricting autonomy can have on both minority groups and general populations. The policy ensures that a fair and consistent approach is taken in all situations were seclusion is used. The policy is writted within the framework of wider legislation, for example, The Human Rights Act, NICE Guidelines NG10/11 and the MHA Code of Practice for Wales (Revised 2016)
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	A health board wide policy pertaining to the seclusion of patients in a designated room which is locked.

2. Brief Aims and Objectives: (Copy from Form 1)	Ensuring the safety, dignity and wellbeing of patients and staff during incidents where the use of seclusion is being utilised/considered and to minimise its use in clinical settings. To ensure that national guidance is adhered to and that practice is lawful.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No X
3b. Could any of the protected groups be negatively affected?	Yes	No X
3c. Is your decision or policy of high significance?	Yes X	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No X
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? Assessment indicated that the policy showed due regard to both miority groups and wider populations and had a neutral impact in all the listed protected charecteristics. A full impact assessment is therefore not neccessary.	
5. If you answered 'no'	Yes	X

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details: No issues identified.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X	No
	How is it being monitored?	The policy addresses monitoring requirements. All incidents are reported via DATIX and are reviewed on an individual basis by the V&A Leads. A monthly report is submitted to QSEEL for scrutiny and review.
	Who is responsible?	MHLD Divisional leads
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Monthly reports are submitted to QSEEL for scrutiny by divisional leads.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	05/02/2021

7. Where will your decision or policy be forwarded for approval?	MHLD Divisional Policy Approval Group

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	The document has been circulated for MHLD division consultation.

9. Names of all parties	Name	Title/Role

involved in undertaking this Equality Impact Assessment:		
	Gareth Owen	V&A Clinical Lead
	Ian Jones	Practice Development Nurse
	Lisa Jones	Modern Matron
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	N/A		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Version: 3.04

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

MD01

POLICY ON CONSENT TO EXAMINATION OR TREATMENT
(Based on the All Wales Model Policy)

Date to be reviewed:	March 2021	**No of pages:**	89
Author(s):	All Wales Consent to Treatment Group Manon Gwilym – Clinical Law and Ethics Legal Advisor Dr Ben Thomas - Assistant Medical Director – Law and Ethics		
Responsible Dept / Director:	Office of the Medical Director Medical Director		
Approved by:			
Date approved:			
Date activated (live):			

Documents to be read alongside this policy:

Key Document - Welsh Government – Welsh Health Circular 2017/036: Guide to Consent for Examination or Treatment.

Policies/ Guidance relating to - Mental Capacity Act 2005; MD21 – Guidance – Production of Informed Procedure Specific Consent Forms, Standard Operating Procedure, MORT/0070 – Post mortem examinations, retention and disposal of human tissue obtained during the course of medical treatment or post mortem, MORT/0068 – Consent (post mortem).All Wales DNACPR Policy; Research Standard Operating Procedure - TM01, Governance; Confidentiality; Spiritual Care, PA02 - Consent Guidance - Treatment & Management of Patients Who Refuse Blood / Blood Components (i.e. Jehovah's Witnesses), Human Tissue Act 2004; Human Rights Act 1998, Safeguarding; Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards (DoLS) – Code of Practice, Mental Health Act 1983 – Code of Practice, Human Fertilisation and Embryology Act 1990, Abortion Act 1967, SCH017– Covert Administration of Medicines, MHLD 0047 – Restraint Guidelines, Department of Health, Human Tissue Authority, Code of Practice 3: Post Mortem Examination, National Institute for Health and Clinical Excellence Guidance, Human Transplantation (Wales) Act 2013 and its Code of Practice, HR1 Health Records Management Procedure (Including Retention and Destruction Schedule), IG17 Information Governance Procedure for the Non-Clinical Photography, Video / Audio Recordings of Patients or Staff. ISU02 Policy – Written Information for Patients. GC06 – Protocol to Deliver Interpretation Services, General Medical Council Guidance, Royal College of Surgeons Guidance, UK Blood Transfusion and Tissue Transplantation Services Guidance, Joint United Kingdom (UK) Transfusion and Tissue Transplantation Services Professional Advisory Committee Guidance, Joint Committee on Medical Genetics Guidance; Royal College of Physicians Guidance, BMA Guidance.

Review	**Purpose of Issue/Description of current changes:**
	Policy Review – Implementation of the New All Wales Model Policy for consent and Examination or Treatment

Date EqIA completed:	May 2010				
First operational:	October 2010				
Previously reviewed:	June 2014	February 2016			
Changes made yes/no:	Yes	Yes			

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents

Glossary

AC	**Approved clinician (Supplementary guidance only)**
ADRT	**Advance Decision to Refuse Treatment**
BMA	**BMA – British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
Cop	**Court of Protection**
CTO	**Community Treatment Order (Supplementary guidance only)**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxy-ribo Nucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**
HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**

IMHA	**Independent Mental Health Advocate (Supplementary guidance only)**
ICSI	**Intracytoplasmic sperm injection**
IVF	***In vitro* fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	**Montgomery v Lanarkshire NHS Health Board**
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
SCT	**Supervised Community Treatment (Supplementary guidance only)**
SOAD	**Second Opinion Doctor (Supplementary guidance only)**
WHC	**Welsh Health Circular**

Foreword

The Supreme Court ruling in Montgomery v Lanarkshire Health Board [2015] fundamentally changed the legal framework for consent to examination and treatment in the UK, focusing the consent process on the specific needs of the individual patient.

Existing best practice guidance from the General Medical Council (GMC) and other regulatory bodies, already highlighted the importance of individual autonomy and the active involvement of an informed patient in a shared decision-making process. The Montgomery judgement closed the gap between the legal and regulatory frameworks. The practical implications for clinical practice are clear, but so too is the legal framework.

The core part of this Policy provides general guidance on consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England. Guidance is also incorporated for decision-making when patients temporarily or permanently lack capacity. Supplementary guidance is provided for specific scenarios which may be encountered in Obstetrics and Gynaecology or Mental Health settings.

We recognise that this is a lengthy policy document, but wanted to provide a detailed point of reference for healthcare professionals covering different situations they may encounter in their clinical practice. This policy also refers to the recently updated 'Guide to Consent for Examination or Treatment', produced by the Welsh Assembly Government, which provides a detailed overview of the current legal framework.

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
  - the patient must have the mental capacity to make the relevant decision about their treatment or care
  - consent must be given voluntarily
  - he or she must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:

- All reasonable treatment options
- All of the intended benefits and material risks
- Any requirement to take and retain tissue samples, photographs etc
- The presence of any trainees or students
- The use of any experimental techniques
- Any requests for further information or clarification should be met
- Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or
- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or
- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or
- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention
- Seeking consent can be delegated to an appropriately trained colleague
- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional
- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances
- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes
- A signature on a consent form does not prove that valid consent has been obtained
- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick* competent can give consent
- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted
- If a competent child consents to treatment, a parent **cannot** over-ride that consent
- If a competent child refuses necessary treatment, legal advice should be sought
- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)
- If you doubt whether a patient has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:
    - They have an impairment or disturbance that affects the way their mind or brain works; and
    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made
- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:
    - **Understand** the information relevant to the decision
    - **Retain** the information long enough to make a decision
    - **Use or weigh up** the information as part of a decision-making process
    - **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

  A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they would take into account if they were able to do so

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) must be instructed where decisions are needed about serious medical treatment (including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

What about refusal of treatment?

- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)

- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the fetus. If a woman in labour refuses treatment seek urgent legal advice

- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

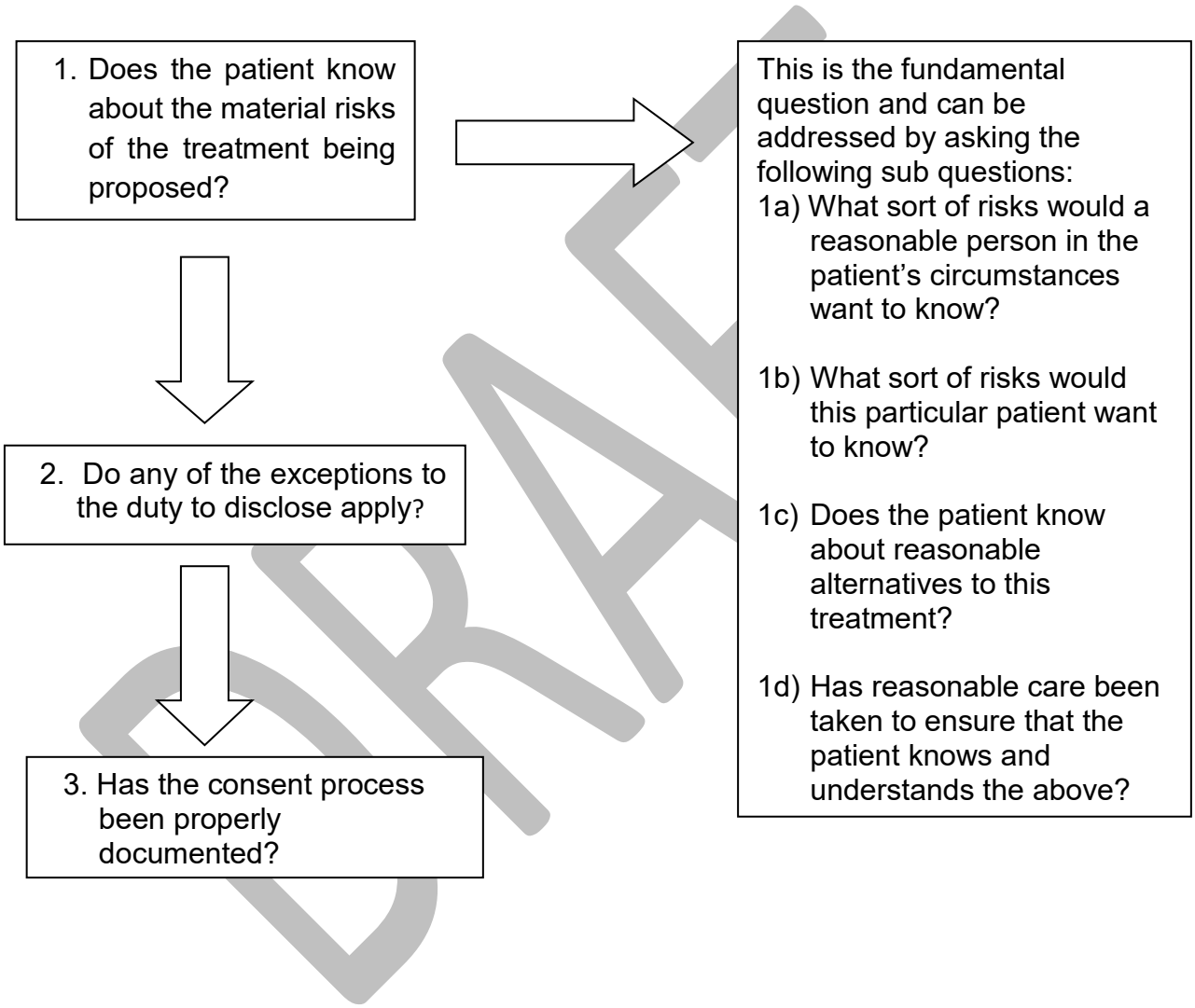
- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**

- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1. This Health Board recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the Health Board and healthcare staff may be liable to legal action if valid consent is not obtained.

2. Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent and can be found on the NHS Wales Governance E-manual at: http://www.wales.nhs.uk/governance-emanual/patient-consent/. The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this Health Board should comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

3. While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

4. A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

What consent is – and isn't

5. Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given his or her **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

6. Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

7. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

8. In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

9. In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA Code of Practice. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

10. When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

11. Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals. Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.

12. When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

13. The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the healthcare professional's clinical knowledge.

14. The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient's best interests in accordance with MCA 2005. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

15. Cultural diversity issues should be actively considered whilst obtaining patient's consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex. Please refer to local organisational policies and guidelines.

16. If there is any doubt or uncertainty in relation to particular consent issues contact the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable and the matter is urgent, please contact the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk.
Out of hours, please contact Bronze on call via switchboard.

2. Documentation

17. Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical notes as necessary) or within an entry in the patient's medical notes. (See chapter 3).

18. Where the signing of a consent form is not required, healthcare professionals must document the consent process followed within an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

19. It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

20. It is rarely a legal requirement to seek written consent[1],but it is good practice to do so if any of the following circumstances apply:

    - the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
    - the procedure involves general/regional anaesthesia or sedation;
    - providing clinical care is not the primary purpose of the procedure;
    - there may be significant consequences for the patient's employment or personal life;
    - the treatment is part of a project or programme of research approved by this Health Board (see chapter 17 of this policy).

21. If you are in doubt about whether a procedure requires written consent, then the safest course of action is to complete an appropriate consent form.

22. It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written, verbal

[1]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

or implied) should be appropriate to the procedure concerned.

23. Abbreviations should never be used on consent forms.

24. Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

25. A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

26. There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or Gillick competent children:
- **Consent Form 2** for parental consent for a child under 16 who is not Gillick competent

27. The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

28. The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4 -** Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

29. Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under a LPA or a CAD is giving consent, then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered to this person.

30. Form 4 requires healthcare professionals to document why the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in his or her best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of

what is in the patient's best interests) the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes

Patient information leaflet

31. Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

32. Consent Forms 1 and 2 and Form 4 can be ordered via the Oracle system.

Procedure/condition specific consent forms

33. Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements set down in the Welsh Language Act.

34. Health Boards must develop clear guidance on the development of procedure specific consent forms which must be approved through appropriate governance arrangements.

3. When should consent be sought?

35. Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

36. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

37. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

38. All clinical staff should have regard to the ruling in the case of Montgomery v Lanarkshire Health Board[2] given on 11th March 2015.

39. Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

40. This standard of consent is similar to that required in GMC Guidance – Good Medical Practice 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[3].

41. Healthcare professionals must be satisfied that:

- The patient knows and understands all the material risks of the proposed treatment;
- The patient is aware of all reasonable alternatives;

[2] https://www.supremecourt.uk/decided-cases/docs/uksc_2013_0136_judgment.pdf
[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

- He/she has taken reasonable care to ensure that the patient understands all of the relevant information
- Valid exceptions to the duty to disclose apply.

42. The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that he or she prefers not to know the risks;
- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing
- Consent is not required as the patient lacks capacity and urgent treatment is required.

43. The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the Montgomery case and is also available online[4].

Single stage process

44. In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

45. If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

Two or more stage process

46. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead[5]. A careful record of the information provided and the related

[4] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

[5] https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/

discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

47. Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process (either in Welsh or English). They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure;
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period;
- the patient's responsible clinician has changed since the form was signed.

48. Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

49. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example, beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

50. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

51. The patient's consent may be obtained by post, as this gives the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure, at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time

to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on his or her behalf (unless provided for in accordance with the MCA – see chapter 8 of this policy) and under parental responsibility: if the competent child or young person wishes the parent to take the decision for them).

52. Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean section even if they have received sedation – see paragraph 274 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient's care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient's medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient's medical notes it is found that the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient's medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interest decisions.

Seeking consent for anaesthesia

53. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

54. Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

55. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it

may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

56. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give his or her consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

57. A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

58. The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

59. If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

60. Issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act are discussed in chapter 18 of this policy.

4. Provision of Information

61. The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example blood transfusion or the removal of particular tissue.

62. Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

63. To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 53 above) as well as information about the procedure itself.

64. The information provided should be tailored to the individual patient.

65. The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context, the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If an EiDO information leaflet has been used, its name, number and date can be documented. All staff producing patient information leaflets are required to develop information in line with ISU02 – Guidance – Written Information for Patients.

66. Patient information in different formats and languages must be made available.

Communication Issues

67. A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

68. Where appropriate those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient. Healthcare professionals are encouraged by this Health Board to follow:

- the Triangle of Care Best Practice Guidelines: https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england_0.pdf

- the Mental Capacity Act 2005 – Code of Practice https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

- the National Institute for Health and Care Excellence Guidance – Decision – Making and Mental Capacity https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

Provision for Welsh speaking patients

69. The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by placing Welsh Language Standards on organisations - Welsh_Language_Standards_Document.pdf. The duties deriving from the standards mean that the Health Board and its staff should not treat the Welsh language less favourably than the English language. In line with the Welsh Language Standards, the language preference of the patient must be offered, established, recorded, acted upon and relayed to others within the Health Board. Welsh speaking healthcare professionals should ideally obtain consent from patients whose preferred language is Welsh. If the relevant healthcare professional is not Welsh speaking, consent should be obtained with the support of Welsh speaking colleagues or simultaneous translation.

- GC06 – Protocol to Deliver Interpretation Services should be utilised to access interpreting / translation services.

70. The All Wales consent forms provided with this policy (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients;
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient; and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met.

Provision for patients whose first language is not English or Welsh

71. This Health Board is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's preferred language, an interpreter should always be used when seeking consent from the patient. It is not appropriate to use children or family members to interpret for patients who do not speak English.

- GC06 – Protocol to Deliver Interpretation Services should be utilised to access interpreting / translation services.

Access to more detailed or specialist information

72. Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets.

Access to healthcare professionals between formal appointments

73. After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information. Patients should be provided with appropriate contact details at the time of their appointment.

74. The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

75. Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

76. Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent?

77. The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. He or she will be held responsible in law if the validity of consent is subsequently challenged.

78. Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

79. Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

80. It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

81. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, discuss with a senior manager.

82. The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations where they have undertaken formal training and their competency has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Completing consent forms

83. The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

84. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to

confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

85. Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

86. In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

87. A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

88. Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

89. It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

90. On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with Capacity – Refusal of treatment

Right to refuse treatment

91. An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the *Mental Health Act 198*3 (see chapter 13 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

92. An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However, in cases of doubt, healthcare professionals should always seek legal advice.

93. If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

94. Where a patient has refused a particular intervention, the healthcare professional must ensure that he or she continues to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

95. If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on request be prepared to transfer the patient's care to that healthcare professional.

96. Whilst a patient has the right to refuse treatment this does not mean that they have the right to require a particular course of treatment.

Self harm and attempted suicide

97. Cases of self harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity

should be made as a matter of urgency.

98. If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then he or she should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

99. Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage him or her to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

100. The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

101. It is important to remember that not all Jehovah's witnesses refuse blood products. Most practising Jehovah's Witnesses who do will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

102. Further information can be found at the following:

- Royal College of Surgeons (2016) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion.

- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*.

- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*.

- UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*.

- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

103. Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the Health Board

- The local Hospital Liaison Committee for Jehovah's Witnesses.

7. Treatment of children and young people

104. When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

105. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

106. Careful consideration should be given to whether the child is competent to give his or her consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (Gillick competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

107. Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

108. It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is Gillick competent.

Children who are not competent to consent to treatment

109. If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

110. Healthcare professionals need to make reasonable enquiries as to who holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

111. Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989 (which applies to both children and young people) sets out the persons who may have responsibility for a child.

Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when he/she is married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order
    - by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
    - by obtaining a residence order
    - by marrying the mother and agreeing with her that he will assume parental responsibility
    - marrying the mother and upon his application to the court
    - by adopting the child
- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother
- a local authority in whose favour a care order has been made[6]
- a person who has been granted an emergency protection order
- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002
- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990
- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002
- the court in wardship procedures

[6]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

- some same-sex partners in certain situations

112. If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

113. Consent is usually only needed from one person holding parental responsibility. However, there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes
- non-therapeutic male circumcision
- hotly contested issues of immunization.

114. Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

115. When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

116. It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility in not available, consent with directions, must be obtained from the Family Division of the High Court.

117. A healthcare professional should not rely on the consent of a parent if he or she has any doubts about whether the parent is acting in the best interests of the child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

118. For forensic examinations different rules may apply.

Young people (age 16 to 17 years) without capacity to consent to treatment

119. Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

120. Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide If there is any doubt about how to proceed it is recommended that advice be sought from the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable and the matter is urgent, please contact the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard. if there is any doubt about how to proceed

121. Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as "Gillick" competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent. In such circumstances legal advice should be sought. See Appendix C.

122. Where a child has refused treatment, and a decision is made to give treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

123. Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

124. If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

Young people aged 16 and 17 who refuse life-sustaining treatment

125. Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C.

126. The management of a young person in an emergency situation, who is likely to die

or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

127. The courts have often commented that such a situation does not detract from the loving and responsible reputation of the parents involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

128. When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

129. Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

130. A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

131. In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the MCA. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

132. When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

133. The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

134. In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of his or her behavior. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment should be carried out and the healthcare professional must be able to justify their conclusions.

135. It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

136. Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

137. A patient lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent.

138. The MCA provides that a patient with an "impairment or disturbance" is unable to make a decision if they are unable to do one or more of the following:

a) understand the information relevant to the decision; or

b) retain that information; or

c) use or weigh that information as part of the process of making the decision; or

d) communicate his or her decision, whether by talking, using sign language or any other means.

139. If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

140. The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

141. Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

142. Where there is any doubt about a patient's capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the Mental Capacity Act 2005 and the assessment must be recorded e.g. using Form 4.

143. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

144. In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

145. Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

146. A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

147. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

148. An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

149. An ADRT is **not** valid if the individual:

a) was under 18 years of age when it was drawn up; or

b) did not have capacity when the decision was made; or

c) was acting under duress; or

d) has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or

e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or

f) creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

150. Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRT made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may be a medical advancement which the patient was unaware of at the time he or she made the advance decision, which could significantly improve their condition.

151. There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes

152. If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

153. An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

154. An ADRT cannot authorise anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

155. It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

156. If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

157. If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

158. A healthcare professional will not be acting unlawfully if he or she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly, they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved to be invalid/ not applicable.

159. If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

160. If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

161. An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

162. Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or her professional judgement acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in his or her best interests.

163. Further information about ADRT is available in chapter 9 of the MCA Code of Practice.

Decisions made in the patient's best interests

164. In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if he or she had capacity, rather than what that professional believes to be in his or her best interests. The healthcare professional must make all reasonable efforts to ascertain:

- the patient's past and present wishes and feelings,
- any beliefs and values that would be likely to influence the patient's decision, and
- any other factors that the patient would be likely to consider if they were making the decision.

165. Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable him or her to do so.

166. A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

167. They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted a LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient.

168. The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

169. If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

170. If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgement that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, he or she is not bound to do so.

Temporary incapacity

171. Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

172. It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 144 to 160). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

173. LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints a person to act as an attorney to make decisions about a person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a

Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see the sealed (OPG stamp) LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However, if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

174. If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA Code of Practice.

175. When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

176. Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

177. As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can he or she direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

178. Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those

instructions. However, a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the interests of the patient, he or she should refer the matter to the Public Guardian.

179. A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

180. If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with the Health Board in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example a care home or a long stay hospital and under the Deprivation of Liberty Safeguards.)

181. The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However, the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see his or her relevant health records.

182. Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

183. Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks
- where there is a choice of treatments, a decision as to which one to use is finely balanced or
- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

184. Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

185. The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision
- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed.

186. Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)
- cases involving organ or bone marrow donation by a patient who lacks capacity to consent;
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)
- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient.

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought

187. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests

decision and that the clinical decision to withdraw CANH is reasonable in the circumstances, given the diagnosis, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to this Health Board. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed clinical record (covering many specified matters) and also full note of all discussions, meetings and reasons for decisions reached. Legal advice can be sought to support the decision.

188. The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral, although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

189. Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.
http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

190. Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

191. The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

192. The Human Tissue Act Codes of Practice and Standards issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. The Codes and Standards can be found on the following link. https://www.hta.gov.uk/hta-codes-practice-and-standards-0

193. The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

194. The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

195. However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken from a patient in their lifetime continues to be treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent. It is too detailed to quote fully here and it should be consulted where relevant decisions need to be made.

196. Consent is required to store and use tissue removed from the living for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation.

197. The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

198. In the Health Board written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project. Please refer to the Health Board's Standard Operating Procedure – MORT/0070 – Post mortem examinations, retention and disposal of human tissue obtained during the course of medical treatment or post mortem.

Consent to post mortem examinations

199. Please refer to the following Pathology Standard Operating Procedures:

- MORT/0070 – Post mortem examinations, retention and disposal of human tissue obtained during the course of medical treatment or post mortem
- MORT/0068 – Consent (post mortem)

200. If a post mortem examination is ordered by the coroner, the consent of relatives is not required.

201. Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient died. In some circumstances it may be appropriate to limit the examination to a particular region of the body.

202. All post mortems are carried out under an HTA licence held by the Health Board. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying relationship" (see also above). The request for a hospital post-mortem should be made by the Clinician who, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

203. For further information on post mortems the *Human Tissue Authority Code of*

Practice – Post Mortem Examination (Code 3, 2009) should be consulted. For further information on retention of tissues, organs and body fluids, please seek advice from the pathologist.

Transplantation - Living Donation

204. The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - Deceased organ donation

205. Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - https://www.hta.gov.uk/sites/default/files/HTA_CoP_on_Human_Transplantation_(Wales)_Act_2013_-_Final_-_May_2014.pdf. This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

206. Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

207. This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

208. Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes.
- For use in teaching, training or assessment of fellow healthcare professionals and students or other appropriate groups e.g. at a conference.
- For use in clinical research.
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet.
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury - see IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.

209. Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is this Health Board policy that written consent must always be obtained prior to making a visual or audio recording of a patient or their art work for any of the purposes described in paragraph 208 (for exceptions see paragraph 215 below).

210. Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 224).

211. If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

212. When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure.
- give patients adequate information about the purpose of the recording when seeking their permission.
- make recordings only when you have appropriate consent or other valid authority for doing so.
- ensure that patients are under no pressure to give their permission for the recording to be made.
- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.
- do not participate in any recording made against a patient's wishes.
- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible or they will be identifiable in any other way in the recording.
- ensure that the recording does not compromise patients' privacy and dignity.
- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.
- make appropriate secure arrangements for storage of recordings.

213. Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:
    - understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Health Board.
    - understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain.

- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.

- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should be written in language that is easily understood. If necessary, translations should be provided.

- have signed a consent form.

- have completed a consent form which is broken down into granular statements for the various purposes, clearly indicating which statements they consent to and which ones they don't.

214. After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording.

- recordings are used only for the purpose for which patients have given consent.

- patients are given the chance, if they wish, to see the recording in the form in which it will be shown.

- recordings are given the same level of protection as with patient's medical notes against improper disclosure.

- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

215. Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks or text (writing in the margins of an x-ray or patient labels, for example):

- Images taken from pathology slides

- X-rays

- Laparoscopic or endoscopic images

- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be accompanied by verbal or written information which may enable inadvertent identification of the patient)

- Recordings of organ functions

- Ultrasound images

Children and young people

216. Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law to be competent and can give permission to recordings themselves, unless they lack capacity.

217. In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However, these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

218. In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

219. If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record should not be used as evidence, unless, at a later date, the patient changes their mind or legal advice is received to the contrary for reasons such as receipt of a police request or court order. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Foetal loss, stillbirth and neonatal death

220. Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

221. If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

222. When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

223. As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

224. The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - Recordings made as part of clinical care, or as potential evidence

225. If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - Recordings made for education and publication

226. If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

227. Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

228. Patients have the right to withdraw consent for the use of their audio or visual records at any time, although they should be made aware that where another legal basis applies, for example compliance with other legislation, their lack of consent may potentially be overridden. The withdrawal should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

229. The above information is drawn from the GMC guidance: Making and using visual and audio recordings of patients (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

- HR1 – Health Records Management Procedure (Including Retention and Destruction Schedule
- IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.

Telemedicine

231. Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

    - it is not the same as seeing a healthcare professional in a face-to-face meeting
    - the information/diagnosis received may be compromised by the technology
    - they have a right to decline review via telemedicine

    Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to Specific procedures

Consent to screening

232. Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening;
- the likelihood of positive/negative findings and possibility of false positive/negative results;
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process;
- any significant medical, social or financial implications of screening for the particular condition or predisposition;
- follow up plans, including availability of counselling and support services.

233. If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to Cosmetic Treatments (surgical and non-surgical)

234. From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: http://www.gmc-uk.org/static/documents/content/Guidance_for_doctors_who_offer_cosmetic_interventions_080416.pdf

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

235. Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

236. When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test.

237. If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

238. It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: http://www.bsgm.org.uk/media/39563/consent_and_confidentiality_2011_1_.pdf.

13. Withholding or withdrawing life – sustaining treatment

General

239. The GMC guidance Treatment and care towards the end of life: good practice in decision making (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

240. A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient or those with an interest in the welfare of the patient, where that patient lacks mental capacity to be involved in the decision.

241. Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

242. Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See reference in paragraphs 164 - 171 above.

243. There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

244. Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any relevant change in a patient's circumstances.

Prolonged disorder of consciousness

245. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see

paragraphs 186 and 187 above.

246. Additional information is available from:

- Royal College of Physicians – Prolonged disorders of consciousness: national clinical guidelines - 2015
- BMA (2007) Withholding and withdrawing life-prolonging medical treatment: guidance for decision making, 3rd edition.
- GMC (2010) Treatment and care towards the end of life: good practice in decision making.
- An Interim Guidance document produced in December 2017 by the GMC, BMA and RCP entitled “Decisions to withdraw clinically-assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden-onset profound brain injury”.

14. Medical treatment of patients with a mental disorder

Basic principles

247. This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder.

248. The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

249. Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24and 25 for further information about consent and the Mental Health Act 1983.

250. Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

251. The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable him/her to understand:

- the nature, purpose, likely and intended effects of the treatment,
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment.

252. A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

253. Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

254. Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

a. patients detained under the Mental Health Act 1983,

b. informal patients who possess capacity to consent to treatment, and

c. informal patients who lack capacity to consent to treatment.

a. Patients detained under the Mental Health Act 1983

255. Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

256. Medical treatment for mental disorder (except treatments under s57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss4 (4) (a), 5(2), 5(4), 35, 135, 136, 37(4)), and
- the proposed medical treatment falls within the provisions of
  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment),
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA.

b. Informal patients who possess capacity to consent to treatment

257. Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

c. Informal patients who lack the capacity to consent to treatment

258. An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment, then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

259. Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in his or her best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm.

260. If a patient who lacks capacity to consent to treatment appears to be objecting to treatment, then consideration should be given to detaining the patient under the MHA.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

261. Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

262. The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

263. Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the treatment of the mental disorder' for example:

- Nasogastric feeding a patient with anorexia nervosa (*Re KB (Adult)* (1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

264. The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming herself or those which alleviate the symptoms of the disorder (B v Croydon HA [1995])

265. If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

266. Any research undertaken within the Health Board must be registered with the Health Board Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced. Please adhere to the Health Board's Health Research Standard Operating Procedure - TM01 which addresses participant information sheets and informed consent. The latest version is available on the BetsiResearch website which is an internal and external website.

267. Consent to clinical trials is covered by the 'Medicines for Human Use Regulations (2004)

268. The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

269. Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

270. There are strict rules within the MCA concerning the involvement of people who lack capacity in research. (See MCA Code of Practice and Welsh Government's Guide to Consent for Examination and Treatment). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. Please adhere to the Health Board's Health Research Standard Operating Procedure - TM01.

271. Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where treatment may benefit the patient.

Consent to research and innovative treatment in children

272. The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best interests.

273. Health Board staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether or not the proposed research will take place in an emergency setting.

Supplementary Guidance

16. Consent in obstetrics and gynaecology

Pregnant women

274. A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to herself and/or her fetus(es). Any treatment involving the fetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean section (including refusal)

275. If a caesarean section is required, the standard Consent Form 1 must be used. Women in labour can consent to a caesarean section even if they have received sedation.

276. It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean section will be offered. A pregnant woman with capacity may refuse a caesarean section, even if "the consequence may be the death or serious handicap of the child she bears, or her own death" (Court of Appeal Re MB). In other words, a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the fetus any legal rights, therefore a caesarean section cannot be authorised by a Court against a competent woman's will and action cannot be taken in the best interests of the pregnant woman or the fetus. In this situation all advice given to the woman should be recorded in her notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that she understands the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of her refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean section to be the most appropriate course and that the patient has refused consent for a caesarean section.

277. If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

278. There have been a number of cases where doubts have arisen, for various reasons, as to a woman's capacity to make a valid decision about a caesarean section. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

279. Where there is any doubt about a woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or her unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean section (or any other intervention) and it has been demonstrated (in line with the Mental Capacity Act) that she lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out. Healthcare professionals should seek advice from the Clinical Law and Ethics Advisors via:BCU.Consent@wales.nhs.uk. If they are unavailable, please contact the DoLS Team on BCU.DoLSAdmin@wales.nhs.uk or BCU.DoLSAdmin@wales.nhs.uk. If they are unavailable and the matter is urgent, the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard. In the case of Re S, the Court of Appeal laid down general principles that should be applied in future cases. If the mother lacks capacity, avoiding the fetus' death may be seen by the Court as being in the best interest of the mother.

280. Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean section may be carried out if it is in her best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant women is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

281. Men and women requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

282. Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

283. Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that reversal operations after sterilisation are not available on the NHS. Assisted reproductive techniques e.g. in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are not routinely provided by the NHS following sterilisation.

284. People requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

285. Written consent must be obtained for vasectomy, and the man should be advised

to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and his partner before vasectomy, so they can make informed decision about additional contraceptive methods.

286. Whilst the consent of the partner is not needed before sterilisation, or any other procedure, clinicians may, however, wish to discuss the proposed treatment with the spouse or partner, provided the patient agrees.

287. Non therapeutic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

288. It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

289. Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

290. The HFEA 1990 as amended makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to the storage of the gametes.

291. Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

292. The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. The husband or putative father's authority is not legally required.

293. If a woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage

if the patient changes her mind between the first and second stages of the procedure.

294. If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if she changes her mind before completing the procedure.

295. Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act, 1967) to indicate that he / she is in agreement with the need for the termination. The woman will receive counselling in advance of the procedure and will then be scanned to assess gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

296. Clinicians are advised to seek legal advice (see Appendix C) where:

- a woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of her pregnancy; or
- a woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy
- a partner wishes to over-rule a decision to terminate a pregnancy

Histological examination and disposal of non-viable foetal products

297. Consent should always be obtained with regard to the histological examination and disposal of non-viable fetal products up to the age of 24 weeks' gestation.

17. Treatment in a Mental Health setting

S57 MHA: Treatment requiring capacity, consent and a second opinion

298. Section 57 treatments include surgical operations that destroy brain tissue or destroy the functioning of brain tissue, and the surgical implantation of hormones for the purpose of reducing male sex drive. S57 applies to all patients, whether or not they are subject to the MHA.

299. Treatment under s57 can only be given if all three of the following requirements are met:

- the patient consents to the treatment,
- a second opinion appointed doctor (SOAD) and two other people appointed by Healthcare Inspectorate Wales (HIW) certify the patient has the capacity to consent to the treatment and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient on form CO1.

S58 MHA: Treatment requiring consent or a second opinion

300. The approved clinician (AC) in charge of treatment must obtain the valid consent of any patient before the administration of medicine by any means after three months, unless such medicine is being administered under s62 (emergency treatment).

301. There can only be one 3 month period for s58 treatment in any continuous period the patient is subject to detention. This includes a patient detained under s2 which is immediately followed by detention under s3 and the patient is then discharged onto s17A (supervised community treatment) followed by the patient being recalled and having the Community Treatment Order (CTO) revoked and again discharged onto s17A.

302. When the patient has given valid consent to take s58 type treatment form CO2 must be completed by the AC in charge of the treatment. All medicines must be designated by their classes (as described in the BNF) rather than individually. Moreover, the doses may be entered as within BNF limits, but specific doses must be included when the BNF limit is being exceeded. Any new addition to the classes of drugs requires a Form CO2 to be completed by the AC in charge of the treatment. A contemporaneous entry must be made in the clinical record to document the discussion between the AC and the patient at which consent was given. A copy of the completed Form CO2 must be attached to the current prescription card.

303. The patient may at any time, subject to s62, withdraw consent before the completion of the treatment (see s60 MHA).

304. Where a detained patient withdraws consent or refuses consent to the proposed treatment with medication under s58 the AC must trigger the safeguards of a second opinion from a SOAD appointed by HIW. The same safeguard of a second opinion will apply to detained patients unable to consent to treatment under s58 of the Act.

305. It is the responsibility of the SOAD to arrange to examine the patient and consult a minimum of two 'statutory consultees' (i.e. one of who is a registered psychiatric nurse and the other who is someone who has been professionally involved in the medical treatment of the patient) prior to making a clinical decision about treatment.

306. The SOAD and the two statutory consultees must record the outcome of their assessment in the patient's clinical notes. The AC in charge of the treatment should inform the patient of the decision of the SOAD.

307. The SOAD, if he concurs with the AC's treatment plan, will complete the appropriate new Form CO3 authorising the proposed treatment plan.

308. In the case of medication, the SOAD's Form CO3 will specify the classes of drug/drugs dosage (mostly within BNF limits) and the route of administration. A copy of the Form CO3 must be attached to the current prescription card and the clinical records with the original to be sent to the MHA Administrator's Office.

S58A: Electroconvulsive Therapy (ECT)

309. Section 58A applies to ECT and medication administered as part of ECT. It applies to all detained patients and to all patients who are under 18 years whether or not they are a detained patient.

310. The written consent of all patients with capacity to consent to receiving ECT must be obtained, whether or not they are subject to s58A. A record of the discussion with the patient and of the steps taken to confirm that the patient has capacity to consent should be made.

311. Patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose, and likely effects.

312. The key differences from s58 are that:

- ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition (s58A(1)(a) and (2) and s62(1)(a) and (1A) MHA),

- no patients under the age of 18 can be given ECT unless a SOAD has certified that the treatment is appropriate, and

- there is no initial 3 month period during which a certificate is not needed.

S58A (3) Detained adult patients with capacity to consent to ECT

313. The AC in charge of treatment or a SOAD can certify on Form CO4 that the patient has attained the age of 18 and is capable of understanding the nature, purpose and likely effects of ECT and has consented to that treatment.

314. The original Form CO4 must be sent to the MHA administrator with a copy kept for the clinical record and one to go with the patient to the ECT department each time the patient is to receive the treatment. The patient may withdraw consent at any time. The certificate would not be valid if the patient subsequently lacks the capacity to make that decision during the course of treatment.

S58A (4) Detained or informal children and young people with capacity to consent to ECT

315. For children and young people ECT may be given if the patient has consented and a SOAD has certified, on Form CO5, in writing:

- that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it; and
- that it is appropriate for the treatment to be given.

S58A (5) and (6) Patients who lack capacity to consent to ECT

316. Patients who lack capacity to consent to treatment may be given ECT if a SOAD has certified in writing:

- that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but
- that it is appropriate for the treatment to be given; and
- that giving the patient the treatment would not conflict with:
- an advance decision which the SOAD is satisfied is valid and applicable, in accordance with s25 of the MCA; or
- a decision made by a donee or deputy or by the Court of Protection.

317. The SOAD must complete form CO6.

318. The SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. One shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner. Furthermore, neither shall be the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question.

S60 Withdrawal of consent

319. Patients treated in accordance with s57, s58 or s58A may withdraw their consent to that treatment at any time. Fresh consent for the implementing of procedures as required by those sections will then be required before further treatment can be carried out or reinstated, except as provided for under the urgent treatment provisions within s62.

320. Where the patient withdraws consent he or she should receive a clear explanation:

- of the likely consequences of not receiving the treatment;
- and in the case of s58 treatments that a second medical opinion under Part 4 of the Act may or will be sought, if applicable, in order to authorise treatment in the continuing absence of the patient's consent; and
- of the power of the approved clinician in charge of the treatment to begin or continue urgent treatment under s62, if applicable.

321. The patient's withdrawal of consent and explanations given to the patient in light of that withdrawal of consent must be clearly documented in the patient's case notes.

S62 Treatment not requiring consent

322. The consent of a patient subject to s56 i.e. most detained patients subject to the exceptions described in para 9(a) is not required for the administration of urgent treatment under s62. The forms of treatment are expected to include only those authorised under s58 and s58A. In urgent situations, such treatments can be administered without a second opinion. Whenever s58 or 58A type treatment is administered under s62, a simultaneous request must be made for a second opinion.

323. The same principle applies to a patient who has consented to take medication and then withdraws his consent after the three month period. HIW will be requested to arrange for the visit of a SOAD. Where the treatment is urgent, s62(2) may be used to continue with the treatment plan if the AC in charge of the treatment considers that discontinuance of the treatment or treatment under the plan would cause serious suffering to the patient.

324. There is no statutory prescribed form to record the use of treatment under s62, but a local record form should be completed each time s62 is used to treat a patient.

S63 Treatment not requiring consent

325. Section 63 authorises medical treatment for mental disorder without consent and includes treatments that may alleviate the underlying causes of mental disorder, but not including treatments covered by s57, s58 or s58A, provided the treatment is given by or under the supervision of the AC in charge of treatment.

Advance Decisions to Refuse Treatment

326. A patient with a mental disorder is able to make a valid and applicable ADRT, as long as they have mental capacity at the time the advance decision is made. The fact that a patient was/is detained under the Mental Health Act when the ADRT advance decision was made does not render him/her incapable.

327. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 or 4A of the Mental Health Act 1983 and consent is not required. An ADRT can override the provisions in s57 of the Act, but not those contained in s58, s62 and s63. In respect of ECT (s58A), a valid and applicable ADRT would prevent a SOAD from issuing a certificate but would not necessarily prevent the AC in charge of the treatment from giving urgent ECT treatment as described in s62.

328. Chapter 8 of this document provides more information in relation to advance decisions.

PART 4A Treatment of patients on a Community Treatment Order (CTO) not recalled to hospital

329. The purpose of a community treatment order (CTO) is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm to the patient or others.

330. Only patients who are detained in hospital for treatment under s3 of the MHA or are unrestricted part 3 patients (i.e. s37 without a s41) can be considered for a CTO.

331. Patients not recalled to hospital include patients on a CTO who are in hospital if they have been admitted informally.

CTO Patients (aged over 16 years) with capacity to consent to treatment

332. Compulsory treatment cannot be given to a patient on a CTO who has not been recalled to hospital and who has capacity to consent or refuse treatment and is refusing. There are no exceptions to this rule, even in emergencies.

333. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto a CTO.

334. The Responsible Clinician completes form CO8 for s58 and s58a for patients with capacity to consent to treatment who are consenting to treatment.

335. A new CO8 form will need to be completed if there is a change of responsible clinician.

336. The Part 4A certification requirement does not apply if the treatment is immediately necessary and the patient has capacity to consent to it and does consent to it.

S64D Adult CTO patients lacking capacity to consent to treatment

337. A person is authorised to give medical treatment for mental disorder to a CTO patient who lacks capacity to consent to treatment if the following conditions are met:

- before giving the treatment, the person takes reasonable steps to establish whether the patient lacks capacity to consent to the treatment;
- when giving the treatment, he reasonably believes that the Supervised Community Treatment (SCT) Order patient lacks capacity;
- he has no reason to believe that the patient objects to be given the treatment; or he does have reasons to believe that the patient so objects, but it is not necessary to use force to give the treatment;
- he is the approved clinician in charge of the treatment, or the treatment is given under the direction of that clinician; and
- giving the treatment does not conflict with an advance decision which he is satisfied is valid and applicable, or a decision made by a done or deputy of the CoP.

338. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto supervised community treatment.

339. The Responsible Clinician must request a SOAD, who completes form CO7, if a patient lacks capacity to consent to s58 or s58A treatment.

340. Before giving a Part 4A certificate, the SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. Of those persons s/he shall consult:

- at least one shall be a person who is not a registered medical practitioner; and
- neither shall be the patient's responsible clinician or the person in charge of the treatment in question.

341. The Part 4A certification requirements do not apply if the treatment is given in accordance with s64G (emergency treatment in patients lacking capacity), or the treatment is immediately necessary and a donee or deputy or the Court of Protection consents to the treatment on the patient's behalf.

S64G Emergency treatment for CTO patients lacking capacity or competence

342. A practitioner is authorised to give emergency treatment to a patient who lacks capacity to consent to treatment, and who is subject to a CTO, if the following conditions are met:

- the practitioner reasonably believes that the patient lacks capacity to decide or is not competent to consent to it;
- the treatment is immediately necessary; and
- if it is necessary to use force against the patient in order to give the treatment; the treatment needs to be given to prevent harm to the patient; and the use of such force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.

343. The responsible clinician will fill in the appropriate form.

What does 'immediately necessary' mean?

344. Treatment is immediately necessary if:

- It is immediately necessary to save the patient's life; or
- It is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or
- It is immediately necessary to alleviate suffering by the patient and is not irreversible or hazardous; or
- It is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

345. However, ECT may only be given in an emergency if it is immediately necessary to save the patient's life or to prevent a serious deterioration of the patient's condition.

S64E Child CTO Patients (aged under 16)

346. Medical treatment may be given when there is authority to give it and the certificate requirements are met.

347. Certification is not needed for the first month after discharge onto the CTO or if it is immediately needed and the child is competent to consent to the treatment.

S64F Child CTO patients lacking competence to consent to treatment

348. A person is authorised to give medical treatment for mental disorder to a patient subject to a CTO under the age of 16 years if the following conditions are met:

- the person takes reasonable steps to establish whether the patient lacks competence to consent to the treatment;
- he reasonably believes that the child lacks competence to consent to the treatment;
- he has no reason to believe that the patient objects to being given the treatment, or he does have reason to believe that the patient so objects, but it is not necessary to use force to give the treatment; and
- he is the approved clinician in charge of the treatment; or the treatment is given under the direction of that clinician.

CTO patients recalled to hospital

349. CTO patients who are recalled to hospital are subject to s58 or s58A. Certification for s58 or s58A type of treatment is needed unless:

- less than one month has passed since the patient was discharged onto the CTO;
- the s58 or s58A treatment is already explicitly authorised for administration on recall by the Part 4A certificate; or
- if the AC in charge of the treatment considers that discontinuance will cause the patient serious suffering, he may continue with the treatment pending a fresh certificate.

350. For more detailed information regarding Community Treatment Orders, please refer to chapter 24 of the HA 1983 Code of Practice for Wales, 2016.

18. Training

352. Training on Consent to Treatment is available on ESR.

353. A generic rolling training programme on the principles and practical aspects of consent will be made available to all relevant Health Board staff.

354. All health care professionals joining the Health Board will be made aware of the policy on seeking consent and their responsibilities under the policy, during their induction.

355. Specific consent training will be provided for specific groups as the need arises.

Members of the Working Group:
Manon Gwilym – Clinical Law and Ethics - Legal Advisor
Dr Ben Thomas – Assistant Director – Clinical Law and Ethics
All Wales Consent Group

Consultation has taken place with:

Title	**Date Consulted**
Aimee Jane Danzi - Carers Lead Officer – Service User Experience Team	March 2019
Lisa Parry - Information Governance Manager – Information Governance Team	March 2019
Alaw Griffith - Welsh Language Standards Compliance Officer – Welsh Language Team	March 2019
Lona Tudor Jones - Research Manager – Research and Development Department	March 2019
Bernadette Astbury - Quality And Safety Manager - Pathology	March 2019
Debbie Kumwenda – Investigations Manager – Corporate Concerns Team	March 2019
Wynne Roberts – Chaplain Manager – Chaplains and Spiritual Care	March 2019
Consent and Capacity Strategic Working Group	April 2019
Mr Hemant Maraj - North Wales Clinical Lead for Women's Services and Obstetrician and Gynaecologist	April 2019
Quality and Safety Group	Approved – 11th June 2019

Appendix A - Link to current consent forms in use in this organisation

NHS Wales – Governance e-manual – Patient Consent

http://www.wales.nhs.uk/governance-emanual/patient-consent

Appendix B - Useful contact / link details

- Clinical Law and Ethics advisors:
  BCU.Consent@wales.nhs.uk

- Head of Investigations and Redress via:
  ConcernsTeam.bcu@wales.nhs.uk or
  Tel: 01248 384603

- Mental Capacity Act and DoLS Team
  BCU.DoLSAdmin@wales.nhs.uk or
  Tel: 01352 803297

- GC05 – Procedure for accessing legal advice
  http://howis.wales.nhs.uk/sitesplus/861/opendoc/291224

- Appendix B – Proforma for accessing legal advice
  http://howis.wales.nhs.uk/sitesplus/861/opendoc/434485

- Pathway for reporting Court Orders, HSE Improvement / Prohibition Notices and Judicial Review Notifications
  http://howis.wales.nhs.uk/sitesplus/861/opendoc/481696

Appendix C – How to obtain legal advice

If you need to obtain legal advice or apply for a court ruling in relation to a complex consent issue you should seek advice from the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable, please contact the DoLS Team via: BCU.DoLSAdmin@wales.nhs.uk or BCU.DoLSAdmin@wales.nhs.uk. If they are unavailable and the matter is urgent, the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard

You should ensure that you have all the relevant information about the case to hand so that you can brief legal services / the solicitor appropriately. You should keep a clear record of the legal advice you have been given.

Where a decision is made to apply to a court, the lead clinician should, as soon as possible, inform the patient and his / her representative of the decision and of his or her right to be represented at the hearing. The patient's solicitor should be informed immediately and, if practicable, should have a proper opportunity to take instructions and apply for legal aid where necessary.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent;

b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent;

c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)

d) all other cases where there is dispute about whether a particular treatment will be in a patient's best interests (including cases involving ethical dilemmas in untested areas).

Appendix D - Assessing and documenting Gillick Competence in Under 16s

Assessment of Gillick competence should document the following[7]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[7] BMA - Children and Young People Toolkit

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example if your treatment involves sedation or general anaesthesia. In this case, you will then be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary on things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a "doctor in training" – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. For some procedures you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decisions to refuse treatment

Some people chose to make "advance decisions" refusing certain care or treatment (sometimes referred to as “living wills” or “advance directives”). If you have made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example to record changes to a skin lesson. You will always

be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication, research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don't go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) so that you can make an informed decision

What are the key things to remember?

It's your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

Betsi Cadwaladr University Health Board has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?

- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or style of life, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the ward sister or senior therapist who will be able to assist and, hopefully, resolve matters to your satisfaction.

Where this is not successful, ask for our leaflet “Putting Things Right: Raising a concern about the NHS in Wales”. This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

The Community Health Council can be contacted as follows:

E-mail: complaints@waleschc.org.uk

Telephone:
Anglesey, Conwy and Gwynedd: 01248 679284
Denbighshire, Flintshire and Wrexham: 01978 356178

Data Protection Act (2018) & General Data Protection Regulation (GDPR) or any subsequent legislation having the same effect

Under current Data Protection Legislation, we are bound to protect the privacy of personal data. If you would like further information regarding what we do with your data please refer to the Health Board’s privacy policy. Further details on how you can request access to your information can be found on our internet page: http://www.wales.nhs.uk/sitesplus/861/page/45098

If you require further electronic copies of this publication please access the NHS Wales Governance E-Manual at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

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EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	The revised Policy on Consent to Examination or Treatment – MD01 (Based on the All Wales Model Policy)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The policy provides general guidance and support to clinical staff by describing the legal and practical requirements in relation to consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England, including: -the consent forms -when consent should be sought, including making the patient of all material risks, benefits and alternatives -provision of information -who is responsible for seeking consent -refusal of consent -treatment of children an d young people -patients who lack capacity to consent -use of tissues -consent to photography/video/audio recording -and various condition/subject specific consent issues e.g. medical treatment of the mentally ill / obstetrics & gynaecology issues etc.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	This is an All Wales Consent Policy. Within BCUHB, the Executive Medical Director is responsible for this policy. The policy will be agreed / approved by the Quality, Safety and Patient Experience Group (QSE)
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	This policy relates to the other policies relevant to consent including:

		• Guidance on Mental Capacity Act 2005 including Deprivation of Liberty Safeguards • MD21 – Guidance – Production of Informed Procedure Specific Consent Forms, Post mortem examinations, retention and disposal of human tissue obtained during the course of medical treatment or post mortem. • Mental Health Act Policies • MORT/0070 – Post mortem examinations, retention and disposal of human tissue obtained during the course of medical treatment or post mortem • MORT/0068 – Consent (post mortem) • All Wales DNACPR Policy • Research Standard Operating Procedure - TM01 • PA02 - Consent Guidance - Treatment & Management of Patients Who Refuse Blood / Blood Components (i.e. Jehovah's Witnesses), • SA01 - Safeguarding; Procedure for Safeguarding Adults at Risk • SCH017– Covert Administration of Medicines. • MHLD 0047 – Restraint Guidelines. • HR1 Health Records Management Procedure (Including Retention and Destruction Schedule), • IG17 Information Governance Procedure for the Non-Clinical Photography, Video / Audio Recordings of Patients or Staff. • ISU02 Policy – Written Information for Patients. • GC06 – Protocol to Deliver Interpretation Services
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	All clinical staff involved in taking consent to examination or treatment (implied, verbal or written consent) or with responsibility for checking consent forms before a procedure is undertaken (e.g. ward and theatre staff). This will include all locums, agency staff and staff with honorary contracts in addition to staff directly employed. All patients, their relatives and carers to whom this policy applies.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	This is a revision of an existing policy which is already widely recognised. Health Board wide training is already in place in relation to the contents of the policy. Staff attitudes and understanding of the importance of capacity and consent issues may have an impact – training aims to clarify these issues for staff.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left: - (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	+	H	The policy differentiates between consent to treat children (aged under 16) young people (16 and 17 year olds) and consent to treat adults. An internet search found no evidence to suggest that any elements of the policy would have an adverse effect in relation to the protected characteristic of age. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Disability	+	H	Some disabilities are associated with impaired cognitive functioning and therefore with the possibility of impaired capacity. Patients who lack capacity to consent to the examination or treatment cannot give consent, but must be treated in their best interests. Form 4: Treatment in Best Interests is designed to ensure that the assessment of capacity and determination of best interests are compliant with the law and protective of the patient.. An internet search found no evidence to suggest that any elements of the policy would have an adverse effect in relation to the protected characteristic of disability. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Gender Reassignment	N/A	L	No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Marriage & Civil Partnership	N/A	L	No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Pregnancy & Maternity	+	M	There are particular legal differences / issues that need to be considered in relation to consent of a pregnant woman. These are highlighted within Chapter 16 of the policy to ensure that clinicians are aware.
Race / Ethnicity	+	M	The policy contains a section which addresses provision for patients whose first language is not English. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Religion or Belief	+	H	The policy makes it clear that an adult with capacity may make a decision based on a religious belief or value system. Also, there is a whole section and a specific consent form relating to patients' who refuse blood or blood components (this is usually as a consequence of religious belief e.g.

			Jehovah's Witnesses). EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Sex	N/A	L	No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Sexual Orientation	N/A	L	No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.
Welsh Language	+	H	The policy advises on use of the Welsh Language where appropriate. The All Wales Consent Forms have been designed to be bilingual, thus supporting the taking of consent in the welsh language. The Welsh copy of the forms must NOT be stored in the patients notes in place of the English copy, for patient safety reasons (all those checking the consent forms need to be able to read the content)
Human Rights	+	H	The policy is designed to address the fundamental human right that we have a legal and ethical right to determine what happens to our own bodies. For patients who lack capacity to consent for themselves, the policy is designed to ensure that the ascertainable wishes of patients lacking capacity are represented and considered by decision-makers. The policy complies with the Human Rights Act, particularly with regard to Articles 2, 3, 8, 9 and 11.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity; and
- Foster good relations between different groups

1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The EQIA itself helps to eliminate unlawful discrimination, harassment and victimisation by screening this policy. It promotes the Human Rights Act Articles – 2, 3, 5, 8 and 11. Those responsible for developing and assessing the policy have attended equality impact assessment training.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Provision of translation services and that an adult with capacity may make a decision based on a religious belief or value system.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Not relevant to this policy

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	The revised Policy on Consent to Examination or Treatment – MD01 (Based on the All Wales Model Policy)

2. Brief Aims and Objectives: (Copy from Form 1)	The policy provides general guidance and support to clinical staff by describing the legal and practical requirements in relation to consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England, including: -the consent forms -when consent should be sought, including making the patient of all material risks, benefits and alternatives -provision of information -who is responsible for seeking consent -refusal of consent -treatment of children an d young people -patients who lack capacity to consent -use of tissues -consent to photography/video/audio recording -and various condition/subject specific consent issues e.g. medical treatment of the mentally ill / obstetrics & gynaecology issues etc.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No x
3b. Could any of the protected groups be negatively affected?	Yes	No x
3c. Is your decision or policy of high significance?	Yes x	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	x
	Record Details: The policy is considered of high importance in relation to equality, diversity and human rights. The policy has been assessed as having an overall positive impact on the protected characteristics as the effect of the policy is to help safeguard the rights of patients giving or refusing consent, and will help to ensure they are provided with enough information to support decision making and to ensure that their views are heard and considered. **Review – March 2019** The policy has been revised in relation to legislative changes as summarised below: - - Montgomery vs Lanarkshire Health Board judgment which changes the emphasis regarding the nature of the risks to be discussed with patients. - the changes to the law in Wales re Organ Donation. The policy adopts the format and any additional information and guidance contained in the new All Wales Model Policy for Consent to Examination or Treatment. Impact in light of above changes has been assessed as neutral or positive in that the policy aims remain consistent and related to helping safeguard the rights of patients giving or refusing consent. A search of similar policies elsewhere indicated a similar impact: - http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/EQIA%20CONSENT%20POL%20EQIA%20Ja	

	n%202016.pdf	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes x	No
	How is it being monitored?	Any complaints, claims or incidents received in relation to equality, diversity and human rights following implementation of the policy will be addressed on an individual basis and appropriate action taken.
	Who is responsible?	Manon Gwyn Gwilym – Clinical Law and Ethics Legal Advisor – Office of the Medical Director Consent and Capacity Strategic Working Group
	What information is being used?	Scrutiny of daily datix reports in relation to on the spot complaints and incidents. Relevant on the spot complaints and incidents are compiled into 1 report for scrutiny by the Consent and Capacity Strategic Working Group. Relevant claims are also highlighted to this Group. An annual audit of consent forms is undertaken.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	March 2021

7. Where will your decision or policy be forwarded for approval?	Quality and Safety Group and then to the Quality, Safety and Patient Experience Group

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	This is an All Wales Model Policy. The revised BCUHB Policy on Consent to Examination or Treatment – MD01 which is based on the All Wales Model Policy has been shared with the individuals below and approved by the Consent and Capacity Strategic Group. The minutes of that meeting are shared with the Clinical Law and Ethics Group where both staff and service users are members.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Aimee Jane Danzi - Carers Lead Officer – Service User Experience Team	March 2019
	Lisa Parry - Information Governance Manager – Information Governance Team	March 2019
	Alaw Griffith - Welsh Language Standards Compliance Officer – Welsh Language Team	March 2019
	Lona Tudor Jones - Research Manager – Research and Development Department	March 2019
	Bernadette Astbury - Quality And Safety Manager - Pathology	March 2019
	Debbie Kumwenda – Investigations Manager – Corporate Concerns Team	March 2019
	Wynne Roberts – Chaplain Manager – Chaplains and Spiritual Care	March 2019
	Consent and Capacity Strategic Working Group	April 2019
	Mr Hemant Maraj - North Wales Clinical Lead for Women's Services and Obstetrician and Gynaecologist	April 2019
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	The adoption of the policy will serve to promote the rights of affected individuals.	Executive Medical Director	Continuously

Version: 0.1

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Restricted Items Policy MHLD 0043

Date to be reviewed:	August 2020	**No of pages:**	14 pages
Author(s):	Rebekah Roshan Julie Macdonald Ruth Joyce	**Author(s) title:**	Head of Nursing MHLD SMS Deputy Service Manager SMS Team Manager
Responsible dept / director:	Director of Mental Health & Learning Disability Division		
Approved by:	MHLD Policy Implementation Group – 02.04.2019 MHLD Q-SEEL – 18.04.2019 PAG – 04.06.2019 QSG -		
Date approved:	18th April 2019 – Approved in Draft whilst progressing through Health Board process		
Date activated (live):	19th April 2019		
Date EQIA completed:	All policies must be Equality Impact Assessed – 8th February 2019		
Documents to be read alongside this procedure:	Any documents this should be read with including supporting procedures/written control documents: Searching Patients and their Property Policy – MHLD 0013 Therapeutic Observation and Engagement Policy – MHLD AC002 Mental Health & Learning Disabilities CPG Acute Care Operating Framework – MHLD 0001 Patients Visitors Protocol Ty Llywelyn Medium Secure Unit – MHLD 0005 BCUHB Medicines Code – MM02.1 Restraint Guidelines – MD02 (Due to be replaced with SCH016) Health and Safety Policy – HS01 (Including individual ward/service risk assessments) Control of Substances Hazardous to Health Guidance – HS13 Fire risk from personal rechargeable electronic devices NHS Wales Alert – WG EFA/2018/007 Ingestion of Cleaning Chemicals NHS Wales Alert – WG EFA/2019/002 Procedure and Guidance Protecting Employees from Violence and Aggression – HS02 (V2 April 2018) Mental Health Act 1983 Code of Practice for Wales (Revised 2016) Mental Capacity Act (2005) CQC Brief Guide: the use of 'blanket restrictions' in mental health wards (2017) North Wales Suicide and Self Harm Prevention Strategic Plan (2018) Welsh Assembly Government: 'Talk to Me 2', Suicide and Self Harm Prevention Strategy for Wales 2015 - 2020 (2015)		

Purpose of Issue/Description of current changes:
New Policy to provide guidance to services and staff regarding the safe management of restricted items on Inpatient Mental Health Wards and in community bases across the MHLD Division.

First operational:	Date the policy was first operational				
Previously reviewed:	**Date**	**Date**	**Date**	**Date**	**Date**
Changes made yes/no:	**Yes/no**	**Yes/no**	**Yes/no**	**Yes/no**	**Yes/no**

Table of Contents

1. Introduction

Suicide and self harm are considered serious public health issues, both the Welsh Government plan to reduce suicide and self harm in Wales and the North Wales Suicide and Self Harm Strategic Plan have been considered in the development of this policy. One of the commitments of these plans were to ensure that where possible, those individuals at risk, do not have access to items that could potentially be used for suicide or self harm. It is suggested that mental health inpatient settings that support individuals at risk, should be risk assessed and all potential aids to self harm or suicide will be made safe. It is recognised that removal of access to the means of suicide, is an effective strategy in terms of prevention.

The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) advises that global/blanket restrictions where possible should be avoided, unless they can be justified as a necessary and proportionate response to risks identified. The Code of Practice makes specific reference to the restriction of communication devices such as mobile phones and computers, however there is no specific guidance offered in relation to the restriction of items associated with the risk of harm to self or others. The following definition is offered within the Code of Practice:

> *"A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others."*

Patients within the Mental Health and Learning Disability (MHLD) Division have a right to privacy and dignity, to be free from unnecessary searches and to retain and use personal property. However patients, staff and visitors to all services also have the right to a safe and therapeutic environment, which under certain circumstances may necessitate taking steps to ensure that patients are not in possession of items that may present a hazard to personal safety, or the therapeutic environment. In order to maintain a safe and therapeutic environment, in addition to the privacy of other patients, services within the MHLD Division may restrict items coming into the inpatient and community facilities. Such restrictions may be justified as a necessary and proportionate response to an identified risk (CQC, 2017).

2. Purpose

The purpose of this policy is to provide staff with clear guidance for the safe management of restricted items within the Inpatient Mental Health wards and across community facilities within the MHLD Division. This in turn will safeguard all patients, staff and visitors to these services.

3. Scope

The contents of this policy apply to all staff working within the Inpatient Mental Health services and community teams across the MHLD Division.

Whilst Ty Llywelyn Medium Secure Unit In Bryn Y Neuadd Hospital is part of the MHLD Division, this service has its own separate procedures and policies in relation to security procedures and staff should consult MHLD 0005.

4. Definition of Restricted Item

A restricted item is an item or substance which could affect the health, safety or welfare of patients, staff and others.

There is an agreed Divisional wide list of items that are restricted within the Inpatient Mental Health wards and community facilities across the MHLD Division:

- Illicit Drugs/Substances
- Alcohol
- Non-Prescribed medications including over the counter
- Sharp instruments – Scissors, razors, knives (see footnote* regarding the kirpan)
- Weapons – Firearms (real or replica), clubs
- Solvents and other toxic, hazardous substances
- Plastic bags
- Ignition sources – Lighters, matches, lighter fluid
- Recording or photography equipment (see footnote** regarding mobile phones)
- Items containing violent/racist or pornographic content

This list is not exhaustive and by local agreement other items may added.

***Kirpan -** *It is legal under the Criminal Justice Act 1988 (section 139) and Offensive Weapons Act 1996 (section 3 and 4) for a Sikh to carry a Kirpan as part of their religion. As the Kirpan is not a weapon but an article of faith, most Sikh patients (and/or the family) will be willing to discuss the issue of Kirpan possession in order to come to a pragmatic solution.*

****Mobile Phones** *– It is acknowledged that most mobile phones can now be used as recording devices, it is not suggested that all mobile phones are removed from patients or classed as a restricted item. As part of the discussions on admission to hospital staff will advise patients about the need for confidentiality of others to be maintained and ask that they abide by this. If there is evidence that the confidentiality of others is not being maintained and any patient is observed or reported to be taking photographs or recordings using their mobile phone, consideration will need to be given to the removal of the mobile phone.*

Personal rechargeable electronic devices present a fire risk during use and when being charged, this includes devices such as e-cigarettes, mobile phones, laptops, tablets, etc. Removal of all chargeable equipment would be considered excessively restrictive and disproportionate, however all staff, patients and visitors must be made aware of this risk, through safety briefings and conversations. Signage can be displayed near accessible socket outlets, and can be obtained from Health and Safety advisors (see WG EFA/2018/007).

There are numerous potential risks in the environment that could affect the health and safety of patients during inpatient admissions. Awareness is being raised on an All Wales basis in relation to such risks associated specifically to plastic bags and chemicals. Plastic bags could be brought in by patients or visitors, or used by staff particularly domestic services, portering and pharmacy department. It would be difficult to completely restrict the use of plastic bags throughout services due to practical requirements, particularly in relation to delivery of items and waste management, similarly whilst hazardous substances are listed as a restricted item, again due to practical reasons cleaning chemicals will be used across services. However all staff

should remain vigilant regarding the potential risks associated to plastic bags and chemicals, and access to both by patients should be restricted. Ward Managers must in conjunction with domestic services ensure that there are adequate controls in place to restrict patient access to such items; these controls will be outlined in service environmental risk assessments (see HS01, HS13 and WG EFA/2019/002).

5. Procedure for Inpatient Mental Health Wards

5.1 Disclosure/Non-Disclosure of Restricted Items

On admission to any Inpatient Mental Health ward and on transfer between wards, all patients will be asked if they have brought any of the restricted items into hospital, some of these items are referenced on the disclaimer that patients are already requested to sign on admission as part of the Acute Care Inpatient Pathway (see MHLD 0001 CPG for more information). As the list is not exhaustive staff must remain vigilant and will consider items that may be manipulated to create a sharp object or weapon. If the patient has brought any of these items onto the ward, staff are to ask that they hand the item in for safe keeping or until arrangements can be made for the item(s) to be returned to their home.

Whenever a patient returns to the ward from a period of leave, they must again be asked if they have brought any of the restricted items back to the ward with them.

In the event that a patient denies having brought in any of these items, however staff have evidence to the contrary, a search is to be undertaken and staff are referred to the Searching Patients and their Property Policy MHLD 0013 for full guidance.

5.2 Risk Assessment

Our patients often present as very unwell when requiring an inpatient admission, due to the nature of their illness, symptoms and presentation and potential risk to self and/or others, a comprehensive risk assessment utilising the Mental Health Measure clinical documents, will be undertaken at the point of admission. In order to safeguard individuals a referral to advocacy will be made on admission or at any other point where required, for those patients subject to Mental Health Act (1983) or Mental Capacity Act (2005), this will support application of this policy in patient's best interests.

As the risk assessment will inform care planning and decisions relating to care delivery, it must be current, and reflective of the patient's presentation taking into account both past and present risks. Particular attention must be paid to any risk of self-harm, harm to others, previous use of weapons and arson. Throughout admission, the risk assessment of any patient will be kept under review and amended to reflect any changes in the level of risk posed. Such changes may also require updates to the patients care plan.

Consideration will also be given to the overall risk any item presents to the general population of the ward, including if it is taken by another patient. Staff will consider what items are appropriate for the environment and the need for urgent access to any particular item; for example items such as scissors and razors are unlikely to be needed urgently and could be accessed on request when needed.

5.3 Information to Patients and Carer's

On admission patients are to be asked if they have brought any of the items listed in section 4.1 into hospital with them, the admitting nurse is to provide the patient and their relative/carer with an explanation as to why the use of such items is restricted whilst they are on the ward.

In the event that a patient denies having any of the restricted items with them, if they are accompanied by a relative/carer the admitting nurse should where possible ask the relative/carer to confirm that this is correct. Relatives/carers will also be informed by ward staff about restricted items, and requested to check with staff before they bring such items onto the ward during visits.

It is also important that patients are reminded of the restricted items when they have a period of leave from the ward, and that should they return from leave with a restricted item, they are requested to inform the Nurse in Charge and will be required to hand the item in for safe keeping or until arrangements can be made for the item(s) to be returned to their home.

Each ward will display an information leaflet (see appendix 1), to advise patients and visitors of what items are restricted on the ward.

5.4 Refusal to comply with the requirements of this Policy.

In the event that a patient's relative/carer does not comply with the request to check with staff before handing any restricted items to the patient, staff are in the first instance to politely remind them of this requirement and the reason why. However if they consistently fail to check with staff before handing restricted items to the patient, consideration must to be given to the need to either supervise their visits or bar them from the ward. In such circumstances staff must consult with their Matron, or Bronze on call Manager (outside normal working hours) before any decision is made.

5.5 Safe Storage and Disposal of Restricted Items

Any items removed from a patient for safe keeping are to be placed in a plastic belongings bag/box which is to be clearly labelled with the patient's name. There will be an inventory sheet kept with the items (see appendix 2) which is to be dated, timed and signed each time an item is removed or returned.

Each patient is to have their own bag/box, and under no circumstances are these to be shared by patients.

All items kept in safe storage will be returned to the patient when they are discharged from the hospital.

The only items that will not be stored in patient's plastic belongings bag/box or returned to a patient, is any item considered to be a weapon, as there is no reason why a patient would need access to such an item during their stay in hospital.

In the event that a weapon is removed from a patient, consideration will be given to the item's type, purpose and rationale for its possession. This will be documented in the patient's clinical notes and recorded in the risk assessment, where appropriate. Staff will

consider contacting the police, who will arrange to collect and dispose of any weapon, if they believe this to be an appropriate action.

Without Police involvement staff do **NOT** have the right to dispose of items without approval of the owner.

In the event that the Police are unable or unwilling to support the disposal of a weapon, but the patient does consent to disposal then the item should be dealt with on a case by case basis with advice/assistance from the Health and Safety advisors and the Hospital Security Team. Some weapons e.g. knives may be suitable to be placed in the larger sharps bins.

If the patient does not agree to disposal then the item will be placed in safe keeping (that is, in a locked area with no patient access) until the patient is discharged.

As discharge approaches, if staff continue to have concerns about the patient being in possession of the item, then this concern will be discussed with the police and their advice sought. All conversations with the police will be documented in the patient's clinical records.

Staff will ensure that a robust and detailed risk assessment is completed to reflect any decision making processes including the involvement of the Multi-disciplinary Team, Senior Management, and the Health and Safety Team were appropriate.

In the event that illicit substances or medications are removed from a patient staff should consult the BCUHB Medicines Code (MM02.1), this provides specific guidance on the handling, storage and disposal of such items. Pharmacy can also be contacted for additional advice.

6. Procedure for Community Settings

6.1 Disclosure/Non-Disclosure of Restricted Items

If a patient discloses information in regard to restricted items, the staff member must approach the situation calmly using de-escalation skills where needed and seeking assistance from colleagues/managers if necessary. As the list is not exhaustive staff must remain vigilant and will consider items that may be manipulated to create a sharp object or weapon. In the event that a staff member believes a patient to be in possession of any restricted item(s), the patient can be directly asked if they have such an item if appropriate to do so, and this policy shared with them.

If the patient has brought any restricted items into a community facility, where necessary to ensure staff and public safety the patient will be asked to leave the premises giving a mutually agreed appointment, instructing the patient not to bring such items to subsequent appointments.

If staff believe that asking a patient to reveal if they have a restricted item would cause undue risk to themselves or others then advice will be sought from police with a detailed explanation as to what the item in question is believed to be, the perceived risk, who may be at risk of harm, the items current location and the patient concerned identifiable details. It is recognised that some confidential information may need to be disclosed - this is permitted in cases where safety and prevention/detection of crime may occur.

In the event that a patient denies being in possession of any of these items, however staff have evidence to the contrary, staff will **NOT** search persons or belongings with the intention of retrieving restricted items.

If restricted items are witnessed or identified on a home visit the staff member will ensure their own safety and leave the visit as soon as it safe to do so; utilising de-escalation skills if required. The appropriateness of future home visits will be discussed with the multidisciplinary team and the risk assessment will be updated immediately following the event to reflect any decisions regarding home visits.

6.2 Risk Assessment

Immediately following any event related to a restricted item, the risk assessment will be updated and the incident will be discussed with the manager and at next multidisciplinary team meeting.

As the risk assessment will inform care planning and decisions relating to care delivery, it must be current, and reflective of the patient's presentation taking into account both past and present risks. Particular attention must be paid to any risk of self-harm, harm to others, previous use of weapons and arson. Throughout an episode of care, the risk assessment of any patient will be kept under review and amended to reflect any changes in the level of risk posed. Such changes may also require updates to the patients care plan.

6.3 Safe Storage and Disposal of Restricted Items

Information will be provided to patients regarding the safe disposal of restricted items via the local police station or amnesty bins when available.

In the event that person voluntarily relinquishes opened containers of alcohol, staff will inform patient that the contents cannot be stored and will be required to be disposed of safely.

Without Police involvement staff do **NOT** have the right to dispose of items without approval of the owner.

In the event that illicit substances or medications are removed from a patient staff should consult the BCUHB Medicines Code (MM02.1), this provides specific guidance on the handling, storage and disposal of such items. Pharmacy can also be contacted for additional advice.

6.4 Information to Patients and Carer's

On initial contact with any community service, staff will make the patient and their relative/carer aware of this policy with an explanation as to why the use of such items is restricted whilst they are in the community facility.

In the event that a patient does not comply with the principles of the policy and continues to be in possession of restricted items during appointments, staff may send them an informal letter (see appendix 3), explaining that this is unacceptable and that any further

incidents may result in more formal management, including alternative arrangements for their ongoing care and treatment, this policy may also be shared with the patient.

7. Roles and Responsibilities

7.1 Director of Nursing

To ensure the provision and distribution of a comprehensive and up-to-date policy reflecting best practice, fit for purpose across all areas of the Division.

7.2 Heads of Nursing

- To support any training needs for staff in relation to this policy.
- To support staff that care for patients at risk.
- Promoting a positive experience of the service for patients and carers.

7.3 Matrons

- In conjunction with Ward Managers ensure that individual ward risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented.
- Ensure that this policy is consistently implemented across all inpatient units and, with the Ward Manager, monitor the frequency of the policy being put into action.
- Highlight any training needs for staff in relation to this policy.
- Promoting a positive experience of the service for patients and carers

7.4 Ward Managers

- In conjunction with Matrons ensure that individual ward/service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented. Assessments must include adequate controls to monitor and restrict access to items that may be found in service areas and could pose a risk to health and safety, such as plastic bags and chemicals.
- To ensure that all relevant staff are consistent in their application of the policy and clear about their individual responsibilities.
- To ensure that all relevant staff have the relevant, up-to-date skills to implement the policy.
- To ensure that all relevant documentation and records are completed to include what restricted items have been handed in or removed and returned, if the Searching Patient's and their property Policy has been utilised, how items are stored/disposed of and where relevant a Datix is completed.

7.5 Service Managers

- In conjunction with Team Managers ensure that individual service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented.

- Ensure that this policy is consistently implemented across relevant community services and, with the Team Manager, monitor the frequency of the policy being put into action.
- Highlight any training needs for staff in relation to this policy.
- Promoting a positive experience of the service for patients and carers.

7.6 Team Managers

- In conjunction with Service Managers ensure that individual service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented. Assessments must include adequate controls to monitor and restrict access to items that may be found in service areas and could pose a risk to health and safety, such as plastic bags and chemicals.
- To ensure that all relevant staff are consistent in their application of the policy and clear about their individual responsibilities.
- To ensure that all relevant staff have the relevant, up-to-date skills to implement the policy.
- To ensure that all relevant documentation and records are completed to include any restricted items that have been handed over to staff, how items are stored/disposed of and where relevant a Datix is completed.

8. Monitoring

Ward Managers and Matrons will have the responsibility to measure, monitor and evaluate compliance with the policy in the inpatient settings. Monitoring will be undertaken each time the policy is invoked to support the management of restricted items including disclosure, non disclosure and removal, every such instance must be documented in the patients clinical records and reported via Datix to support the monitoring. The Matron will report directly to the Head of Nursing any deviance from the policy, and where appropriate make further recommendations. The Matron will report directly to the policy authors any need to amend the policy in light of changing service need. There will be an annual audit of inpatient areas to review completion of assessment for restricted items at the point of admission.

Team Managers and Service Managers will have the responsibility to measure, monitor and evaluate compliance with the policy in community settings. Monitoring will be undertaken each time the policy is invoked to support the management of restricted items including disclosure and non disclosure, every such instance must be documented in the patients clinical records and reported via Datix to support the monitoring. The Service Manager will report directly to the Head of Nursing any deviance from the policy, and where appropriate make further recommendations. The Service Manager will report directly to the policy authors any need to amend the policy in light of changing service need.

Any breaches or deviance from the policy will be discussed in the Putting Things Right PTR forums and reported to Divisional QSEEL where appropriate.

9. Personnel Involved in the development of the Policy:

Name	Title
Rebekah Roshan	Head of Nursing MHLD – East
Julie Macdonald	SMS Deputy Service Manager
Ruth Joyce	SMS Team Manager

10. Engagement has taken place with:

Name	Title	Date Consulted
Tom Regan, Fiona Hughes, Paul Hanna, Nichaela Jones	Heads of Nursing	31/08/2018
Fleur Evans, Gaynor Kehoe, Sam Watson, Carole Evanson	Heads of Operations & Service Delivery	31/08/2018
Steve Forsyth	Director of Nursing MHLD	31/08/2018
Adrian Jones	Assistant Director of Nursing MHLD	31/08/2018
John Paynter	Fire Safety Officer	31/08/2018
Hilary Owen	Head of Governance	31/08/2018
Stephen McCabe	MHLD Divisional Estates and Health & Safety Lead	31/08/2018
Samuel Newitt	Health and Safety Advisor – East	31/08/2018
Denise Charles	Caniad Service Manager	31/08/2018
Simon Newman	Head of Healthcare – HMP Berwyn	08/09/2018
Request to circulate to others via Heads of Nursing.	Ward Managers, Matrons, Clinical Directors & Service Managers.	31/08/2018
Circulated widely within MHLD by Policy Lead Wendy Lappin.	Mental Health Act Manager	25/01/2019

INFORMATION LEAFLET / POSTER (Appendix 1)

EITEMAU CYFYNGEDIG / RESTRICTED ITEMS

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

Er mwyn cynnal diogelwch bob claf, ymwelydd a staff, ni chaniateir yr eitemau canlynol ar y ward. Os oes gennych unrhyw un o'r eitemau hyn gyda chi, gofynnir i chi eu rhoi i staff i'w cadw'n ddiogel, a byddent yn cael eu dychwelyd i chi os yw'n briodol pan rydych yn gadael y ward, fel arall, gallwch drefnu i'r eitemau hyn gael eu dychwelyd i'ch cartref.

- Cyffuriau/Sylweddau Anghyfreithlon
- Alcohol
- Meddyginiaethau heb eu Rhagnodi yn cynnwys rhai dros y cownter
- Offer miniog- Siswrn, raseli, cyllyll
- Arfau- Gynnau (gwir neu replica), pastynau
- Hydoddyddion, ac unrhyw sylweddau peryglus, gwenwynig eraill.
- Bagiau Plastig
- Ffynonellau tanio- Tanwyr, matsis, hylif tanwyr
- Offer recordio neu offer tynnu lluniau
- Eitemau sydd â chynnwys treisgar/hiliol neu bornograffig

Os oes gennych unrhyw eitemau eraill sy'n cael eu hystyried yn beryglus neu'n anaddas gan staff, gofynnir i chi roi'r rhain iddynt.

Diolch am eich cefnogaeth i gynnal amgylchedd diogel a therapiwteg.

In order to maintain the safety of all patients, visitors and staff, the following items are not permitted on the ward. If you have any of these items with you, it is requested that you please hand them in to staff for safe keeping, and they will be returned to you if appropriate when you leave the ward, alternatively you can arrange for the items to be returned to your home.

- Illicit Drugs/Substances
- Alcohol
- Non-Prescribed medications including over the counter
- Sharp instruments – Scissors, razors, knives
- Weapons – Firearms (real or replica), clubs
- Solvents and other toxic, hazardous substances
- Plastic Bags
- Ignition sources – Lighters, matches, lighter fluid
- Recording or photography equipment
- Items containing violent/racist or pornographic content

If you have any other items that staff consider to be hazardous or inappropriate, you may also be asked to hand these in.

Thank you for your support in maintaining a safe and therapeutic environment.

INVENTORY OF RESTRICTED ITEMS (Appendix 2)

Hospital Number:.....

Patients Name:.....Ward:.....Date of Admission:.....

Item Details	Logged In		Logged Out		Logged In		Logged Out		Logged In		Logged Out	
	Date	Time	Date	Time	Date	Time	Date	Time	Date	Time	Date	Time

INFORMAL LETTER TEMPLATE (Appendix 3)

PRIVATE AND CONFIDENTIAL

Ein cyf / Our ref:
Eich cyf / Your ref:
Rhif Ysbyty / Hospital Number:
Rhif GIG / NHS Number:
☎:
Gofynnwch am / Ask for:
Ffacs / Fax:
Dyddiad / Date:

Dear

It has been brought to my attention that during your appointment on .....at..... you had in your possession a restricted item. The Betsi Cadwaladr University Health Board treats all such incidents extremely seriously, and following careful consideration the Health Board is writing to you on an informal basis at this time.

During the above appointment it is reported that you acted in a manner which can be considered to be unacceptable to the ..... Team/Service. I am therefore writing to inform you that if any further incidents occur involving restricted items within the 6 month period from the date of this letter, this will be considered in a more formal manner using the Betsi Cadwaladr University Health Board 'Procedure and Guidance Protecting Employees from Violence and Aggression (HS02)' and possible liaison with North Wales Police.

Betsi Cadwaladr University Health Board has a duty to ensure that the safety of its employees and the public using their building is maintained, and as such alternative arrangements for your continuing care and treatment may be implemented.

Yours sincerely

Team/Service manager

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

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Restricted Items Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A standardised approach across the Mental Health & Learning Disability Division (MHLD) to ensure the safe management of restricted items within the Inpatient Mental Health wards and across community facilities within the MHLD Division. This in turn will safeguard all patients, staff and visitors to these services. A restricted item is an item or substance which could affect the health, safety or welfare of patients, staff and others The policy offers procedural guidance to staff working across both the Inpatient Mental Health wards and community services in relation to dealing with disclosures and non disclosures of restricted items, and the safe storage and disposal of such items. The policy also aims to offer information to service users and carers regarding restricted items.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Mental Health and Learning Disability Division – Nursing Directorate
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Searching Patients and their Property Policy – MHLD 0013 Therapeutic Observation and Engagement Policy – MHLD AC002 Mental Health & Learning Disabilities CPG Acute Care Operating Framework – MHLD 0001 CPG

		Patients Visitors Protocol Ty Llywelyn Medium Secure Unit – MHLD 0005 BCUHB Medicines Code – MM02.1 Restraint Guidelines – MD02 (Due to be replaced with SCH016) Health and Safety Policy – HS01 (Including individual ward/service risk assessments) Procedure and Guidance Protecting Employees from Violence and Aggression – HS02 (V2 April 2018) Mental Health Act 1983 Code of Practice for Wales (Revised 2016) North Wales Suicide and Self Harm Prevention Strategic Plan (2018) Welsh Assembly Government: 'Talk to Me 2', Suicide and Self Harm Prevention Strategy for Wales 2015 - 2020 (2015)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Service Users Carers Staff Visitors
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Compliance from all professionals involved Training to all staff Policy launch Communication Willingness of service users and carers to adhere to the policy

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	N/A		The policy relates to all inpatient settings and community services. There is no discrimination against age.
Disability	N/A		Disability discrimination act 1995. The policy does not affect disabled and non disabled people any differently.
Gender Reassignment	N/A		The Equality Act 2010 which includes Gender reassignment. The policy does not affect people of any gender differently.
Marriage & Civil Partnership	N/A		Marital status has no bearing on this policy or who people are affected.
Pregnancy & Maternity	N/A		The Equality Act 2010. There is no difference in the policy for pregnant women.
Race / Ethnicity	N/A		Human Rights Act 1998. The policy applies to people of all race and ethnicity.
Religion or Belief	(-)	Low Negative	The only consideration with regards to religion if the Kirpan - It is legal under the Criminal Justice Act 1988 (section 139) and Offensive Weapons Act 1996 (section 3 and 4) for a Sikh to carry a Kirpan as part of their religion. As the Kirpan is not a weapon but an article of faith, most Sikh patients (and/or the family) will be willing to discuss the issue of Kirpan possession in order to come to a pragmatic solution.
Sex	N/A		The policy treats men and women the same.
Sexual Orientation	N/A		The policy does not differentiate between sexual orientation.
Welsh Language	N/A		Distribution list for Consultation included welsh speakers. The information leaflet is bi-lingual (Welsh & English). A translated copy of the full polity could be provided upon request.
Human Rights	N/A		Human Rights Act 1998

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability t:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The document does not treat individuals any differently regardless of their sex, race, disability etc. The policy is written for all staff who work within the inpatient mental health wards and community services, and it is aimed at all patients who use these services. The only consideration is that this policy may impact on people of the Sikh religion due to the possession of the Kirpan, however it is anticipated that through discussion with any service user and their family, a pragmatic solution will be able to be identified without resulting in a negative impact on any individual.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	There is a potential for improved engagement with service users and carers.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	A Restricted Items Policy for use within the MHLD Division.

2. Brief Aims and Objectives: (Copy from Form 1)	A standardised approach across the Mental Health & Learning Disability Division (MHLD) to ensure the safe management of restricted items within the Inpatient Mental Health wards and across community facilities within the MHLD Division. This in turn will safeguard all patients, staff and visitors to these services. A restricted item is an item or substance which could affect the health, safety or welfare of patients, staff and others The policy offers procedural guidance to staff working across both the Inpatient Mental Health wards and community services in relation to dealing with disclosures and non disclosures of restricted items, and the safe storage and disposal of such items. The policy also aims to offer information to service users and carers regarding restricted items.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No X
3b. Could any of the protected groups be negatively affected?	Yes	No X
3c. Is your decision or policy of high significance?	Yes X	No

4. Did the decision	Yes	No X

scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes X	No
	Record Details: Staff will need to ensure that discussions are held with any Sikh service users and their families in relation to the possession of the Kirpan, to ensure that this policy does not have a negative impact on their religious beliefs.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X	No
	How is it being monitored?	Monitoring of incidents relating to restricted items will be monitored through DATIX and via PTR groups and QSEEL.
	Who is responsible?	Mental Health and Learning Disability Division
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Datix reports
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Same time as Document review

7. Where will your decision or policy be forwarded for approval?	MHLD Policy Group

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Discussion in MHLD PTR and QSE, guidance from Health & Safety. The policy has been widely circulated on 3 occasions within the MHLD Division, to Health & Safety, fire officer and Caniad, with a great deal of feedback received, this has helped with the development of the policy but also to inform this assessment.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Rebekah Roshan	Head of Nursing MHLD East
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	Staff will need to ensure that discussions are held with any Sikh service users and their families in relation to the possession of the Kirpan, to ensure that this policy does not have a negative impact on their religious beliefs.	Heads of Nursing to ensure all relevant staff are aware of the action.	Immediate & Ongoing
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	No		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group

Meeting date:	8th May 2019

Name of Chair:	Mrs Deborah Carter, Acting Executive Director of Nursing and Midwifery

Responsible Director:	Acting Executive Director of Nursing and Midwifery

Summary of key items discussed:	**Restrictive Physical Intervention (RPI) Policy update – Steve Forsyth** In summary, the results illustrate that BCUHB has robust systems in place to educate staff in violence and aggression prevention strategies and providing post incident support to patients and staff. - 86% staff are trained in preventing Violence and Aggression - 90% risk assess Violence and Aggression - 28% use the Person Centred Support Plans - Training plan in place led by our PICCS team in conjunction with the corporate V&A trainers. - 7% use Violence checklist - The DASA (Dynamic Appraisal of Situational Aggression) is now included in the reviewed Restraint Policy MHLD0047 and the new Proactive Reduction & Therapeutic management of Behaviours which Challenge Policy MHLD0049 **Schwartz rounds presentation – Ru Hazarika** RH talked through the presentation, and explained that the rounds are a confidential forum, which is facilitated by a trained expert, this results in a safe place where staff can talk honestly and openly about stress and concerns. The aim is to deliver monthly and all staff involved in patient care are invited refreshments are provided to aid attendance over lunch periods. Group questioned what the outcome would be and how we would measure the tangible outcomes, such as a reduction in work

	related stress in staff. It was confirmed that Mental Health & Learning Disabilities (MHLD) Division have agreed to pilot for BCU and feedback on outcomes. Group were concerned how it would be piloted in the area to make sure that the right focus and support is given to result in positive outcomes within timescales included. MHLD were asked to provide feedback at a later meeting. **Medical Devices Safety Officer (MDSO) – Patrick Hill** BCU doesn't currently have this role within the Health Board which was identified as a requirement by the patient safety alert directive issued jointly by the Medicines & Healthcare Products Regulatory Agency (MHRA) and NHS England in 2014, and followed by the Deputy Chief Medical Officer for Wales in 2015. Group supported the recommendations which included approving the nomination of a suitable MDSO, and secure appropriate support and resourcing at an appropriate staff banding within the medical device team, the preferred option would be to upgrade an existing member of staff or alternatively appoint to a new post. **Policies/ Guidelines/ written control documents** The group agreed the following policies: • MHLD 0044 Section 17 Leave of absence policy • MM01 BCU medicines policy • MM15 Policy for administration and use of Emergency and non-emergency oxygen in adults • Therapeutic engagement and observation policy • Unlicensed medicine policy And Written control documents: • BCU Neonatal in-patient medication administration record – Gentamicin • BCUHB Adult Lipid modification guidelines • Guideline for the management of Hyperosmolar Hyperglycaemic state (HHS) in adults with diabetes and monitoring chart • SOP to support medicine optimisation tasks by the medicines management team in Primary Care
Key advice / feedback for the QSE:	**Risks to highlight:** • Central area - Failure to recruit GPs into Primary Care – **score 20** • Secondary Care - Defibrillators – there are 3 models being used across BCU, all of which have been decommissioned, risks with this being mitigated. Working closely with the suppliers (Phillips) to purchase a new model and developing the process for switching over. Roll out and training plan will be developed–

	Score 10 • West - Recovery plan for Neurodevelopment service – AXIA were commissioned to review longest waits in March 2019, as a result a business case under review by the area to meet target – **score 20** • East - Children's services – Neurodevelopment team will fail to meet performance target – **score 20,** this will be escalated to Executive Management Group (EMG) and there is a lack of funded pharmacy resource for MH at Wrexham Maelor Hospital– **score 25** • Women's – Countess of Chester Hospital (CoCH) –the information received following the issue of an exception report was not sufficient, and a request for further info has been made– **Score 16** • Estates - There is a huge challenge trying to increase Performance Appraisal Development Review (PADR) compliance, they are currently working with Workforce & Organisational Development (WOD) to try to look at different approaches to improve • MHLD - Heddfan doors – had a further episode but with the opening latch in this incidence. Will be running an exercise of how to break into these doors and develop a standard operating procedure WG incidents – we are off on the trajectory to clear all historic cases by the end of June, apart from Women who are in real time. Overall picture shows an improvement, with a slow steady decrease. Group were informed that Board has requested that this information be included in QSE reporting from this month.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	Wednesday 11th June 2019

Quality, Safety & Experience (QSE) Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group

Meeting date:	11th June 2019

Name of Chair:	Deborah Carter, Acting Executive Director of Nursing and Midwifery

Responsible Director:	Deborah Carter, Acting Executive Director of Nursing and Midwifery

Summary of key items discussed:	**Ward Accreditation/ Hospital Acquired Pressure Ulcer(HAPU)/ Falls Collaborative update** Deborah Carter escalated that we are currently behind the scheduled plan to visit all wards by end of the year, this is due to a number of factors including embedding the process, reprioritising of resources based on need. <u>Improving Quality Together (IQT) training</u> –Group were informed that plans have been agreed to extend Silver to a 4 day process, for which concern has been raised about timescales and anxiety about releasing staff from the wards to attend and the outcome value. There will be a slight change that attendees will be expected to have a project from the start so that there is an outcome benefit. HAPU work launched last month and shows early indications of improvement for early test wards. Results have shown a concurrent reduction in falls. The Falls collaborative starts today on cohort wards and has an expert faculty to support. Aim to reduce in-patient falls by 15% by end of 2019, framework developed to aid how to achieve reductions. **Community Health Council (CHC) Report – A&E Patient Experience Review: A View Across Wales** Group were informed that the Report was received at the end of last year and was taken to the Secondary Care Quality Committee. The committee received the report and discussed the findings. It was confirmed that the improvements within Emergency Departments (EDs) are incorporated in the Building Better Care

	Programme. The report was also shared with site Hospital Management Teams (HMTs) for further discussion and dissemination. **Policies/ Guidelines/ written control documents** The group agreed the following policies: • Massive haemorrhage BCU operational policy –Acute sites • MD01 – BCUHB policy on consent to examination or treatment • MHLD 0051 Community treatment order policy • Seclusion policy And Written control documents: • Assessment of Mental Capacity pilot form for Deprivation of Liberty Safeguards (DOLS) • Protocol for referral for computerised tomography (CT) of the Head from nurses work in a stroke specialist role • Standards of best practice and standard operating procedures for medicines management for carers working in all care settings for adults • BCUHB Paediatric aminoglycoside dosing and monitoring guidelines • Infant safer sleeping guidance • Surrogacy procedure
Key advice / feedback for the QSE:	**Risks to highlight:** <u>Central</u> • Lack of access to IT infrastructure for community nursing teams – score 15 • Failure to recruit/ retain primary care GPs and clinical staff – score 15. <u>Secondary Care</u> • Ysbyty Gwynedd (YG) ED fire compartmentalisation – issues were identified during recent refurbishment, working with estates for exploration work, awaiting report. RT stated that there is damage to the walls, for which Welsh Government (WG) will be visiting end of July for an assessment – **score 8** • Failure in delivery of the breast service due to inability to recruit breast radiologists - **score 25** <u>Women's</u> • An update on the ongoing issues with CoCH are that they are declining to sign the maternity specification. There has been re-arrests of staff involved in neonatal deaths – score 16. • Use of Emergency Gynae Unit (EGU) in East as part of the site escalation plan – score 16. Chair asked for a piece of work to be completed regarding this risk. <u>MH&LD</u> • High number of breach WG reported incidents requiring a closure form – **score 15**

	Estates • Wrexham Emergency Management Services infrastructure – **score 16** • Facilities provisions budget over spend and legacy cost pressures – **score 12** • Work taking place with MHLD regarding Unwanted incidents and fire signals in residential accommodation – **score 9** East • Prescribing competencies of junior doctors – **score 25** • GP Practice sustainability – **score 16** • Establishment control process – effected ability to recruit – **score 16** Complaints – progress is off trajectory, primarily in secondary care. Some areas are on target to achieve by the end of June with discussions taking place, most challenge is with Ysbyty Glan Clwyd (YGC). The 30 day target currently stands at 32%. Reviewing again how to support remediation. There is an issue with the monitoring of level 3 safeguarding training, as the current system doesn't collect the data, the division are in talks with WOD to resolve. Group were informed that the mortality review group is due to be relaunched, which will be included in the cycle of business to report in via chair reports.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	Tuesday 2nd July 2019

Quality Safety & Experience Committee

16.7.19

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

To improve health and provide excellent care

Report Title:	Progress report of Recommendations arising from HASCAS (Health and Social Care Advisory Service) independent investigation and Ockenden governance review
Report Author:	Miss Claire Brennan, Head of Office
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	HASCAS & Ockenden Improvement Group
Governance issues / risks:	Additional resources required have been identified for a number of recommendations to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	Executive Team have agreed in principle the funding for the required additional posts to support progress of the relevant recommendations. Director of Mental Health & Learning Disabilities to confirm financial allocations.
Recommendation:	The Committee is asked to: 1. note the progress of the recommendations to date

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√

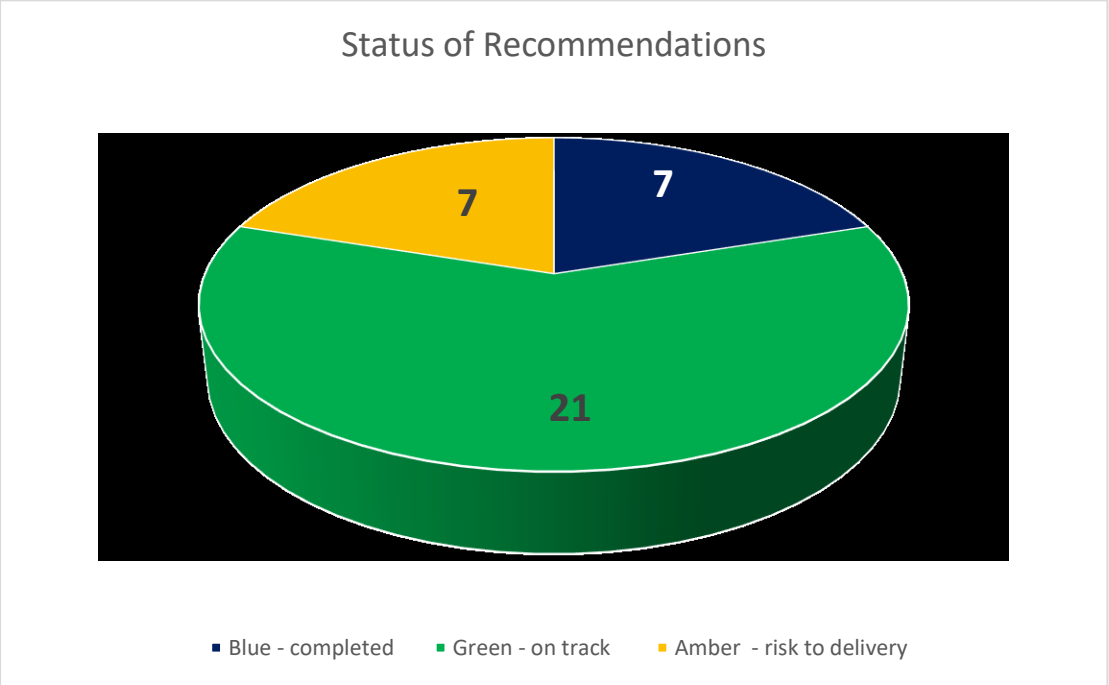
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance & Leadership Mental Health Services			
Equality Impact Assessment *n/a*			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

HASCAS & Ockenden Recommendations status

Progress for all HASCAS & Ockenden recommendations is well underway; the status of the total 35 recommendations is detailed below;

- 21 are reporting green, as on track to achieve delivery, some of these recommendations are almost due to complete and any that are proposed for closure will be formally reviewed at the Improvement Group meeting on 31st July and shared with Stakeholder Group members;
- 7 are reporting amber, where work is progressing but some additional focus or support is required to address some challenges that is impacting on timely progress;
- 7 recommendations have now been completed; these are relation to;
  - HASCAS 4: Safeguarding training
  - HASCAS 5: Safeguarding Informatics & Documentation
  - HASCAS 6: Safeguarding Policies & Procedures
  - HASCAS 7: Tracking of Adults at Risk across NW
  - HASCAS 13: Restrictive Practice Guidance.
  - Ockenden 2d: Recruitment of the second Consultant Nurse for Dementia
  - Ockenden 14: Board Development and prescribed disengagement.



The following recommendations have achieved the relevant actions and are therefore now proposed by the respective operational leads as being fully implemented. These will be formally reviewed for approval at the Improvement Group meeting on 31st July.

- HASCAS 3: Care Homes & Service Integration
- Ockenden 4b & 4c: Staff Surveys

- Ockenden 10: Reviewing External Reviews

Improvement Group

The Improvement Group held bi-monthly has now met 5 times since its inception in August 2018 and is well attended by core members as well as operational leads and or executive lead for each Recommendation to provide progress update reports.

In addition to the bi-monthly Improvement Group meetings, additional one to one meetings have been established between the operational lead and the Acting Executive Director of Nursing, for a deep dive into the progress and issues of each recommendation and to identify any areas that are not progressing at the anticipated pace and agree required actions and any support to address barriers.

Stakeholder Group

The Stakeholder Group has now met 4 times since its inception in October 2018, the next meeting is due to be held on 30th July which the BCUHB Chairman will be attending to enable discussions directly with Stakeholder Group members to receive their feedback on the progress of the recommendations.

Ongoing engagement between operational leads and stakeholder members remains for the recommendations where stakeholders had expressed an interest to support progress, the majority of Stakeholder members are now actively engaged with the work of the relevant groups. Operational leads have formally acknowledged the valuable contribution that stakeholders are making in supporting the progress of actions.

The Stakeholder Group has received presentation at previous meetings to highlight the work being undertaken to progress actions in the following areas;

- End of Life Care;
- Dementia Care in Emergency Departments;
- Restrictive Practice Guidance
- Neurological conditions (pathways)

A work programme has been developed and it has been agreed to receive a presentation on Estates and anti-ligature work at the next Stakeholder Group meeting on 30th July.

HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee, 16th July 2019

Recommendation	Current position	Progress update	Risks
HASCAS 1: Integrated Care Pathways Operational Lead: Reena Cartmell Associate Director of Nursing *'An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those) confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need'.* **Ockenden 1: Integrated Service Model for Older People and those with Dementia** Operational Lead: Reena Cartmell Associate Director of Nursing *"The patient pathway for service users of older people's mental health was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017).* *As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the voluntary sector and other independent sectors.* *There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing oversight by the BCUHB Board and Welsh Government as this work progresses".*		It is important to note that BCUHB's response to the HASCAS and Ockenden recommendations and all clinical actions will support the wider strategic programmes for older persons, such as the North Wales Regional Plan (Area Plan) and the Integrated Care Fund revenue plan. The HASCAS and Ockenden recommendations will therefore inform wider workstreams under the Regional Partnership Board and the North Wales Social Care and Wellbeing Services Improvement Collaborative, particularly dovetailing with the Dementia Strategy. Integrated care pathways affects all aspects of service delivery, the work programme ahead is therefore interweaved into other recommendations such as HASCAS 2 (Dementia Strategy), HASCAS 3 (Integrated Care Homes) and Ockenden 12 (Long Term Clinical Plan). • ***Logic Model***: The logic model has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into the logic model, which is now used as our baseline. Due to the similarities between HASCAS 1 and Ockenden 1, the recommendations have been combined to create one single logic model / action plan, ensuring an integrated approach. There are six main outputs to be achieved within the programme of work, these include: 1. An Integrated Service Gap Analysis 2. Integrated CRT care pathways with joined up mental health, primary and secondary care services. 3. Clearly defined BCUHB Older Persons care pathways across all services. 4. North Wales Integrated OPMH Improvement Hub. 5. An annual audit and reporting schedule for older person's services and those with a diagnosis of Dementia 6. A North Wales Integrated Service Model for Older Persons and Dementia. • ***Integrated Service Gap Analysis***: A meeting has taken place with the Director of Primary Care & Community Care and Acting Director of Nursing to agree a way forward for the development of an older person's service gap analysis through the support and engagement of Area Directors. A presentation on the methodology, aims and objectives was delivered on 2nd of July. Following the completion of the gap analysis, a single action plan will be developed to support the future vision of an integrated service model for older people. The findings of the Care Closer to Home review will also support the analysis, and will not duplicate any existing work programmes. • ***Integrated Community Resource Teams (CRTs)***: As part of the evolving service model of community resource teams, BCUHB is looking to define the care pathways for older persons to join up primary, secondary and mental health care services. Care Homes are also an integral part of this work as monitored under the Care Inspectorate Wales (CIW) / Healthcare Inspectorate Wales (HIW) Action Plan (November, 2018) questions 4 and 5: "The CRT workstream must incorporate access for care homes. This will be achieved by developing a partnership approach i.e. a care pathway between CRT's and care homes whereby mutual goals and objectives are agreed in order to improve the patient experience and promote seamless services". • ***BCUHB Drafted Pathways:*** The main care pathways under development include: → ***'Meeting the Physical Health Needs of People Admitted to an Older Person Mental Health (OPMH) Ward'*** (January 2019) remains under construction. The pathway aims to integrate the clinical pathways between physical health and Older Persons Mental Health. An improvement programme of work is in development with	Timescale to achieve review of a broad range of services - Joint and clear action plan including milestones and timelines to be developed. Progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas) - Ensure joint responsibility of translating strategy into action via an improvement sub-group and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services) - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy

Recommendation	Current position	Progress update	Risks
		support from consultant psychiatry and medical staff to review and revise the clinical pathways between Emergency Department (ED) and Care of the Elderly (COTE). Outcome measures are being developed in order to help measure service change. The Improvement plan will also be shared with the OPMH Quality and Workforce Group for support, spread and sustainability purposes. → ***End of Life Pathway***; meeting held between Improvement Lead and Head of Nursing for Palliative Care in May 2019. Work ongoing to review and refine end of life pathways across primary and secondary care, including care homes. → ***Emergency Department (ED), Acute Medical Unit (AMU), Surgical Assessment Unit (SAU) pathways*** under early discussions; meeting held between Improvement Lead and Head of Nursing for ED in May 2019. Significant amount of work is progressing in relation to admissions to hospitals discharge processes. Task and finish groups in each locality are under early development. → ***Advanced Nurse Practitioners (ANP):*** To support the above development; clinical teams from Care of the Elderly Services and OPMH have met to determine the service changes required to support further our OPMH patients. This has resulted in the identification and support for further ward based clinical sessions for physical assessment by appointing Advanced Nurse Practitioners (ANP) to assess the physical health needs of older persons on mental health wards and the development of an integrated pathway for rapid response. These ANP posts have been advertised with a prospective applicant. • ***An OPMH Improvement Hub***: is also in the early stages of planning. In addition the Foundations of Nursing via Bangor University has been approached to support our work programme, further discussions are awaited. • ***Audit and Reporting Schedule***: Programme Manager has met with BCUHB's Head of Audit to map out current mandatory audits that concern older persons and the opportunities for corporate and ground level audits that evaluate care pathways across all services. Risk to delivery currently involves lack of resources, however once the other five outputs are near achievement, a program for audit, governance and reporting can be set out against the service 'products' developed. • ***Integrated Service Model***: The integrated service review of older persons needs to be scoped out in partnership with support from the Regional Partnership Board with stakeholder engagement. Work has progressed in relation to the Improvement Lead having met with our stakeholders to discuss the model for presentation and wider consultation. • ***A set of priorities*** for the Older Person has been drafted by BCUHB's Improvement Lead and are awaiting endorsement by Area Directors and Executive Director of Community & Primary Care to help create a baseline for the service gap analysis and all older persons' work streams listed above. The priorities for older persons have been open to consultation to a wide range of clinical leads and patient experience. • ***Stakeholder Engagement***: Individual engagement has taken place with wider stakeholders regarding the findings of care pathways listed above. Consultation on an ongoing basis will help inform the design and service improvement models with inclusion of patient experience. To note, engagement to date has identified 'care outcomes' as being central to an integrated service model and care pathways. BCUHB's set of priorities for older persons are therefore reinforced, and are given priority at this current time.	

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Recommendation	Current position	Progress update	Risks
HASCAS 3: Care Homes and Service Integration Operational Lead: Reena Cartmell Associate Director of Nursing *The current Care Home workstreams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB mental health and dementia strategies.*	Proposed as fully implemented (Pending approval at HASCAS Improvement Group on 31st July)	The relevant actions have now been completed to address the requirements of this recommendation and the Associate Director of Nursing, as operational lead, is proposing that this recommendation now be signed off as fully implemented. This will be formally reviewed for approval at the next Improvement Group meeting on 31st July. An update of the progression of the actions is provided below; • ***Logic Model:*** The logic model for HASCAS recommendation 3 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are three main outputs to be achieved within the programme of work, these include: 1. Action plans based on engagement with the care home sector. 2. A single care home action plan that supports the implementation of the BCUHB Dementia Strategy and pre-existing BCUHB 'Together for Mental Health' Strategy. 3. Integrated Training programmes for BCUHB to include Care Home Staff. • ***Care Home Event***: A series of 4 hour 'getting to know you' events with care home and clinical health board staff were held on four days throughout March 2019 across West, Central and East areas. BCUHB hosted the event, supported by the CEO of Care Forum Wales, which were delivered within a world café approach to generate ideas on how to improve working partnerships for patient centred care and to discuss ways to improve relations, safer discharges, and celebrating successes in older person's services. Area Nurse Directors have reviewed the recommendations provided and considered how to develop (both immediately and long term) action plans for their local regions. Feedback to all partners who attended the events have been provided, and the programme manager for this work stream has co-ordinated all responses and shared this with Care Inspectorate Wales (CIW) in March 2019. • ***Single Care Home Action Plan:*** The 'BCUHB Single Care Home Action Plan' will be launched in July 2019 and attempts to incorporate all current care home work-streams into a single plan, which in turn will dovetail into other pre-existing BCUHB Mental Health and Dementia Strategies. The action plan has been developed as a direct response to the following requirements: → CIW / HIW Review of healthcare support provided by BCUHB for older people living in care homes in North Wales (November 2018). → Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report, HASCAS (May 2018), (Recommendation 3). → Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013 and governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time, Donna Ockenden (June 2018). → BCUHB's Living Healthier, Staying Well Draft Framework for Care Closer to Home. → North Wales Social Care and Wellbeing Service Improvement Collaborative, Market Shaping Statement; Care Homes for Older People in North Wales (2018). → BCUHB Care Home Partnership Event (March 2019). The '*BCUHB Single Care Home Action Plan'* will be overseen by BCUHB's Corporate Nursing Department. Progress will be monitored and updates requested on a bi-monthly basis. Any new and emerging BCUHB care home work-streams will be added to, and form part of this integrated process. The aim of the action plan is to bring together all ongoing service re-design initiatives, and to capture evidence of improvements through a single framework of governance.	Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews. - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas). - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services). - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.

Recommendation	Current position	Progress update	Risks
		Local area teams are responsible for updating the action plans, providing evidence of achievements with actions that are relative to local needs. Area Nurse Directors will therefore assume overall responsibility for the delivery of action plans. The drafted BCUHB priorities for the older persons have also been incorporated and mapped through a consultation process to help drive forward the older person's agenda for the health board. Output measures are also identified with desired outcomes made clear. It is expected that each action will evidence the application of the following factors: • Stakeholder's engagement / service user involvement in the design of all action plans. • Key practice issues that relate to the workforce. • Timescales for completion. • Lead person(s) for management and delivery. • Quality Impact Assessments. A strategic review of progress and completion date is aimed for April 2020. • ***Integrated Training Programme***: A long-term training schedule for BCUHB to include Care Home staff for the care of older person and those with Dementia is under development. This work stream will be completed under the remit of Ockenden 12; Long Term Clinical Plan. The inclusion of care home providers within the design of a North Wales Training Programme will be central to its achievement. BCUHB aim to ensure ESR modules are accessible to all with specific training around the care of the older person and those with a diagnosis of Dementia. • ***Presentations***: The Programme Manager for this work stream has delivered a presentation to the East, Central and West Partnership Forums to raise awareness of BCUHB's progress made against HSCAS and Ockenden recommendations. The partnership forums have provided the opportunity to move action plans forward, restoring confidence with wider stakeholders in relation to BCUHB supporting North Wales care homes with nursing. The same presentation was warmly received by the Flintshire's 50+ Action Group in June and a further presentation will be offered to the Carer's Strategy Group in September 2019.	
Ockenden 12: Older Persons Long Term Clinical Strategy Operational Lead: Reena Cartmell Associate Director of Nursing *Develop a clear plan for the clinical services of older people to improve training across the workforce, set clinical standards and uniformity with a solid foundation of evidenced based policies and procedures*	Expected to be fully implemented by December 2019	• The Older Persons Long Term Clinical Plan is fully dependant on the delivery of actions as set out in HASCAS 1 / Ockenden 1 (Integrated Care Pathways and Service Model), HASCAS 2 (Dementia Strategy) and HASCAS 3 (Care Home Integration). Recognising that all elements of these work streams are ongoing, a draft plan has been developed and is being consulted with through BCUHB's stakeholder and engagement groups. • ***Logic Model***: The logic model for Ockenden R.12 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are five main outputs to be achieved within the programme of work, these include: 1. BCUHB wide set of clinical standards and procedures for older persons. 2. Clinical and evidenced based policies for older persons care and treatment. 3. Annual BCUHB training programme for our workforce. 4. A clinical plan that is based on engagement with wider stakeholders. 5. Ultimately, a BCUHB long-term clinical plan for older persons and those with Dementia.	Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews. - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas). - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services).

Recommendation	Current position	Progress update	Risks
		• ***Shaping a Long Term Plan***: Work has commenced on shaping the long-term clinical strategy by setting out the desired principles, regulatory requirements, Tawel Fan legacy and a baseline of data. Merging HASCAS work streams 1, 2 and 3 has helped promote a consistent approach in managing all projects with Nurse Director oversight. This also includes the development of governance processes, audit and performance management, ward to board reporting, review of all clinical policies, staff training and an older person's right based culture for clinical standards of care. • ***Clinical Standards:*** BCUHB's Dementia Nurse Consultant is currently mapping out all clinical standards / policies in relation to Dementia care with a view of the second newly appointed Dementia Nurse Consultant assisting this programme of work. A task and finish group for the care of older persons is also being initiated to embark on the same review of all older persons' related care standards and policies. • ***Evidence Based Practice:*** An initial response document has been drafted by BCUHB's Head of Therapies Services that identifies evidenced based practice in relation to therapeutic support to the older person and those with Dementia. Further work is required to set out best practice guidelines, with support from Bangor and Wrexham Universities to help review clinical standards of care against the most up to date evidence based practice. • ***Annual Training Programme***: A comprehensive training programme is being considered in relation to the care of the older person and Dementia with support from Bangor and Glyndwr Universities. This will have a tiered approach from basic level to post graduate courses. A task and finish group is in early developmental stages. • ***Engagement:*** The partnership events to date have been key to shaping the future delivery of services along with further engagement opportunities across all clinical BCUHB services to help set the direction of travel. The BCUHB dementia strategy / action plan will also underpin the long-term clinical plan and an engagement process map drafted to ensure all aspects of the projects listed above involve a wide range of consultation. • ***Long Term Clinical Plan***: As mentioned, the plan is fully dependant on the delivery of actions as set out in HASCAS 1 / Ockenden 1 (Integrated Care Pathways and Service Model), HASCAS 2 (Dementia Strategy) and HASCAS 3 (Care Home Integration). The outcomes and outputs of which will inform the long-term plan and will therefore be developed alongside work as it progresses. This plan will also compliment and include BCUHB's wider strategies in relation to 'Living Healthier, Staying Well', a 'Healthier Wales' and 'Dementia Strategy'.	- Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.
HASCAS 2 : Dementia Strategy Operational Lead: Chris Lynes, Area Nurse Director (West) *BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with (HASCAS) Recommendation 1. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the mental health directorate) in all care and treatment settings (community, primary and secondary care).*		The NW Regional Partnership Board are developing an integrated North Wales Dementia Strategy for the 6 Local Authorities and BCUHB, setting out joint aims and objectives. Project management is supported by the Regional Collaborative Team and BCUHB Director of Partnerships (MH&LD). BCUHB are included in this Dementia Strategy Group, for North Wales, which offers an opportunity for BCUHB to work with the Regional Partnership Board on the following areas; • ***Logic Model:*** The logic model for HASCAS 2 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are seven main outputs to be achieved within the programme of work, these include: 1. A Costed Action Plan for Non-Medical Therapies. 2. A Performance Managed Dementia Strategy Implementation Programme. 3. BCUHB Dementia Training Programme.	Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews. - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas). - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved.

Recommendation	Current position	Progress update	Risks
Ockenden 8: Dementia Strategy *The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&LD division. The dementia strategy should incorporate care across home, primary care and secondary care.*		4. Clearly defined Dementia Care Pathways across community, primary and secondary services. 5. Evidence based policies and procedures that set clinical standards in Dementia 6. Dementia Governance Framework 7. Independent Consultation. • ***A Costed Action Plan for Non-Medical Therapies***: A BCUHB's response to 'Dementia Therapies Action Plan' has been drafted with further work ongoing in relation to obtaining stakeholder engagement and a gap analysis to inform the costed action plan. This dovetails with the work of HASCAS 10 to reduce the use of antipsychotic medication. A task and finish group has been established and met on the 14th of June. A process map is to be developed with senior support requested from the mental health division. • ***A Performance Managed Dementia Strategy Implementation Programme***: A BCUHB Dementia Strategy Group is in the process of being established in order to oversee all health board work streams in relation to Dementia. An initial gap analysis has taken place that addresses how the current 'BCUHB Dementia Plan' meets with the WAG (2018) Dementia Action Plan for Wales. The group also intend to provide input into the wider regional 'Area Plan' by supporting the development of the Regional Partnership Board Dementia Strategy for North Wales. • ***BCUHB Dementia Training Programme***: BCUHB will continue to train staff as 'dementia friends' champions and actively run sessions to support this. There are 10 dementia friendly communities across North Wales this needs to be upscaled; there are a further 9 dementia friendly communities which are working through the foundation criteria to become accredited by the Alzheimer's society. Dementia friends' awareness sessions will also be included in all BCUHB mandatory dementia training. BCUHB will have representation in every dementia supportive community project group. A project plan will be developed to outline the above ambitions with clear measurable outcomes, timescales and a governance structure. Whilst this program of work remains ongoing, BCUHB also intend to assess the capacity and capability of the workforce with strategic and board oversight via the BCUHB Dementia Strategy Group, which will focus upon sufficient training, recruitment and retention of staffing (dovetailing with Ockenden recommendation 1). • ***Dementia Care Pathways***: Working alongside HASCAS 1 / Ockenden 1, BCUHB 'Dementia Friendly Organisation Action Plan' will apply evidenced based practice such as the 'King's Fund National Quality Standards' for the Dementia supportive and enabling environments. The action plan is scheduled for completion by end of Q4 2018-19 – further upscaling to be shared across all BCUHB pan wide services to ensure implementation is consistent within both primary and secondary care, such as the mental health liaison service within general hospitals. The 29 recommendations from the Royal College of Psychiatrists National Audit of Dementia in general hospitals is pivotal within 'BCUHB's Dementia Friendly Organisational Plan' and we will continue to adopt the principles of the 'John's Campaign' in all work streams to this effect. In agreement with Bradford University, BCUHB has innovated the use of dementia care mapping as a measure of cultural change and published this work in an international peer reviewed social research journal. Furthermore, accessing information will play a key part in the Dementia care pathways. The action required, as seen within the context of HASCAS 2, is to ensure readily available information for patients, carers and representatives about services available, ensuring most up to date information is accessible on the BCUHB intranet.	Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services). - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.

Recommendation	Current position	Progress update	Risks
		Referrals are now routinely made to the Carers Trust for any individual with a diagnosis of dementia, from BCUHB's memory clinics. A scoping exercise will be taken forward via the HASCAS/Ockenden working group to review all current BCUHB information ensuring that present and future public information is compliant with 'Accessible Communication' standards as per action 8 of the Welsh Government Audiology Framework for Action. Dementia Helpline has been launched across BCUHB providing 24hr advice, information and support. • **Evidence Based Policies and Clinical Standards**: A BCUHB wide systematic approach in reviewing all current policies relating to older people and those with Dementia (dovetails with Ockenden 12 and Ockenden 3, is currently in early development. Review of clinical policies is to be supported by the Dementia Nurse Consultants, with University support. • **Dementia Governance Framework:** A single point of governance arrangements that underpins all service provision and encourages continuous improvement, lessons learnt and transparent reporting from ward to board level will be overseen by the BCUHB Dementia Strategy Group. BCUHB are also in the process of establishing a third sector partner's group with Alzheimer's Society and the Carers Trust to shadow all BCUHB's Dementia transformation work. A task and finish group is in the process of being established in response to BCUHB's Dementia Audit Plan (2018-2020) to undertake audits and all future reporting from 'ward to board'. BCUHB have launched a 'dementia feedback toolkit' for service users. This will be developed further by involving community services and expecting services to undertake their own performance management arrangements to report directly to Area Directors. The work streams under BCUHB's Dementia Friendly Organisation Plan will also be included within the audit process. The HASCAS/Ockenden working group are also reviewing the process of gathering self-service feedback in order to have in place one single point of data to help with ward to board reporting. • ***Independent Oversight*:** The acting Executive Nurse Director for BCUHB has confirmed that the current stakeholders and audit groups can provide independent oversight for the programmes of work listed above. In addition, WG have also newly appointed an All Wales Dementia Allied Health Practitioner Consultant post who will be approached to give advice and support to health boards and local authorities to enable the delivery of person-centred care and drive forward service improvements. This post forms part of the All Wales Dementia Action Plan. • **Regional Approach to Dementia:** BCUHB are required to subsume this programme of work and to develop it alongside the North Wales Social Care and Wellbeing Service Improvement Collaborative who are project managing the development of a North Wales Dementia Strategy. A mapping exercise is underway to scope all ICF programmes that are currently providing transformational work across BCUHB in relation to Dementia. In addition, this implementation plan will work alongside our partnership programmes, such as: → BCUHB's *Together for Mental Health Strategy* → The North Wales Social Care and Community Health Workforce Strategy (RPB, 2018) → North Wales Population Assessment: Older People and Dementia. → North Wales 'Area Plan'. A representative of the North Wales Social Care and Wellbeing Service Improvement Collaborative will be attending the working group meetings to update on the partnership approach to the North Wales Dementia Strategy. BCUHB are also in the process of responding to the North Wales Social Care and Wellbeing Service Improvement Collaborative online consultation regarding the Dementia Strategy for North Wales.	

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Recommendation	Current position	Progress update	Risks
Ockenden 2d: Appointment of a second Consultant Nurse in Dementia Operational Lead: Chris Lynes, Area Nurse Director (West) *There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the currently extensive work plan this single post-holder is already likely to be stretched very thinly. Going forward there will not be sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.*	Fully Implemented	• Recruitment process for the second Consultant Nurse in Dementia post has been successful and the candidate Suzie Southey commenced in post on 1st July, this role will include a focus on Acute Care, End of Life Care and Primary Care.	
HASCAS 4 Safeguarding Training Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB will revise its safeguarding training programme to ensure it is up to date and fit for purpose. The updated training programme will incorporate all relevant legislation and national guidance* *BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt if the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation* *BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. there are multiple factors involved which will require a detailed and timed action plan with external oversight.*	Fully Implemented	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – All existing safeguarding training packages have been refreshed and updated to ensure that packages are in line with current legislation. – National recognition has been received for the Ask and Act Training - VAWDASV (Domestic Abuse) which has been accepted as a National Training package for Wales. – A learning environment has been led and embedded by Corporate Safeguarding, through the Safeguarding Bulletin, which targets education, learning and updates relating to legislation, policy and procedures. – A robust analysis of Training compliance occurs through the refreshed Safeguarding Reporting Framework and into Area/Secondary Care /Divisional governance forums. – Training Reports are undertaken and areas of low compliance within Safeguarding Training are identified and scrutinised. Underperforming areas are reported via the Safeguarding Reporting Framework and into Area / Secondary Care / Divisional governance forums. • Whilst this recommendation has been recognised as implemented, the important role of Training in embedding good safeguarding practice is recognised, and activity will continue in this high priority area.	
HASCAS 5 Safeguarding Informatics and Documentation Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' casenotes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protections of People at Risk of Harm Annual Report 2017-18 are implemented namely;*	Fully implemented	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – The Health Records department has worked alongside the Associate Director of Safeguarding to support the review and amendment of the safe storage of safeguarding information in clinical records in line with the Social Services & Well-Being Wales Act and GDPR. – Good Record Keeping (GRK) training has been delivered, which incorporates a sign off element for safeguarding to ensure that records are correct.	Digital informatics and the management of clinical records is an organisational risk based upon the challenges relating to the availability of different systems of which do not support the identification of risk or sharing of information.

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Recommendation	Current position	Progress update	Risks
• *The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;* • *Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;* • *Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.* *BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.*		– Initial scoping work has been completed to review the approach for the transition to digitalisation system from paper records by the Health Records Department. – The Health Records Service have completed actions with the following deliverables: (i) Good Record Keeping Training explicitly includes a section on filing safeguarding information; (ii) Communications cascaded on Things You Need To Know (TYNTK) to remind staff of the importance of appropriately filing 'safeguarding' information; (iii) Supplier of the safeguarding divider (for the casenote folders) are being updated to reference updated Safeguarding terminology, and to include the Harm agenda. A list of documents which are to be included behind the divider has been set out. • The GRK Training and communications from the action above are being used to strengthen the HR1 Policy for appropriate filing of safeguarding information – this is being prepared in line with a full review of HR1 in light of GDPR. Work has been undertaken with MHLD colleagues to ascertain their use of the safeguarding divider, remind them of their responsibilities in its use, and ask for assurance of appropriate use. • In order to assure progress in this area, internal audit are scheduled to undertake a records management audit and a review of the implementation of safeguarding documentation. This has been included within the planned works for 2019-20. • Level 3 Record Management training is included within the Safeguarding Training portfolio. This package incorporates the safe storage of safeguarding information. • When areas / departments identify high levels of safeguarding activity, a review of record management takes place, this also includes where cases are discussed and supervision and support is provided. • The Safeguarding Bulletin has a 'Learning' theme once a quarter and these Bulletins specifically highlight education, legislation and policy and procedure updates. • The monthly Safeguarding Bulletins provide reference, advice and guidance relating to records management and remains a key activity of dissemination of information by Teams and Ward managers. • Whilst this recommendation has been recognised as implemented, the important role of Good Record Management in embedding good safeguarding practice is recognised, and activity will continue in this high priority area.	
HASCAS 6 Safeguarding Policies & Procedures Operational Lead: Michelle Denwood, Associate Director Safeguarding *The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017-2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are;* • *To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners* • *Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding*	Fully Implemented	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – Good progress has been made in the management and control of Safeguarding policies. All policies and procedures within Corporate Safeguarding have been identified and a register has been implemented which manages version control and the publishing of policies in a timely and accurate way. – To ensure the governance structure is in place and in accordance with organisational procedure the Safeguarding Business Manager is linking in with the Board Secretary and the Policy on Policies (PoP) and their work on developing a central repository as part of this process. – A priority list has been identified with a full review of Phase 1 completed. The following procedures and guidance were requested for approval at QSG following ratification at the Safeguarding Governance and Performance Group on 31 January 2019. ▪ The Adult at Risk Procedure – ratified for publication and builds on the guidance issued by Welsh Government. (HASCAS 8.3)	

Recommendation	Current position	Progress update	Risks
• *Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy band legislative safeguarding frameworks;* • *Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;* • *Update and maintain the Safeguarding Policy webpage;* • *Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards*		▪ Safeguarding Supervision Procedure – BCUHB Supervision ▪ Female Genital Mutilation (FGM) Standard Operating Procedure ▪ Best Interest Meeting Guidance – Deprivation of Liberty Safeguards (DoLS) • In addition, to the above policies, the following processes were approved at Safeguarding Governance and Performance Group in January 2019 and subsequently implemented: – Procedural Response to Unexpected Death in Childhood (PRUDIC) which have been published in line with National guidance. – Safeguarding Team; Area Domestic Abuse Workplace Safety Group. Terms of Reference (ToR) – Safeguarding Supervision Procedure – Safeguarding Only Supervision • Full engagement takes place across the organisation and with participation at the North Wales Safeguarding Adult Training Sub Group, this ensures internal and external expertise to be captured.	
HASCAS 7: Tracking of Adults at Risk across North Wales Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will work with multi-agency partners through the North Wales Adult Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.*	Fully implemented	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – BCUHB worked in collaboration with North Wales Safeguarding Adult Board to coordinate a Task and Finish Group for shared learning with regard documentation and communication. – This Task and Finish Group has now been disbanded due to completion as agreed by the North Wales Safeguarding Adult Board. – The Lead Practitioner programme has been developed in collaboration with the North Wales Safeguarding Adults Board (NWSAB). Over seventy key BCUHB staff have been identified to participate in the pilot and undertake the Lead Practitioner training, which will be implemented by July 2019. – This programme represents a major change in how Adults at Risk are coordinated and managed across the Health Board and will result in a more individualised and improved experience for the patient. • The programme will continue to be rolled out, implementation is a priority for 2019-20.	
HASCAS 8: Evaluation of Revised Safeguarding Structures / Ockenden 6: Safeguarding Structures Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.*	Expected to be fully implemented by November 2019	• The Senior Safeguarding Structure is now being implemented with pace. The outstanding posts for Head of Safeguarding Adults and Head of Safeguarding Adults MHLD have been advertised and the recruitment process is underway and is expected to be completed by August 2019. • A full evaluation of the existing 2017 Organisational Change Policy Safeguarding Structure is to be finalised and reported upon and presented to QSG when completed. • A 7-day on-call / flexible working arrangement will be costed and implemented to support Safeguarding service delivery. • Identified Safeguarding Job Descriptions will be reviewed and amended to support a fit for purpose Safeguarding Team and will be completed by September 2019. • Based on the approval at Quality & Safety Group (QSG) of the findings and recommendations of the Structure Evaluation paper, the refreshed job descriptions will be implemented. This is expected to be completed by November 2019. • The Named Doctor Adults at Risk job description, implementation and engagement requires a further review prior to recruitment/appointment. It is expected to be completed by September 2019.	

HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee, 16th July 2019

Recommendation	Current position	Progress update	Risks
HASCAS 9: Clinical Records Operational Lead: Dylan Williams, Chief Information Officer *Restructure and redesign of paper records archiving and retrieval systems*	Expected to be fully implemented March 2020	• Recruitment to the *Deputy Head of Health Records* post has been successful with the appointment of an internal candidate. Discussions are in place to confirm a start date which is hoped will be agreed as soon as possible. • Funding for the B7 Project Manager post has been confirmed in principle. Once this post is appointed to, and able to start the work, Mental Health services will be the priority area. It is expected to be completed by March 2020. • Confirmation that responsibility for the management of all patient records is within the remit of the Executive Medical Director. • Request has been made to Clinical Audit to include within the Clinical Audit Team corporate project to: *(i) review the content of the audit; (ii) explore if it can be extended to checking comingling; (iii) be extended to cover all casenote types on all sites; and (iv) agree the reporting lines (governance) of your audits.* Discussion due to take place beginning of July to progress further. • Following significant issues in processing through TRAC recruitment system, all recruitment is now complete. The new ATHR service will commence as a pilot in Central in August / September with an anticipated roll out to East and West in October. The readiness assessment is high and detail will be presented for assurance in the Patient Records Group in July.	
HASCAS 10: Prescribing and Monitoring of Anti-psychotic medication Operational Lead: Berwyn Owen, Chief Pharmacist *A) The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.* *B) BCUHB will continue to work with care homes across North Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of anti-psychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit.*	Expected to be fully implemented by end of September 2019	• Antipsychotic prescribing has been audited, in accordance with the BCUHB MM010 guidance, across all OPMH dementia wards in March 2019, a full report on the results is pending which is unfortunately delayed due to staff sickness. • CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and Community Mental Health Teams (CMHT) across MH&LD division which has limited uptake to date. Posters and reminders will be issued to wards and further audits undertaken to monitor completion of the forms. • CAIR forms will be sent out to care homes and discussions around education and training are in progress • Variation in practice regarding follow up and review of people on antipsychotics has been escalated to OPMH Consultant for action. A proforma is in development to report on the use of anti-psychotics and length of treatment which is being progressed through the care home subgroup of primary care pharmacists and will identify support and intervention required for care homes. The subgroup are meeting on 9th July. • A community pharmacy care homes National Enhanced Service (NES) is in place to monitor antipsychotic use in care homes and increase the number of pharmacies signed up to the NES. • Meeting has been arranged for 19th July with primary care pharmacists to discuss how pharmacy can support the delivery of the recommendations in primary care. • Discussions to be held with the Programme Manager for Recommendation 3 regarding the pilot of an Adverse Drug Reaction (ADRe profile) tool for use within care homes which has demonstrated a significant reduction in falls in Swansea to align with work ongoing for Recommendation 3. • Funding agreed in principle for the additional data analyst resource to support analysis of audit, this is being worked through with the Director of Mental Health. • Older Person's Mental Health services are partnering with people affected by dementia, academics from Bangor University, Clinical Psychology services and the Positive Interventions Clinical Support service to develop a training module exploring behaviour change in dementia. The module will support staff to understand that many changes are caused by unmet needs for the person to feel safe, understood and valued. The aim is that staff will acquire the skills to effectively identify trigger factors and ways of responding. As part of the module staff will acquire knowledge about the safe use of	Lack of pharmacy staff to deliver training for safe use of antipsychotic and support review • Resource requirement to support implementation of recommendations. • Business case in progress to support resources required to implement HASCAS recommendations. • Presentation distributed including care home subgroup. Community pharmacist uptake of the NES for care homes has been minimal so far. Care homes not trained to deliver care that reduces need for antipsychotics • MDT bid in place to support this (links to recommendation 2) • Discussions underway to confirm development of behaviour module or a standalone module on dementia and medicines

Recommendation	Current position	Progress update	Risks
		antipsychotic medication and introduced to an approach aimed at reducing the prescribing of these medications.	
HASCAS 11: Evidence Based Practice Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet.*	Expected to be fully implemented by December 2019	• Further sessions held with Governance Leads and most recently the NW Managed Clinical Services Group to discuss the new policy and the review and transfer of documents to the new site. A series of individual meetings continue to take place with each Lead to agree transfer of documentation, communication plan for key staff and removal of old links. In addition, a joint Informatics / Corporate Communications and Office of the Board Secretary meeting will be held for Governance Leads in order to discuss alternative options for storage post transfer (i.e. IT solutions for documents that are not suitable for the new Policy on Policies and other Written Control Documents (WCD) website). • Staff have been reminded that all clinical policies should be developed using a person centred approach. Existing Policies and WCDs are being reviewed to ensure the evidence-base in relation to older adults and/or those with dementia is specified and if necessary separate clinical policies and procedures developed with input from experts. • A Project Initiation Document (PID) has been drafted and a GANTT chart is being populated to ensure there are clear timelines documented as each cohort of policies and other WCDs are agreed for transfer by the relevant leads. Following agreement at the last meeting, discussions have taken place with the Communications Team regarding use of the Staff App to host the new Intranet page. This will be possible but only if the page is moved to the Internet. As a consequence this Group took a decision at the last meeting to defer the transfer of all documentation to the new site as all information will need to be reloaded to the new external website – it is important to note that this will involve a significant amount of time to upload the current policies that have been reviewed and approved and will be an ongoing process going forward in respect of uploading revised and new policies. The new website is expected to be available for testing/initial uploads in July 2019. • Leads are being advised of the change in direction i.e. to host all policies and other WCDs on the external website via targeted (governance leads) and BCUHB wide communications. No issues have yet been identified aside from data protection requirements – staff are being informed that any personal identifiable information must have consent from the owner/author/contributor etc. prior to uploading to the public site. A desktop exercise is to be undertaken to review documentation against the new Welsh Language Standards in terms of translation. An assessment / impact document is in development to identify priority areas and documents that must be translated.	
HASCAS 12 Deprivation of Liberties (DoLs) Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018-2019.* **Ockenden 9: Deprivation of Liberties** *BCUHB will complete a review of the 2017-18 DoLS work plan*	Expected to be fully implemented by November 2019	• A full review of the 2018-19 DoLS work plan is underway and will consider the demand, complexity and challenging nature of this specialist service. It is expected to be completed by September 2019. • An evaluation of new working practices will be carried out including the Mental Capacity documentation pilot and the Signatories training package which is expected to be completed by October 2019. • A paper to QSG (Aug 2019) will identify funds relating to DoLS signatory activity which have been previously held by the Office of the Medical Director • A new proposal for the DoLS service will be developed based on the outcomes of the review and evaluation. A proposal will be submitted to QSG in November 2019. • A review of Best Interest Assessors (BIA) job descriptions is underway and they have been submitted for re-banding in line with the Health Board's Organisational Change Policy for implementation on receipt of outcome. Following a refresh of BIA job description the final BIA will be appointed by October 2019 • Two impact assessments on the Liberty Protection Safeguards (LPS) legislation will be submitted to QSG. The first will provide a headline analysis in August 2019. The second will provide a detailed impact assessment after the Code of Practice has been published	The implementation of a revised DoLS structure, due to the recognition of the organisational demands and the required service delivery based upon the annual data of applications, training statistics, findings within reviews will have a cost pressure as the service is under resourced. The current resource cannot maintain the demand, high risk and complexity of cases.

Recommendation	Current position	Progress update	Risks
		in the Autumn. This will cover the full spectrum of the LPS implications. It is expected to be completed by November 2019.	
HASCAS 13: Restrictive Practice Guidance Operational Lead: Steve Forsyth Director of Nursing MH&LD *BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision.*	Fully Implemented	• The Improvement Group for the HASCAS & Ockenden recommendations held 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – The 2 recently developed policies relating to the positive reduction of challenging behaviours and physical restraint, have both been subject to governance scrutiny and review and are fully ratified and operational. – Training in proactive approaches has begun in earnest with a full schedule of training dates available for all clinical areas where a training need has been identified. Moreover, the corporate training team are receiving ongoing support from the Positive Interventions Clinical Support Service (PICSS) team and are on track to being able to independently to deliver this training to the wider organisation by the end of the calendar year. – Training in the use of Datix to report incidents of restrictive physical intervention is included. – Within the MHLD division, BCUHB PICU staff (Tryweryn) together with Caniad recently showcased to the Leaders Collaborative conference a number of initiatives being introduced to the wards – these included new ideas and approaches in reducing restrictive practices, improved co-production and a revised all Wales training syllabus in the prevention and management of behaviours which challenge. Furthermore, the excellent work being carried out by Tryweryn staff and Caniad has been shortlisted for the 2019 Nursing Times Awards'.	
HASCAS 14: Care Advance Directives Operational Lead: Dr Melanie Maxwell, Associate Medical Director *BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care*		• The monitoring process commenced November 2018 is ongoing to continue to capture data on End of Life paperwork for inpatient deaths, this includes 'What Matters', future care plans, Advance Care Plans (ACP), treatment escalation plans (TEP), care decisions, DNACPR etc. This will provide baseline data for improvement work and also enable the identification of patients for more in-depth review. • An end of life case note review for inpatient notes was held on 18th April and 10th May with clinical staff from palliative care and mental health teams, based on the 5 priorities of care for the dying person. Results have been analysed and an audit report is being finalised. Initial findings demonstrated that documentation of care was poor and difficult to follow. However, there was some evidence of good care and anticipatory prescribing but the need for end of life conversations to be held earlier. There was no evidence of obvious inequity of care between patients with or without a diagnosis of dementia. There was evidence that the involvement of specialist palliative care appeared to lead to earlier implementation of appropriate end of life care (EoLC). • The Audit Team agreed amendments to the audit pro-forma in light of some outcomes of this baseline review and a repeat audit will be undertaken in June 2020. • Two members from the Stakeholder Group were invited and keen to take part in the audit but were unfortunately unable to do so. • Discussions were held with the stakeholder group members at the HASCAS EoLC Task & Finish Group Meeting (held 14th May 2019) to share early findings of the case note review and determine what further actions are required to support delivery of the recommendations. The final case note review report will be discussed again at the next Task & Finish Group (which is being arranged for Autumn 2019)	Staff are unable to commit to additional data collection in a timely way.

Recommendation	Current position	Progress update	Risks
HASCAS 15: End of Life Care Environment Operational Lead: Dr Melanie Maxwell, Associate Medical Director *Improve end of life environment on OPMH wards and associated guidance training*		• The End of Life (EoL) / OPMH pathway has been developed alongside a standard operating procedure (SOP), an MDT / relatives joint risk assessment and a dedicated training module. The draft SOP was presented to Stakeholder Group in January 2019 for input and minor amendments made from stakeholder feedback. Further changes were made following discussion at the HASCAS EoLC Task & Finish Group which included valuable comments from two members of the stakeholder group who are members of the Task & Finish Group. The SOP includes real time audit of the process. The low number of deaths on an OPMH ward makes this realistic. The SOP identifies when DATIX is to be used. • Relative rooms have been developed on each OPMH 'organic' ward. Plans have been made for two members from the Stakeholder to review the rooms in July with the Consultant Nurse for Dementia and Head of Nursing Palliative Care. • A bespoke EoLC training programme developed for all older person Registered Nurses commenced 6th December 2018 and has run consistently from December 2018 to June 2019. An evaluation report is being completed but overall feedback has been very positive and staff have engaged well. A further session will be held in September for OPMH medical staff – details currently being agreed and then training will be advertised. • Work in relation to EoLC has been presented to a number of groups and committees across BCUHB and identified some minor changes to the SOP and a gap in knowledge to access community stores at weekends. • A proposal for Strategic and Operational Delivery Groups for Palliative and EoLC has been developed and approved by EMG on 3rd July 2019. Draft Terms of Reference have been produced and dates will now be set for meetings to commence in September 2019. • Agreement received for the recruitment of a dementia specialist Admiral Nurse to provide expert practical, clinical and emotional support to families living with dementia. This is being progressed in partnership with St Kentigerns' Hospice for End of Life care and will be joint funded by MH&LD / Area and the Hospice for 2 years. Interviews to be held in July 2019.	Staff not being released for training. • Training is mandated on OPMH wards for Registered Nurses.
Ockenden 2a: Quality Impact Assessment Operational Lead: Dawn Sharp, Deputy Board Secretary *QIAs (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB board) were 'still in the process of refinement' (as of Spring 2017). Evidence is required of focussed Board attention going forward.*	Expected to be fully implemented by November 2019	• An update to HASCAS/Ockenden Improvement Group in January confirmed that a system is in place for Quality Impact Assessment (QIA) of savings schemes. Progress will be measured from samples of completed QIAs and a record of outcomes. Monitoring will also take place as part of the internal audit programme 2019/20. The audit is timetabled for Q1-2 in the draft IA plan for next year which was approved by the Audit Committee on 14th March 2019.	
Ockenden 2b: Integrated Reporting Operational Lead: Dawn Sharp, Deputy Board Secretary *There is a need for further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.*		• Two cycles of the new health economy process have been undertaken during February and June 2019 and further review will be undertaken in August. • Learning from the February reviews resulted in improvements in June with the development of an action log, decision log and risk log. The annual plan actions are also being actively tracked and reported to increase accountability for delivery	

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Recommendation	Current position	Progress update	Risks
Ockenden 3: Policy Review Operational Lead: Dawn Sharp, Deputy Board Secretary *Ensure a review of all clinical policies within all BCUHB divisions to include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review.* *This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.* *BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies.*	Expected to be fully implemented by December 2019	• This recommendation dovetails with HASCAS Recommendation 11 (above) and will be progressed in tandem with the other recommendations in the report relating to corporate governance. • Under the sponsorship of the Executive Director of Nursing and Midwifery, and with the Deputy Board Secretary acting as the operational lead, a programme of work commenced in July 2017 to review existing arrangements for the creation, cascade, access and storage of policies, guidance documents, protocols, and other written control documents. • The breadth, volume and complexity of the work was recognised and it was agreed that in order to progress the work successfully, governance/policy leads would need to be identified in each Directorate. This was achieved in Autumn 2017 and an initial training session was held with the leads in November 2017 to outline the requirements to review all policies and procedures both clinical and non-clinical within their remit and bring them up to date, or confirm that they remained extant. In doing so leads were asked to identify current locations of all policies to be removed both, in paper copy or online, on the Health Board's intranet pages. • In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based. • Work has also been undertaken to construct a new intranet page which will host all Health Board wide policies and other associated documentation in one location making the documents more accessible and easy to find. This will be hosted on the new external website at the point the new website goes 'live' which will enable staff to access the page via the Staff App.	Clinical staff not being aware of the transfer of key policies to the new site • Targeted communication plan for each transfer to be agreed with the leads. Redirect system to be in place (from existing location) where possible Resources to review policies and bring them up to date (across the wider organisation) • Meetings continue to take place with leads to agree the programme of transfer of documentation to the new site and to prepare communication plans and identify any issues
Ockenden 10: Reviewing external reviews Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns.* *The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.*	Proposed as fully implemented (pending approval at Improvement Group on 31st July)	• Following the review undertaken by the Corporate Nursing Team to strengthen assurances, the BCU / HIW management plan was introduced to provide additional assurance processes continues to be implemented. • All open / outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. • It was agreed at the Improvement Group meeting held on 29th January that a period of time is required for embedding this work and as a result this action should continue to remain open to ensure ongoing monitoring. This will be reviewed at the next meeting in July to seek approval that the recommendation is fully implemented with the assurance of ongoing monitoring.	

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Recommendation	Current position	Progress update	Risks
Ockenden 14: Board Development Operational Lead: Dawn Sharp, Deputy Board Secretary *The work of Swaffer and the WHO/ United Nations should be introduced to the Board in a Board seminar/ Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018- 19 with reports to the Board on the introduction and utilisation of 'Prescribed Dis-engagement' every quarter.*	Fully Implemented	• The Executive Director of Nursing and Midwifery determined that this ambition would be best met by the full Board participating within a dementia friendly awareness session which was delivered on 10th January 2019. • At the Improvement Group meeting held on 29th January it was formally approved that this recommendation was fully implemented as the action has been completed for required Board members. However, the Executive Director of workforce & OD agreed to take forward an action to consider how to incorporate dementia awareness sessions into the Health Board's induction programme. • A dementia friendly awareness session for senior managers as members of the Executive Management Group took place on 3rd July.	
Ockenden 2c Workforce Development Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, timely and effective recruitment processes in place at all times to support MH&LD going forward.*		• The BCUHB Workforce strategy was approved by the Board in March 2019. Workforce objectives and actions to deliver year 1 of the Strategy are established. • MHLD Division has successfully appointed MHLD nursing students who will become eligible for registration and employment in September 2019 through the central recruitment campaign. Work continues to allocate students to preferences were possible into the available band 5 vacancies across the MHLD Division. This process will continue as the summer months progress • An Improvement Lead Programme Manager and four TODAY ICAN Change Facilitators commenced in roles within the MH&LD division and are working to support each of the triumvirate teams. • Tier 5 / 6 restructuring has been signed off by Divisional Directors, consultation process has now closed and themes are being developed from feedback. • A continued focus remains on engaging frontline staff and operational managers in training to develop skills and processes that are required to understand service demand and capacity, in order to improve flow within the CMHTs. Work continues to build on current learning and will be used to support further improvements in the delivery of care within the current system and also the work of our Quality & Workforce Group to redesign services. • Revised substantive clinical leadership and management structure is now in place within the MH&LD division with dedicated project management support in place to enable triumvirates to engage with the Quality Improvement Governance Plan and produce Divisional Action Plans.	
Ockenden 4a: Staff Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The BCUHB board and the MH&LD divisional senior management team is recommended first to ask front line staff 'what does the term 'staff engagement' mean to you, 'what would effective staff engagement look like for you?' and then to develop a system of bespoke meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is*		• The Board approved the Staff Engagement Strategy in August 2016. The strategy identified key activities and achievements required to successfully realise the strategy. The Board have received six monthly updates on progress and achievements since the launch of the strategy. One of the elements included in the strategy was the adoption of a tool which would give the Health Board the ability to measure staff engagement on an ongoing basis. • The 'Go Engage' tool developed by Wrightington, Wigan and Leigh NHS Foundation Trust has been rebranded and implemented for BCUHB as 'ByddwchynFalch / BeProud' in order to maintain consistency with the Proud of theme adopted as part of the staff engagement strategy. The tool offers: – a simple way to understand the science behind staff engagement in terms of cause and effect – Clear practical recommendations to improve staff engagement – Regular trend analysis – not a once a year/two years snapshot in time.	

HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee, 16th July 2019

Recommendation	Current position	Progress update	Risks
required to staff engagement across the whole of BCUHB		– Ability to act quickly on data, two week turnaround from close of survey to presentation of results – Organisational and team level diagnosis of culture • The 'Be Proud' Pioneer Programme is specifically aimed at teams to improve and sustain staff engagement so that they can better understand challenges and barriers to engagement and provide support to build improved engagement behaviours. The programme runs over a 26 week period and starts with a cultural team survey and comprises workshops for 2.5 days, 3 action learning sets and a celebration event. • As part of the ongoing priority work relating to the HASCAS / Ockenden recommendations and in an effort to support unscheduled care, teams were nominated from 10 priority areas to undertake the first Pioneer Team Programme which commenced in March. Cohort 2 started their Pioneer journey on the 19th June 2019 and will run until 12th December 2019. • The Pioneers have used the 3D model to carry out listening events with their team to gain buy-in to the programme and clarify priorities going forward. They are in the process of gathering feedback which will inform their 'you said we did'. Example case studies are available which highlight what the Pioneers did and the reasons why they felt it was important. • The Pioneer teams have commenced several initiatives to engage teams and celebrate success. Noticeboards have been created to share Be Proud news and positive staff stories as well as highlight staff recognition. Many have also started the 'You've been Mugged' campaign which involves someone who has gone the extra mile being awarded a mug filled with goodies at the end of the week which has been well received. • The Pioneers have been taught the process of action learning and recognise the benefits of using it collectively to solve problems and remove barriers. These sessions are also an opportunity to update their peers on their progress so far, and gain useful feedback.	
Ockenden 4b & 4c: Staff Surveys Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The Ockenden review team was informed that the NHS staff survey across Wales is completed every 3 years and is next due in 2019. WG may wish to consider an annual staff survey in line with that carried out in England.* *Aside from any potential decision by WG, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales staff survey at BCUHB on an annual basis from 2020.*	Proposed as fully implemented (Pending approval at HASCAS Improvement Group on 31st July)	• The relevant actions have now been completed to address the requirements of this recommendation and it is being proposed that this recommendation now be signed off as fully implemented. This will be formally reviewed for approval at the next Improvement Group meeting on 31st July. An update of the progression of the actions is provided below; • The 2018 NHS Wales annual staff survey has been undertaken and the results revealed a number of positive improvements since the 2013 and 2016 survey. Whilst BCUHB are behind the overall NHS Wales scores on some questions, we have made significant improvements in many areas. The engagement index score also saw an increase from 3.51 to 3.76 and whilst still behind the NHS Wales score, the rate of improvement, is greater than or equal to that seen across Wales. • The top three areas for improvement at an organisational level were identified and the main focus of the improvement plan with identified measures; 1. Work related stress 2. Harassment, bullying or abuse 3. Executive Team visibility and engagement • The Organisational Survey has been redesigned and tailored to the Health Board's needs with additional Wellbeing and Equality & Diversity questions. The first Organisational engagement survey report will be available in July 2019. The main aim of the survey is to review trends of staff engagement across BCUHB and identify the factors that may be enabling or inhibiting staff engagement. The report will highlight staff	

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		engagement measures across staff groups and divisions and will highlight areas for development for the Organisation. • Draft organisational and divisional plans were submitted to SPPH Committee on the 5th February 2019 with final plans being submitted and approved by the Board on the 28th March 2019. Monitoring progress against the organisational improvement plan and divisional improvement plans will take place at the Workforce Improvement Group. • It is important to note that the survey content, administration and execution is under complete review nationally. The Cabinet Secretary has been clear of the expectation that staff locally need to be involved in driving the change and improvements required to improve experiences at work. NHS Wales has historically facilitated pan-organisational surveys bi-annually. These have been contracted out to organisations who have provided pan-NHS Wales and organisational reports. There has also been access to the results database to allow more localised interrogation of the data, but this has not allowed organisations to drill down fully to team and departmental level in a meaningful way. • Furthermore organisational level quarterly surveys of 25% of the staff within BCUHB which include priority areas have been identified to include HASCAS/Ockenden review; Older People Mental Health pathway and Unscheduled Care. • In addition, as part of the 'Be Proud' Pioneer Programme, surveys are undertaken locally in teams to establish an engagement baseline measure which the pioneers are working on to develop local improvement plans which focuses on the three lowest scores within their survey. Each team takes ownership to agree which engagement tools they will use to make improvements. At the end of 26 weeks another team survey is undertaken and comparisons are made against the first survey. All ten teams have fully engaged with the programme and the response to the programme by the Pioneers and their teams has been excellent and very encouraging.	
Ockenden 4d: Clinical Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB*		• The 3D (Discover, Debate, Deliver) Framework has evolved into a flexible staff listening methodology widely used throughout the Health Board by Staff Engagement Ambassadors and anyone who wishes to access the comprehensive and interactive toolkit, which is available on-line and bilingually on request. The toolkit includes flowcharts, question banks, templates and all relevant information for utilising 3D. • A range of resources are available via a webpage as well as induction sessions to learn about staff engagement and the 3D framework. • Collating case studies and outcomes, using the 'You Said, We Did / What Happened Next' approach, forms an integral part of the 3D toolkit for feedback and to also capture progress and impact during and after any event. To promote organisational learning these case studies and outcomes can be found on the intranet pages – there are currently 39 either in progress or complete. The case studies emphasise how flexible 3D can be to fit around specific service needs. • The promotion of 3D has been undertaken widely across Senior Leadership Teams as well as holding roadshows, team away days, site visits and was included as part of the first BCUHB Annual Medical and Dental Conference held in partnership with NHS Wales Confederation and BMA Wales. The toolkit is also integrated into Leadership & Management Programmes, included in relevant Senior Leadership Masterclasses as well as being included in the Quality Improvement (QI) Hub. • Close links continue to be made with other initiatives across the Health Board such as Mental Health & Well-being Champions, Today ICAN and the Improving Quality Together team. The aim is to build better relationships and become better connected with colleagues from across the Health Board to bring about positive change and increase staff satisfaction, which in-turn has a direct impact on our patients	

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		• 3D (as well as other internal engagement tools) is also an integral part of the Be Proud Pioneer team toolkit. • The Generation 15 Ward Manager programme has been designed to develop management and leadership skills and competencies to enable individuals to build effective capability within their roles as clinical leaders. It provides practical skills and tools which enables the Ward Manager to manage and lead their team effectively in order to improve patient outcomes. This programme, is now called the **Ward Managers Development Programme** and has been refreshed following feedback and consultation with the Executive Director of Nursing, Deputy Director of Nursing and the corporate nursing team. The new programme commenced in March 2019 with 19 delegates attending. A further cohort is planned for July 2019. • Building on the Ward Manager Leadership Development Programme the first cohort of this brand new **Matron Leadership Development programme** will commence in November 2019. • A bespoke engaging leadership development programme 'Leading for Transformation' has been developed in partnership with our external provider Carter Corson Business Psychologists. The programme supports the ambition to develop an engaging, inclusive and compassionate leadership style across the organisation through enhancing the capability of leaders to deliver results, by better engaging with their staff at an individual and team level, as well as with partners and stakeholders across sites, sectors and services. • Carter Corson hosted a pre-programme session with the Executive team on the 27th March 2019. This session introduced some of the key components of the programme and provided an opportunity for Executive directors to ask questions and clarify expectations. This also ensured alignment of the programme to key priorities and the need for executive sponsorship to drive leadership behaviour and improvement.	
Ockenden 13: Culture Change Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way.* *The cultural change that is necessary towards dementia needs to happen across BCUHB and to happen from Board to Ward. This cultural change needs to happen not just within MH&LD but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.*		• The national Staff Survey Project Group is leading on implementing approaches which develop and build an "in-house" ongoing sustainable approach to measuring colleague experiences which was agreed by the Welsh Partnership Forum in November 2018, in line with Welsh Government strategies. The new approach will help develop the NHS Wales culture so that colleagues regularly give and receive feedback. • The Organisational Improvement Plan has been developed following a number of staff engagement events held during December 2018 as well as drawing on data from the qualitative element of the staff survey. The Improvement Plan was approved by Board in March 2019 and a number of improvement actions have since been met. As the organisation approaches the end of the first quarter, a process is in place to feedback these outcomes to our staff through as many communication channels as possible. The Organisational Development team have worked closely with the Communications team to develop a Communication Strategy to support this. • Furthermore, the Organisational Development team engaged with and supported divisional managers to ensure divisional improvement plans are drafted and discussed with staff locally and worked up into final plans. Staff engagement events were held locally to further inform and develop local plans. All divisions are progressing their improvement plans and developing their communication approach to ensure staff receive feedback on local actions. The '*You Said, We Did'* template has been shared with divisions but any local communications channels can be used to update staff. The Workforce Improvement Group will monitor progress against the Divisional Improvement plans • As part of the Quality Improvement and Governance Programme (QIGP), a Quality Improvement Strategy will be developed through an established collaborative task & finish group in consultation with staff, partners and people with lived experience of using	

Recommendation	Current position	Progress update	Risks
		our services which will continue to meet monthly to ensure the production of an MHLD Quality Strategy. The 10 themes of the QIGP have been fully mapped out for actions which are reviewed in 90 day cycle meetings. The next meeting is in June. • The Strategy will assure our stakeholders of our continued determination to focus on delivering high quality patient care and challenging ourselves to achieve the highest of standards. It is aimed to launch the strategy in July. • The Health Board is strengthening its offer of skilled level dementia training for clinical staff. Current training is aligned to the 'Good Work' framework and we are developing our modules further by placing additional emphasis on the important role of the carer. To support this work is underway with TIDE, an involvement network for carers of people living with dementia, hosted by the Life Story Network CIC. Its mission is to be the voice, friend and future of all carers and former carers of people with dementia. TIDE is supporting carers to share their experiences by training them to acquire appropriate skills and competencies in delivering training. The project is overseen by the Consultant Nurse for dementia. • As part of the celebrations for the 70th anniversary of the NHS last year, all members of the Executive Team participated in a 'Back to the Floor' initiative to celebrate with staff, families and volunteers the incredible work conducted by our staff and volunteers on a daily basis. Further to this, a proposal has been made to continue with a rolling programme of a refreshed approach which will be known as 'Walk in my Shoes' for all Executives and Senior Leaders • This will involve each member of the Executive Team undertaking a 'shift' of a minimum half day within a range of services, both patient facing and non-patient facing such as catering, estates and administrative services. The aim is to undertake a shift which presents an opportunity for high visibility or within hard to reach/remote areas such as community teams. The whole ethos of the shift will be to integrate with the team and undertake tasks that the team would normally perform on a day to day basis. This will not only improve visibility but will also allow staff to get to know Executives/Senior leaders on a more personal level.	
Ockenden 5: Partnership Working Operational Lead: Sally Baxter, Assistant Director Health Strategy *BCUHB needs to work effectively at a strategic level with the voluntary sector and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales.*		• The Executive Management Team at the meeting on 5th June supported the proposal to devolve the centrally held Voluntary Organisation budget and establish a commissioning forum. This will support local ownership, management and decision-making in relation to these budgets and services and increase assurance and governance in relation to service expectation and outcomes for the relevant population across all such grants and contracts. There has been some initial positive recognition in respect of this proposal from some representatives of the third sector, raised during discussions on the refresh and review of strategic working with the sector which are currently underway. • A number of network events have taken place including; – an engagement practitioners' network event in the West Area on 11trh June. – Conwy CVC network event on 13th June – Denbigshire third sector network event on 26th June • Feedback will be collated and analysed from all third sector events and an outcome report produced. • A meeting is being arranged to discuss third sector issues for Mental Health	Complexity of the Health Board presents challenges in developing a fully embedded approach – Develop a set of principles to be adopted across the Health Board Partnership approaches differ across the 6 counties – Ensure corporate arrangements are supportive of and link closely with county based arrangements Objectives need review and refresh to reflect the wider strategic approach – Include wider strategic development within objectives

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Ockenden 7: Concerns Management Operational Lead: Deborah Carter, Associate Director Quality Assurance *Whilst it is acknowledged that on many occasions since 2009, BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis.* *It is clear that the BCUHB Board have very little knowledge of the **actual** everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised the reluctance of families and service users to complain and the fear they have of complaining.*		• Work continues to progress to respond to the actions identified to better manage concerns in a timely and effective manner. • Revised trajectories have been set to deliver real time management of complaints and incidents which are being monitored via weekly incident review meetings. The current position against trajectories is as follows; – No WG incidents overdue by end of June 2019 – 95 as at 3rd July – No complaints graded as 1 or 2 overdue – 144 overdue as at 3rd July – No more than 15 complaints graded as level 3 overdue – 96 overdue at 3rd July – No more than 30 complaints graded as 4/5 overdue – 24 overdue at 3rd July – No more than 5 complaints overdue by over 6 months and must be grade 5 – 1 overdue at 3rd July 19 • The number of open and overdue incidents has decreased from 6,130 in October 2018 to 4,978 in June 2019. There has also been a decrease in the number of open Welsh Government closure forms from 611 in January 2019 to 163 as at 3rd July 2019 (of which 95 are overdue). • Putting Things Right (PTR) 1 revised policy has been approved by QSE committee. • PTR1a procedure for staff has been developed to simplify the process for staff and will be presented to Quality Safety Group in August. Standard Operating Procedure for writing a complaint response has been implemented within corporate concerns team. • Recruitment process for the appointment of Patient Advice & Liaison Service (PALS) officers is now complete with all vacancies appointed to. • The PTR Annual Report was approved by the May QSE committee and will be presented to Board.	Capacity within divisions to prioritise investigation and report writing for Concerns (against operational priorities) – Trajectories developed by division to deliver required deadlines by week commencing June 17th Quality of historic information to support robust learning – Training and support in place for investigation of new cases. Corporate team offering support to divisions to review historic cases, identify learning and move to closure
Ockenden 11: Estates OPMH Operational Lead: Rod Taylor, Director of Estates & Facilities *BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns with internal audits and external reviews and inspections.* *The estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes where care is provided to people with dementia.* *The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.*		• A number of actions have been completed for Workstream 1, as follows; – A multi Directorate/Divisional working group that includes Operational Estates, Estate Development and Mental Health and Learning Disabilities is established with agreed Terms of Reference which will be updated as the worsktreams progress. – A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is progressing through Operational Estates to complete any outstanding jobs and the schedule is updated monthly to monitor progress and report to the group. – A detailed inventory of previous External Audits and Inspections by HIW & CHC relating to MH&LD OPMH facilities has been prepared and all outstanding actions are now completed. • Funding of £200k has been identified in the 2019/20 Revenue budget setting process to undertake additional repairs and maintenance in MH&LD establishments and to commence the assessment of a Safe Healing Environment. Procurement and planning will now be undertaken for this work to support work stream 2. • Funding agreed in principle for the additional project management capacity to support the project and actions required in Workstream 2, this is being worked through with the Director of Mental Health. • With regards to workstream 2, a report is being prepared to seek approval to draw down additional revenue funding to undertake the ward assessment and undertake additional repairs and maintenance. This will be submitted to EMG for approval in August.	Project management capacity – Paper to go to executive team for review of resources required Capital and Revenue funding to undertake identified works – Revenue funding bids have been included within Estates and Facilities budget cost pressures for 2019/20

Quality, Safety & Experience Committee **16.7.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board To improve health and provide excellent care

Report Title:	Summary of In Committee business to be reported in public
Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
Approval / Scrutiny Route Prior to Presentation:	The issues listed below were considered by the Committee at its private in committee meeting on 21.5.19 • Individual cases being managed under the 'Dealing with Unreasonable Behaviour procedure and guidance for staff' • Update on media inquest • Executive briefings • Briefing on endoscopy services • Briefing on follow up delays
Governance issues / risks:	None identified
Financial Implications:	None identified
Recommendation:	The Committee is asked to: 1. Note the information in public.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	✓	1.Balancing short term need with long term planning for the future	✓
2.To target our resources to those with the greatest needs and reduce inequalities	✓	2.Working together with other partners to deliver objectives	✓

3.To support children to have the best start in life	✓	3. Involving those with an interest and seeking their views	✓
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services	✓	5.Considering impact on all well-being goals together and on other bodies	✓
6.To respect people and their dignity	✓		
7.To listen to people and learn from their experiences	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance			
Equality Impact Assessment No equality impact assessment is considered necessary for this paper.			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board