Bundle Quality, Safety & Experience Committee 24 September 2019

9.30am Boardroom, Carlton Court LL17 0JG

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 QS19/126 Chair's Opening Remarks

1.2 QS19/127 Declarations of Interest

1.3 QS19/128 Apologies for Absence

1.4 09:30 - QS19/129 Minutes of Previous Meeting Held in Public on the 16.7.19 for Accuracy, Matters Arising and Review of Summary Action Log

QS19.129a Minutes QSE 16.7.19 Public V0.03.docx

QS19.129b QSE Summary Action Log Public.docx

1.5 09:40 - QS19/130 Patient Story : Mrs Gill Harris

QS19.130 Patient story.docx

2.0 FOR DISCUSSION

2.1 09:55 - QS19/131 Mental Health & Learning Disabilities Division Exception Report - Mr Andy Roach

Recommendations:
The Committee is asked to note:
1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to:
- *Compliance with Mental Health Measure*
- *Lessons Learned from incidents*
- *HIW outstanding actions*
- *Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan*

2. The risks that are identified are being managed through locality structures and overseen by Divisional Directors

QS19.131 Mental Health.doc

2.2 10:25 - QS19/132 Annual Plan Monitoring Report : Dr Jill Newman

Note to members - the attachment is a copy of paper previously scrutinized by Health Board on 5.9.19 - for information

QS19.132 Annual Plan Progress Monitoring Report - July2019 FINAL.pdf

2.3 10:30 - QS19/133 Integrated Quality & Performance Report : Dr Jill Newman

Recommendation:
The Committee are asked to note the current performance and consider the actions being taken to deliver improved performance. The committee are asked to determine areas of concern for escalation to the Board.

QS19.133a IQPR Coversheet.docx

QS19.133b IQPR updated 18.9.19.pdf

2.4 11:00 - QS19/134 Concerns, Litigation, Incidents, Coroner and Healthcare Inspectorate Wales (CLICH) Report : Mrs Gill Harris

Recommendation:
The Committee is asked to note the content of the report

QS19.134a CLICH coversheet.docx

QS19.134b CLICH Q1.docx

2.5 11:20 - QS19/135 Occupational Health and Safety Gap Analysis Report : Mrs Sue Green

Recommendation:
The Committee is asked to:
1. Note the position outlined in Gap Analysis Report.
2. Support the proposed improvement plan and findings of the gap analysis of legislative compliance and subsequent proposed project plan and time line.

QS19.135a H&S report.docx

QS19.135b H&S Appendix 4.pdf

2.5.1 11:40 - COMFORT BREAK

2.6 11:50 - QS19/136 HMP Berwyn : Health and Wellbeing Service Her Majesty's Inspectorate of Prisons Inspection Report and Action Plan : Dr Chris Stockport

Recommendation:
The Committee is asked to receive and note the report.

QS19.136a HMP Berwyn.docx

QS19.136b HMP Berwyn_HMIP Action Plan Recommendations_Appendix 1.docx

QS19.136c HMP Berwyn_HMIP Report_Appendix 2.pdf

QS19.136d HMP Berwyn Action Plan_Appendix 3.docx

2.7 12:00 - QS19/137 Medicines Management Key Risks : Dr David Fearnley

Berwyn Owen in attendance

Recommendation:
The Committee is asked to note the report.

QS19.137a Medicines Management coversheet.docx

QS19.137b Medicines Management.docx

2.8 12:15 - QS19/138 Royal College of Obstetricians / Royal College of Medicine (RCOG/RCM) Review of Maternity Services at Cwm Taf Health Board (15-17 January 2019) : Report Published by Welsh Government on 30th April 2019 : Q 2 Update

Recommendation:
The Committee is asked to note the assurances provided by the Directorate and support the identified areas for improvements.

Note - some appendices contain reference to embedded items which are available to members on request

QS19.138a Maternity services coversheet.docx

QS19.138b Maternity services Appendix 1.pdf

QS19.138c Maternity services Appendix 2a.pdf

QS19.138c Maternity services Appendix 2b.pdf

QS19.138d Maternity services Appendix 3.pdf

QS19.138e Maternity services Appendix 4.pdf

3.0 FOR CONSENT

3.1 12:35 - QS19/139 Quality & Safety Group Assurance Reports July and August 2019 : Mrs Gill Harris

QS19.139 QSG Chair's reports.doc

3.2 12:45 - QS19/140 Progress report of recommendations arising from HASCAS independent investigation and Ockenden governance review : Mrs Gill Harris

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

QS19.40a HASCAS Ockenden coversheet.docx

QS19.140b HASCAS Ockenden.docx

3.2.1 13:05 - **Lunch Break - members/attendees to make arrangements to bring their own refreshments**

3.3 13:25 - QS19/141 Ward Accreditation, Health Acquired Pressure Ulcer (HAPU) Collaborative & Falls Collaborative update : Mrs Gill Harris

Recommendation:
The Quality, Safety & Experience Committee are requested to continue to support the ward Accreditation process and implementation of the Improvement Collaboratives.

QS19.141 HAPU and Falls Collaboratives.docx

3.4 13:35 - QS19/142 BCUHB Response to Healthcare Inspectorate Wales (HIW) Annual Report 2018-19 : Mrs Gill Harris

Recommendation:
The Committee is asked to note the contents of the HIW Annual Report and to the Health Board's response to the report.

QS19.142a HIW Annual Report coversheet.docx

QS19.142b HIW Annual Report 2018-19 Appendix 1.pdf

3.5 13:45 - QS19/143 Public Sector Ombudsman Wales Annual Letter 2018-19 : Mrs Gill Harris

Recommendation:
The Committee is asked to note the Annual letter and the actions taken by the Health Board for information.

QS19.143a PSOW annual letter.docx

QS19.143b PSOW Annual Letter 2018-19.pdf

3.6 13:55 - QS19/144 2019 Annual Nurse Staffing Levels(Wales) Act 2016 Reporting framework : Mrs Gill Harris

Recommendation:
The Committee is asked to amend its cycle of business in respect of the compliance report for Nurse Staffing Act 2016.

QS19.144 Nurse Staffing levels Act 2016.docx

3.7 14:00 - QS19/145 Accessible Healthcare Annual Report incorporating Wales Interpretation Translation Service Report : Mrs Gill Harris

Recommendation:
To endorse the controls/corrective actions highlighted in this report, and to ensure that staff, managers and other stakeholders recognise and act on their responsibility to ensure that service users with sensory loss are able to access our services on the same basis as all other service users.

QS19.145 AHCS and WITS.docx

3.8 14:10 - QS19/146 Policies, Procedures or Other Written Control Documents for Approval : Mrs Gill Harris

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

QS19.146 Policies_coversheet.docx

3.8.1 QS19/146.1 Organ Donation Policy

QS19.146.1a Organ Donation Policy specific coversheet.docx

QS19.146.1b Organ Donation Policy v14.Final.docx

QS19.146.1c Organ Donation Policy EQIA.pdf

3.8.2 QS19/146.2 Handcuffs Policy

QS19.146.2a Handcuff Policy Specific Coversheet.docx

QS19.146.2b Handcuff Policy.docx

QS19.146.2c Handcuff Policy EQIA.doc

3.8.3 QS19/146.3 Threats to the Person in Forensic Establishments Policy

QS19.146.3a Threats to Person in Forensic Establishment Policy coversheet.docx

QS19.146.3b Threats to the person in Forensic Establishments Policy.docx

QS19.146.3c Threats to the Person in Forensic Establishments EQIA.doc

3.8.4 QS19/146.4 Major Incident Protocol – Ty Llywelyn Medium Secure Unit

QS19.146.4a MHLD Major Incident Protocol Coversheet.docx

QS19.146.4b MHLD Major Incident Protocol.doc

QS19.146.4c MHLD Major Incident Protocol EQIA.doc

4.0 14:15 - FOR INFORMATION

4.1 QS19/147 Issues Discussed in Previous In Committee Session

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

QS19.147 In Committee items reported in public.docx

4.2 QS19/148 Documents Circulated to Members

12.6.19 Concerns Trajectories
4.7.19 Policy approval process
9.7.19 Gosport briefing
9.7.19 Homeless & Vulnerable Groups qualitative report
9.7.19 Complaints handling / PSOW letter
16.7.19 QSG notes May and June 2019
24.7.19 Copy of endoscopy paper with formatting corrected
17.9.19 QSG notes July and August 2019

4.3 QS19/149 Issues of Significance to inform the Chair's Assurance Report

4.4 QS19/150 Date of Next Meeting

Tuesday 19.11.19 @ 9.30am

4.5 QS19/151 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 16.7.19 in The Boardroom, Carlton Court, St Asaph

Present:

Mrs Lucy Reid	Independent Member (Chair)
Mrs Jackie Hughes	Independent Member
Mrs Lyn Meadows	Independent Member

In Attendance:

Mr Peter Bohan	Associate Director of Health, Safety and Equality (deputising)
Mrs Deborah Carter	Acting Executive Director of Nursing and Midwifery
Mrs Kate Dunn	Head of Corporate Affairs
Ms Liz Fletcher	Assistant Area Director – Children (West) (*part meeting*)
Mr Steve Forsyth	Director of Nursing, Mental Health and Learning Disabilities (*part meeting*)
Dr Arpan Guha	Deputy Executive Medical Director (deputising)
Ms Fflur Jones	Wales Audit Officer (Observing)
Dr Jill Newman	Director of Performance
Ms Carolyn Owen	Head of Patient and Service User Experience (*part meeting)*
Miss Teresa Owen	Executive Director of Public Health
Mr Andy Roach	Director of Mental Health and Learning Disabilities
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Rod Taylor	Director of Estates and Facilities (*part meeting)*
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Mr Mark Thornton	Chair of Community Health Council (CHC)

Agenda Item Discussed	Action By
QS19/95 Chair's Opening Remarks **QS19/95.1** The Chair welcomed everyone to the meeting. She went on to note with some disappointment that she continued to have concerns over the quality of many of the submitted papers, even though guidance had been provided to authors to try and ensure they met the requirements of the Committee. The Chair emphasised the importance of ensuring robust reporting to the Committee in order to provide assurance to the Board on quality and safety matters. This would be formally escalated as part of the Chair's assurance report to the Board. **QS19/95.2** Chair's action was reported regarding approval of the Covert Administration of Medicines Clinical Policy previously considered by the Committee which now was supported by an equality impact assessment. The Chair thanked JH for her input on this.	LR

QS19/96 Declarations of Interest None declared.	
QS19/97 Apologies for Absence Apologies for absence were recorded for Mrs Sue Green, Dr Evan Moore, Dr Melanie Maxwell, Cllr Cheryl Carlisle and Mr Gareth Evans.	
QS19/98 Minutes of Previous Meeting Held in Public on the 21st May 2019 for Accuracy, Matters Arising and Review of Summary Action Log The minutes were approved as an accurate record and updates were provided to the summary action log.	
QS19/99 Patient Story - Welsh Language Communication **QS19/99.1** Mrs J Hughes presented the patient story which related to the experience of her late father in law and family members in terms of failures to meet his first language communication needs whilst an in-patient at Ysbyty Glan Clwyd. **QS19/99.2** The Committee were grateful for the reminder of the importance of communication in the delivery of services. It was reported that the newly appointed Patient Advice and Liaison Service (PALS) officers on each site were all Welsh speakers which would enable patients to be able to communicate in Welsh when providing feedback on their experience across the Health Board. In terms of next steps, it was noted the patient story was scheduled for the next Quality Safety Group (QSG) and it was also suggested that the story be featured within the next Welsh Language monitoring report. The Chair suggested that there be an annual reflection on the outcomes and improvements made as a result of the patient stories received in-year as part of the Committee Annual Report process.	DC DC
QS19/100 Integrated Quality and Performance Report (IQPR) **QS19/100.1** The Director of Performance presented the report. She highlighted that the performance team were working to standardise all the elements of IQPR that fed into Committees and up to the Board and aligning them to the health economy and divisional reports. She indicated that the revised format aimed to show current performance using the latest available validated data to illustrate where performance had improved or worsened since the previous report, and to include clear actions being taken with intended outcomes within an expected timeline. **QS19/100.2** The Director of Performance confirmed that training sessions were being delivered with lead officers on how to write exception reports. She also set out continued challenges in linking up the various reports and to ensure the Committees received data in a timely manner to scrutinize ahead of the Board meetings. A broad discussion ensued on	

the format of the IQPR which the Director of Performance would take on board. These included • A request that, where known, an explanation be included as to why performance had deteriorated against a specific indicator; • The need to report timeframes consistently ie; to provide an indication as to when improvement was anticipated, not when the action would be undertaken by. • The range of options available for display of data, including 'SPC' graphs, whilst balancing the need to ensure the data and performance was easily understood by both clinicians and independent members. **QS19/100.3** With regards to postponed procedures (Chapter 1 – Quality) members found the information difficult to interpret as to whether an improvement had been made, and also that many of the actions set out appeared to be basic good practice rather than additional areas for improvement. It was noted that a Wales Audit Office review had been undertaken with benchmarked statistics on the wider planned care agenda and that the report was due to be received by the Audit Committee soon. On this basis the Committee were content to defer further consideration to the Audit Committee (via the Committee Chair's report to Board) but wished to receive strengthened narrative within this Chapter in the next IQPR. **QS19/100.4** The Chair of the CHC referred to Chapter 2 (Infection Control) which appeared to indicate deteriorating performance in many elements. The Acting Executive Director of Nursing and Midwifery explained that more patients were now being screened and the sensitivity of screening had improved, A large percentage of infections have been acquired in the community setting and were not necessarily hospital acquired, which is not specifically identified within the report. Work is continuing to reduce antimicrobial prescribing across the Health Board. **QS19/100.5 It was resolved that** the Committee note the report.	JN LR JN
QS19/101 Annual Plan 2019-20 Progress Monitoring Report **QS19/101.1** The Director of Performance presented the report, noting firstly that there was an error in that the Executive Lead for the first indicator (Adverse Childhood Experiences) should be shown as the Executive Director of Primary and Community Services. It was also requested that a note be circulated outside of the meeting to clarify for members which actions were being tracked by this Committee. **QS19/101.2** The Chair of the CHC referred to the action for stroke services within the planned care programme and noted that this had been some two years in development and there was still a way to go before actual benefits were delivered for patients. The Acting Executive Director of Nursing and Midwifery referred to recent discussions at the Strategy, Partnerships and Population Health (SPPH) Committee and within the Executive Team around how some benefits could be realised sooner. **QS19/101.3** A discussion ensued around the RAG style reporting and the need for a more granular focus on deliverables, and that members would wish to be assured that actions did not report as on track for the majority of the year and then turn red at year-end. Executives would consider how best to honestly reflect performance and to provide robust monitoring.	JN JN

QS19/101.4 It was resolved that the Committee note the report.	
QS19/102 Quality and Safety in Primary Care **QS19/102.1** The Executive Director of Primary and Community Services presented the paper, noting that the format was a work in progress and he would welcome feedback from Committee members. **QS19/102.2** A discussion ensued. A member commented that whilst a comprehensive report, the paper did not assure the reader as to whether there were any major concerns about individual contractors. It was noted that this was partly due to the independent contractor status and reporting requirements not being mandatory. There was discussion about other quality performance indicators that would assist, including for example the Quality Outcomes Framework and the Clinical Governance Practice Self Assessment which could be incorporated into the report. Where concerns or complaints had been shared with the Health Board by practices , the Clinical Governance teams would feed this into the local Quality Safety Groups following which the findings were collated and learning shared with other practices. It was confirmed that there had been no removals from the performers' list during the period reported as a result of a performance concern. In terms of ongoing monitoring and support it was reported that a Quality Assurance Visiting Programme was in place and ideally each practice would receive a visit from the Health Board at least annually, but this was dependent on capacity and would likely be undertaken based on an assessment of risk. The focus for 2019/20 is for all GP practices to be visited. The Chair requested whether a heat map style summary could be provided in future reports and the Executive Director of Primary and Community Care would work to provide this. **QS19/102.3** The CHC Chair welcomed the detailed report at Committee level. He enquired whether the data for General Dental Services related to NHS practices only. It was confirmed that the majority of practices in North Wales held an NHS contract although there was a significant variation in terms of how much NHS activity was delivered alongside private work. The CHC Chair also wished to record the value of information relating to patient views of GP practices which could be gleaned from CHC visits to practices. **QS19/102.4** In terms of incidents it was confirmed that there had been no catastrophic graded incidents within the reported quarter. It was also clarified that the references to temporary pharmacy closures related to short notice applications from pharmacies to temporarily curtail their hours. A pattern had been established, particularly in the West, of these becoming frequent. The Chair asked that future reports include details of lessons learnt from incidents and not just the numbers. The Chair asked how primary care related Patient Safety Alerts were shared. It was confirmed that the Area Clinical Governance teams had a rolling programme to ensure these were cascaded. **QS19/102.5** A question was asked regarding Health and Safety (H&S) requirements for primary care contractors and the Executive Director of Primary and Community Services indicated that the recently appointed H&S Adviser for primary care had been broadly welcomed by practices. He was not aware of any serious concerns or practices not engaging at all, however, there were a few practices that had not yet prioritised the H&S agenda as he would have hoped.	CS CS

QS19/102.6 The Director of Performance welcomed the report and invited members to reflect as to whether there were additional primary care indicators they would wish to see developed within the IQPR. **QS19/102.7 It was resolved that** the Committee 1. Confirms the core indicators meet the requirements of the Committee – pending strengthening of lessons learnt and key risk areas as discussed 2. Notes the actions taken in terms of the core indicators 3. Notes the progress in relation to the health and 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	
QS19/103 Infection Prevention Report Q4 (January to March 2019) Incorporating the Infection Prevention Annual Report for 2018 -2019 **QS19/103.1** The Acting Executive Director of Nursing and Midwifery presented the paper which provided an overview of infection prevention activity, achievements and performance and highlighted some risks. Members were informed that the report from Jan Stevens on her revisit to the Health Board had recently been received and was broadly positive in terms of her ability to identify significant improvements, together with setting out guidance as to making further progress. The Committee were informed that the Safe Clean Care campaign would continue and it was acknowledged that basic infection prevention and control measures make a real difference. **QS19/103.2** Members identified a range of concerns mentioned within the report around water safety including a lack of representation by Estates and Facilities on the water safety group and a lack of clarity as to where that group reported to. It was confirmed it reported to the Strategic Infection Prevention Group (SIPG) with cross-over into the Strategic Health and Safety Group. The matter would be picked up further under the Occupational Health and Safety report later on the agenda. **QS19/103.3** A question was asked regarding the lack of isolation areas in Wrexham and the Acting Executive Director of Nursing and Midwifery confirmed this matter was on the relevant risk register and that SCC monies had been utilised to create a decant facility to allow for the effective isolation of patients. **QS19/103.4** The Chair raised issues regarding the content and flow of the report and that it did not explain what actions had been taken or were planned to address issues or risks raised. In addition, there was reference to monthly reports to the QSE Committee which needed amending to reflect the change to the frequency of Committee meetings. The report would be refreshed to take into account the discussion and comments. **QS19/103. It was resolved that** the Committee: 1. Note the Infection Prevention Q4 report and improvements requested by the Committee 2. Note the Annual Report for 2018/19	DC
QS19/104 Occupational Health and Safety (OHS) Annual Report 1st April 2018 -31st March 2019	

[Mr R Taylor joined the meeting] **QS19/104.1** The Associate Director of Health, Safety and Equality presented the report which provided an overview of incidents, accidents, occupational health, safety activity and training. He drew members' attention to section 4 of the executive summary which set out key issues of note. He also reported that the newly established Strategic Occupational Health and Safety (OHS) Group had met twice since his appointment and had been well attended. He summarised that a lot of work had been undertaken completing a gap analysis to ensure that the Health Board was actively managing OHS risks and were in compliance with the legislation. **QS19/104.2** A discussion ensued. A comment was made that whilst the report advised on training activity it would have been useful to have included a trajectory and confirmation of the gap between actual and planned delivery. A point was raised regarding the number of occasions staff did not attend for planned training and that there were no consequences for this. It was confirmed that the training needs analysis would be key to managing this more effectively going forward. The Independent Member (Trade Unions) very much welcomed the re-establishment of a strategic group for OHS and she felt it was working well so far. In terms of violence and aggression towards staff she suggested that very often this was seen as the norm, with staff 'expecting' to receive some abuse. She highlighted that the role of the Violence and Aggression Case Manager was not resourced to undertake prevention work and she also had concerns at the security of staff on some sites. The Associate Director of Health, Safety and Equality indicated that a full assessment of security and violence and aggression incidents was planned which would inform areas to be addressed. He noted though that there would be a resource implication to this. The Executive Director of Public Health felt there was an anomaly within the data of violence and aggression incidents within Public Health Wales and she would look into this further with the Associate Director of Health, Safety and Equality.	TO
QS19/104.3 The Chair enquired about the 38 deaths reported by the Mental Health Division in Datix, the nature of these deaths and why they had been included within the OHS report. The Acting Executive Director of Nursing and Midwifery explained that all deaths were reported within mental health services even if the individual was not receiving care from the Health Board at the time. She agreed to work with the Associate Director of Health, Safety and Equality to ensure clear reporting parameters. She did assure the Committee that all deaths were monitored on a weekly basis.	DC
QS19/104.4 In response to a query regarding root cause analysis (RCA) for RIDDOR incidents, the Associate Director of Health, Safety and Equality reported that there was no consistently applied system for tracking RIDDOR RCAs and he and the Acting Executive Director of Nursing and Midwifery would pick this up jointly in terms of incident reporting training.	DC/PB
QS19/104.5 The Committee Chair raised the issue of water safety management as linked to the earlier discussion around infection prevention and legionella. The Director of Estates and Facilities confirmed that the Water Safety Group had been established in line with Welsh Government (WG) guidance with an annual report to the group being prepared which was submitted to the IPSG and onto QSG. He accepted there had been challenges in terms of little used outlets where taps had not been flushed regularly. Overall, he reported that the controls were robust but that operational management and checks at	

ward level were essential to ensure that water safety management became everybody's business. The associated risk of legionella had been escalated appropriately with an action to review and refresh the policy to clarify responsibility. The Committee Chair outlined her concern that the closing of areas due to water supply issues impacted directly upon the provision of care and that there must be more of a focus on prevention. **QS19/104.6** The Director of Estates and Facilities added that the matter of representation on the Strategic OHS Group had been noted and he was working to address capacity issues to enable attendance. **QS19/104.7 It was resolved that** the Committee: 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. *[Mr R Taylor left the meeting]*	
QS19/106 Patient and Service User (PSUE) Experience Strategy 2019-2022 *[Agenda Item Taken out of order at Chair's discretion]* **QS19/106.1** The Acting Executive Director of Nursing and Midwifery introduced the Strategy which aimed to provide a vision for patient and service user experience in line with the NHS Wales' "quadruple aim". The Head of Patient and Service User Experience was pleased to present the Strategy to the Committee and felt that it would address the identified gaps and variations across North Wales in terms of an equitable model for PSUE. She highlighted key points from the Strategy in terms of: • The targeting of areas which had been identified as lacking in feedback; • Use of the "You Said We Did" real-time feedback mechanism; • A refresh of the Listening and Learning Group with a focus on more senior representation; • The important role of the CHC in terms of feeding into PSUE mechanisms. **QS19/106.2** A discussion ensued. The Director of Performance commented that connecting PSUE to the outcome measures was critical to improving services and delivering care closer to home. The Executive Director of Primary and Community Services was pleased to see that managed practices had been involved in the deployment and development of the sensory loss toolkit as the majority of patient contacts were within a primary care setting. The CHC Chair welcomed the Strategy and the clear focus on making a positive difference. The Committee Chair felt that the Strategy would be a valuable service improvement tool but did ask that the aspects relating to primary care be strengthened, in particular to widen the scope beyond general medical services. She also noted that Primary Care Cluster Development Teams were listed as part of external engagement opportunities which she felt was inaccurate. The Director of Performance noted that there was a cohort of patients who had a long-term relationship with the Health Board in terms of delivery of their care and there would be opportunities to engage with them relating to their experience of the associated care pathways. It was also suggested that the workforce was also a valuable resource in terms of user experience as they were patients too. The Head of Patient and Service User Experience would take all these comments on board.	DC/CO CO

QS19/106.3 The Committee Chair requested that the next steps for formally ratifying the Strategy be confirmed, but also suggested that a workshop session on service user experience as a whole would be beneficial. **QS19/106.4 It was resolved that** the Committee endorse the ratification of the Patient and Service User Experience Improvement Strategy for organisational and operational delivery to be adopted across BCUHB.	DC
QS19/105 Listening and Learning from Experience Report **QS19/105.1** The Head of Patient and Service User Experience presented the report which provided a summary of PSUE within the Health Board. She accepted there were ongoing issues in terms of readability but confirmed that arrangements were in hand going forward to rationalise and strengthen the narrative. She highlighted that the role of the PSUE team had been reviewed in terms of remit, responsibilities and consistency of application. She added that the standardising of the Patient Advice and Liaison Service (PALS) would also contribute to improvements and a better patient experience. **QS19/105.2** A discussion ensued. The CHC Chair welcomed the implementation of PALS but was keen to ensure that this did not deter people from utilising the formal Putting Things Right (PTR) process where appropriate. The Head of Patient and Service User Experience agreed and indicated that this was covered in staff training as part of trigger points within the pathway. The recent clarification from Welsh Government with regards to the categorisation of 'On the Spot' resolution was noted and may result in an increased in the number of concerns recorded as a result . The Committee Chair enquired whether there was any evidence that negative feedback in Emergency Departments (ED) was dependent upon the point within the pathway that patient satisfaction was measured as specified in the report. It was clarified that there was a trend to suggest this, but it was an assumption based on the location of the feedback kiosk. **QS19/105.3** In terms of future reporting the Committee Chair requested that attention be given to improving the analysis of data to clearly show what improvements had been made as a result of feedback. She also felt that the improvement actions for each quarter needed to be more distinct to enable clear monitoring of progress. **QS19/105.4 It was resolved that** the Committee 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. *[Ms Carolyn Owen left the meeting. Mr S Forsyth joined the meeting]*	DC /CO
QS19/107 Mental Health Quality Safety and Experience Report [including progress against Quality Improvement Governance Plan, Together for Mental Health Strategy and Performance]	

QS19/107.1 The Committee Chair invited comments and questions on the report, noting that all members would have read the paper. A query was raised regarding the ward metrics data in the table on page 14 and the Director of Nursing for Mental Health and Learning Disabilities Services (MHLDS) clarified it indicated a decline against all headings which was disappointing. The Acting Executive Director of Nursing and Midwifery added that ward staff were being supported to improve their understanding of the dashboard and how data should be input. A member asked about the performance against the Mental Health Measures which are not meeting the national target. The Director of MHLDS confirmed that whilst performance was delivered regularly in some areas there were ongoing resource capacity issues which impacted on other areas. He was however confident that a sustained improvement would be achieved which would be key to taking mental health out of special measures. He also reported positively that additional capacity had been approved by Welsh Government. The Chair of the CHC enquired whether this would reduce the reliance on locum or agency staff. The Director of Nursing of MHLDS indicated that the division was not a significantly high user of agency or locum staff. Whilst the funding would allow for improved opportunities to make substantive appointments, there were also historical challenges with the recruitment of medical staff particularly in the West. **QS19/107.2** The Committee Chair noted that the paper referred to an Internal Audit review of governance arrangements during 2018-19 but there was no detail within the report as to how the recommendations had been addressed. The Director of MHLDS would pick this matter up at the relevant management meeting and ensure detail was included within the next report. A comment was made that section 4.3 of the report stated that there was a continued downward trend in the number of reported incidents, however, it was accepted this was a statistical normal variation. The Committee Chair referred to section 4.7 on learning from concerns, incidents and complaints and asked that the next report include a narrative to provide examples of lessons learnt and/or improvements made. She also noted reference to good practice and learning having been applied in Cefni Hospital following a desktop review of adult at risk referrals, however, the QSG report had highlighted some safeguarding issues at that site. The Director of Nursing for MHLDS explained this was a timeline issue with the desktop review looking at data from April to August 2018. It was also noted that the report did not meet the Committee's requirements. The Director of Nursing for MHLDS stated that he had decided not to include some of the information as he understood it had been reported elsewhere. The Committee Chair went on to note that section 5.1 provided very little narrative around performance against the Mental Health Measure and asked that this be addressed in future reports. In terms of the Quality Improvement Governance Plan the Committee Chair suggested that it could be better aligned to the Board's overall strategy and used the Children's paper, also on the agenda, as an example of good practice. The Director of MHLDS would take all of the above comments regarding content of future reports on board. **QS19/107.3** The Director of Nursing MHLDS took the opportunity to celebrate that a TODAYICAN publication had been included in a national journal for the first time and that the Division had had two areas shortlisted for Nursing Times awards. **QS19/107.4 It was resolved that** the Committee note the contents of the report and the requirements for future reports.	AR

QS19/109 Children's Services Update *[Agenda item taken out of order at Chair's discretion]* [*Mrs Liz Fletcher joined the meeting]* **QS19/109.1** The Committee Chair welcomed the report which she found to be clear and helpful and was also pleased that it was laid out in terms of aims and objectives. The Executive Director of Primary and Community Services summarised that there were areas that continued to be a challenge but the report did highlight good progress including a positive partnership approach within children's services. He also acknowledged that the Sub Regional Neonatal Intensive Care Centre had been operational for a year and was setting standards in terms of ward accreditation. **QS19/109.2** A discussion ensued. An Independent Member expressed concern at the risks identified within the report. It was noted that Healthcare Inspectorate Wales (HIW) had recently undertaken a thematic review of Children's Services, which provided a summary of performance across Wales. The Committee Chair asked that the organisational response to this review be agendered for September's meeting. The Executive Director of Primary and Community Services indicated that for him the biggest concerns were around Child and Adolescent Mental Health Services (CAMHS) and the ward environment, although he did have a sense that there was movement towards a sustainable solution for CAMHS and that overall the actions in place were sufficient to enable the Board to sustain services. He alluded to other areas of risk, for example, issues with Tier 4 services and the Abergele Unit not being commissioned to accept 24/7 admissions. The Assistant Area Director for Children's Services felt that overall the Board could be better sighted on Children's Services but the position across BCUHB had improved compared to 3-4 years ago. She suggested that a focused drive on the pre-conception and early years care would positively impact on Children's Services as a whole. **QS19/109.3** An Independent Member expressed concern at the workload of school nurses and the capacity of one individual to support a caseload of around 3000 children. The Assistant Area Director for Children's Services acknowledged this concern and confirmed it was included on the relevant risk registers. The Director of Performance referred to the positive discussions at the recent deep dive event pertaining to neuro-development and the expectations on partners. The Executive Director of Primary and Community was of the view that Local Authorities did acknowledge this as an issue and that it was on the relevant action plan. **QS19/109.4** The Executive Director of Public Health welcomed the paper and the focus on the child's voice and improving outcomes in the first 1000 days. In terms of obesity she enquired whether partners were engaged in this agenda. The Assistant Area Director for Children's Services indicated that partners were keen to see initiatives focused on achieving a healthy weight in children. **QS19/109.5 It was resolved that t**he Committee 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 *[Mrs L Fletcher left the meeting]*	CS

QS19/108 Quality Improvement Strategy (QIS)

QS19/108.1 The Acting Executive Director of Nursing and Midwifery delivered a presentation on the ongoing opportunities from the QIS which included:

- Five pillars of reducing mortality - reducing harm, improving the reliability of care, delivering what matters most and delivering integrated care;
- Leadership and Culture;
- Reducing mortality;
- Ward accreditation programme;
- Focus on four main harms – falls, pressure ulcers, safe clean care and medication errors;
- Collaborative approach to reducing harms;
- Interactive harms dashboards;
- Delivering what matters most – PALS; embed 'always events' as part of the nurse rounding; dignified end of life care; listening and learning from real time feedback;
- Improving the reliability of care;
- Building capacity;
- Celebrating successes.

QS19/108.2 The Director of MHLDS welcomed the work around ward accreditation and noted there was a good level of momentum amongst staff. The Executive Director of Therapies and Health Sciences added that the buy-in from teams on leadership walkarounds was commendable. The CHC Chair welcomed the positive focus on cultural change. An Independent Member suggested that the roll-out of ward accreditation would be useful even for those wards that had their own schemes.

QS19/110 Update paper following National audit of Handover of Care at Emergency Departments - Health Board Related Recommendations

QS19/110.1 The Committee Chair reminded members that the national audit report had originally been considered by the Audit Committee who had referred a quality and safety concern to this Committee to be monitored. The update was requested to provide assurance as to how the transfer of risk associated with the handover of patients from the Ambulance to the Emergency Department was being managed.

QS19/110.2 The Acting Executive Director of Nursing and Midwifery reported that a range of mechanisms were being implemented to reduce the risk and the position was mapped on a weekly basis, with a key aim being to reduce congestion in corridors. She assured the Committee that the numbers of related incidents had reduced significantly and in her view handover was broadly safe although she acknowledged that from a patient experience perspective it was still not where it needed to be.

QS19/110.3 It was resolved that the Committee 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	
QS19/111 Policies, Procedures or Other Written Control Documents for Approval **QS19/111.1** A new composite coversheet was received together with a range of written control documents. The Committee Chair noted that it was not easy for the Committee to be aware of whether the document was a new or amended version and what the substance of the changes were. She reminded the Committee of previous discussions and proposals with regard to the review and ratification of policies by Committees. The Committee were informed that discussions were still ongoing. **QS19/111.2** The Committee approved the Community Treatment Order Policy MHLD0051 for implementation within BCUHB. **QS19/111.3** The Committee approved the Seclusion Policy for implementation within BCUHB. **QS19/111.4** The Committee would wish to seek clarification whether the Consent to Examination or Treatment Policy MD01 was "based on an All Wales Policy" or was in fact an All Wales Policy, as there were conflicting references in the policy. If the latter then the Committee would expect the Equality Impact Assessment to reflect the local population and any particular issues in BCUHB. A point was also raised around the accuracy of the terminology relating to the legislation in that the correct reference was the Equality Act. Following clarification of these points with the author, the Committee would be happy to agree Chair's Action to approve. **QS19/111.5** The Committee approved the Restricted Items Policy for implementation within BCUHB.	
QS19/112 Quality Safety Group (QSG) Assurance Reports **QS19/112.1** The Acting Executive Director of Nursing and Midwifery presented the reports from the meetings of the QSG held on 8th May and 11th June. **QS19/112.2** An Independent Member noted there were two 5x5 risks highlighted relating to the recruitment of breast radiologists and prescribing competencies of junior doctors, and sought assurance that the associated action plans were sufficient. The Executive Director of Therapies and Health Sciences confirmed that the breast radiology services was being managed appropriately on an interim basis until newly recruited radiologists took up their posts in September. The Acting Executive Director of Nursing and Midwifery indicated there was an active conversation around the 5x5 scores but confirmed that these areas did remain the highest scoring risks. **QS19/112.3** The CHC Chair noted that the organisation still did not have a Medical Devices Safety Officer which was a recommendation of a Patient Safety Alert (PSA) from 2014. The Executive Director of Therapies & Health Sciences assured the Committee that this	

role was discharged effectively through other mechanisms but he would check whether that specific PSA was closed at that time even without this appointment being made. **QS19/112.4** The Committee Chair made reference to the Countess of Chester Hospital (CoCH) neonatal issue and the Executive Director of Public Health confirmed that the situation continued to be monitored, however the maternity specification had not yet been signed off by CoCH.	AT
QS19/113 Progress report of Recommendations Arising from HASCAS Independent Investigation and Ockenden Governance Review **QS19/113.1** The Acting Executive Director of Nursing and Midwifery presented the report and indicated that this version attempted to address a previous request to confirm the percentage of compliance element. She also reported that the Coroner had now asked for all reports on patients who had died at the time of or since Tawel Fan, amounting to over 80 cases. The Coroner was now considering which of those may require an inquest to be opened. It was noted that ongoing support to the affected staff was continuing to be provided. **QS19/113.2** The CHC Chair was pleased to note that the Health Board Chair would be attending the Stakeholder Group. It was also confirmed that the Estates and Facilities team would be represented. **QS19/113.3 It was resolved that** the Committee note the progress of the recommendations to date.	
QS19/114 Issues Discussed in Previous In Committee Session **It was resolved that** the Committee note the information in public.	
QS19/115 Documents Circulated to Members It was noted that the following had been circulated: • 28.5.19 Updated safeguarding annual report	
QS19/116 Issues of Significance to inform the Chair's Assurance Report To be determined with the Chair.	
QS19/117 Date of Next Meeting Tuesday 24.9.19 @ 9.30am in Carlton Court	
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."	

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. 16.7.19 On the basis that the Committee were assured there was a specific action plan relating to this individual complaint, and that the basis of reporting of future PSOW cases would be more robust in terms of learning, the Committee were happy to close this action.	July Closed
19th March 2019				
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 16.7.19 PB confirmed that the risk score had not been reduced and that a wider gap analysis on H&S was being undertaken.	 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 North Wales and linking in with the Quality Improvement Hub.	July	21.5.19 Noted is also a board action and in hand via Louise Howard-Baker. 16.7.19 Would be picked up as part of the medicines management report due in September. 17.9.19 Medicines Management paper on agenda does not cover this action specifically. The Assistant Director for Medicines Management (East) reports that - pharmacists on all three acute sites are now consistently using the same process for reporting medication-related admissions so that they can be coded correctly. The 1000 Lives National Primary Care Programme Manager is visiting BCUHB in September to discuss how this	 September

			project can be rolled out across Wales to fit the new WG strategy to reduce medication-related admissions. A national safety dashboard has been developed. The outcome of this meeting will inform the safety programme for BCUHB to reduce medication-related admissions.	
21st May 2019				
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. 6.8.19 Letter distributed	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		
~~E Moore~~ M Maxwell	**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	17.9.19 A revised format has been submitted and agreed at Quality Safety Group, and will inform the next report to Committee.	Closed
16th July 2019				
L Reid	**QS19/95.1** Raise continued concerns over quality of papers within Chair's report	Sept	Picked up as part of wider conversations with Chair and other IMs	Closed
D Carter	**QS19/99.2** Include patient story re Welsh Language in the next Welsh Language monitoring report		13.9.19 As recommended by QSE, Head of Patient and Service User Experience for BCUHB has produced a Quality Assurance for Patient Stories Framework Sept 2019 to ensure that all Patient Stories are monitored. BCUHB has ensured adequate resources are in place to sustain the growth and development in	Closed

			capturing, monitoring and measuring quality improvements from patient stories. The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. 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). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements. The LLG will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. This includes Patient Stories. Patient Stories will be integrated into the Clinical Harm Dashboard along with all other feedback methods. Quality improvement actions will be captured, monitored and measured in triangulation with incidents and complaints. The one system approach strengthens the service improvement management.	
D Carter	**QS19/99.2** Reflect on outcomes and improvements made as a result of patient stories as part of Committee annual report process	Sept	13.9.19 Quality Assurance for Patient Stories Framework developed Sept 2019 to provide assurance against the organisation's Patient Stories. ISUE01 – BCUHB framework for undertaking patient stories-outcomes and demonstrate what has improved. Capturing people's personal stories through a patient story	Closed

			'tracker' system will allows us to keep a focus on and ensure that we deliver dignified compassionate care and make improvements where necessary. The tracker system will be managed by the Head of Patient and Service User Experience for BCUHB, ensuring that all patient stories presented at the Quality Safety Experience (QSE) committee meetings have clear outcomes and demonstrate what improvements have been made. An annual update report will be provided to the QSE committee meeting to reflect the outcomes and provide assurance that Patient Stories reflect BCUHB improvement framework that 'we support providers to give patients safe, high quality, compassionate care within local health systems' (NHS Improvements Patient experience improvement framework June 2018).	
J Newman	**QS19/100.2** Take into account the discussion around IQPR format (detailed in minutes)		22.8.19 The format of the IQPR has been reviewed to include a section for understanding the reasons for the current performance, the presentation of actions, outcomes and timelines has been put into a grid format to aid read across between actions expected outcomes and timelines for delivery of improved performance. Training has continued and includes requirement to consider the timeline to improvement. Increased focus on graphical trend information is being included. Further discussion is taking place as to the future arrangements for performance reports.	Closed
L Reid	**QS19/100.3**	Sept	Completed and submitted to Board 5.9.19	Closed

	Confirm within Chair's report that QSE were content to defer further consideration of the WAO report on planned care to the Audit Committee			
J Newman	**QS19/100.3** Ensure a strengthened narrative on planned care in next IQPR	Sept	22.8.19 A planned care plan was presented to the August F&P committee.	
J Newman	**QS19/101.1** With regards to the Annual Plan Monitoring Report, circulate a note to clarify which actions were being tracked by which Committee.	August	3.9.19 Briefing note circulated	Closed
J Newman	**QS19/101.3** Work with Exec Team to consider how best to honestly reflect performance and to provide robust monitoring.	Sept		
C Stockport	**QS19/102.2** Work to provide a heat map summary in future primary care reports	By next report (March)		
C Stockport	**QS19/102.4** Ensure that future reports include narrative on lessons learned from incidents	By next report (March)		
D Carter	**QS19/103.4** Refresh the IPC report to take account the discussion and comments made (detailed in minutes)	Sept	13.9.19 The report was updated to include the comments raised and was taken to the Board meeting in September.	Closed
T Owen	**QS19/104.2** Look into potential anomaly of V&A data for Public Health (discuss with Peter Bohan)	Sept	17.9.19 Peter Bohan and Teresa Owen have discussed the data, and investigations suggest errors at the recording stage.	Closed
D Carter	**QS19/104.3**	Sept	13.9.19 Interim Assistant Director of Service User Experience (Kath Clarke) is meeting with Peter Bohan to progress	

	Work with Peter Bohan to understand the data regarding deaths as a result of incidents within mental health			
D Carter P Bohan	**QS19/104.4** Jointly take forward the issue of there being no consistent system for tracking RIDDOR root cause analysis	Sept		
D Carter C Owen	**QS19/106.2** Take on board comments made (detailed in minutes) regarding strengthening the PSUE Strategy particularly in terms of primary care and widening scope beyond GMS	Sept	13.9.19 PSUE Strategy updated to reflect and include additional detail as recommended by QSE.	Closed
D Carter	**QS19/106.3** Confirm the next steps for ratifying the PSUE Strategy and consider whole board session on service user experience	Sept	Agreed that the PSUE Strategy need not go separately to the SPPH Committee as it did not relate to organisational redesign. The Strategy would be reported to the Board through the Chair's Assurance Report. Topic also added to the forward plan for board workshops.	Closed
D Carter C Owen	**QS19/105.3** Work to improve the analysis of data to show improvements within future Listening and Learning reports	November	13.9.19 The Head of Patient and Service User Experience is reviewing the report content detail and has requested a meeting with QSE Chair to discuss.	Closed
A Roach	**QS19/107.2** Take into account the discussion (detailed in minutes) around content and format of future MHLDS assurance reports	November	3.9.19 The Director of Mental Health and Learning disability has met with the Chair of QSE and agreed the future reporting requirements into the committee, it has been agreed that an exception report will be provided to the September committee to provide additional information and assurance to the Chairs comments under section 19/107.2 with agreed reporting and content being included in the November MHLD assurance report	

C Stockport	**QS19/109.2** Arrange for the organisational response to the HIW thematic review of children's services be agendered for the next meeting.	Sept	Added to cycle of business. 13.9.19 Agreement reached with QSE Chair to defer to November meeting.	November
A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept		

Patient's Stories Transcript Form for Quality, Safety & Experience Committee 24.9.19

Who took the patient's story:	Llinos Roberts, Patient Advice and Liaison (PALS) officer
Contact details:	Patient Advice and Liaison Officer, (PALS) Ysbyty Glan Clwyd.
Reason for taking the story and areas covered:	Patient's son wanted to raise Dementia Care and Awareness within the Acute and Community Hospital Setting.
Brief summary of the story:	Patient's son, contacted the PALS Manager to discuss his mother, journey from presenting in the Emergency Department (ED), Glan Clwyd Hospital to being transferred to Ruthin Community Hospital. Patient – Linda Patient's Son – Ben. Both Linda and Ben have given consent to use their Christian names but not their Surname. In February 2019 Linda was taken to Glan Clwyd Hospital ED by Ambulance following a fall at home. Linda was taken from the Ambulance into the ED to undergo tests which confirmed a fractured neck of femur. Linda was later transferred from ED to the Emergency Department Observation Unit (EDOU) Linda was placed in a bed near the Nurses' Station to allow the nursing staff to 'keep a close eye on her". A Dementia Butterfly sticker was placed on the notice board above the bed. **Ben felt it was rather obvious and although understood it was for staff to identify that his mother had Dementia he thought a sicker on the Wrist Band would be more appropriate.** As Linda was in the bed closest to the Nurses' Station she could hear every conversation the Nurses were having despite them being unrelated to her, **Linda thought they were talking about her which made her want to go home**, despite Ben reassuring her numerous times. Ben asked if his mother could be moved to another bed as overhearing the conversations was making her paranoid and anxious due to her dementia. Ben was told that his mother was placed there as there was a possibility she would try to abscond due to the dementia and as she had a Fractured Neck of Femur they wanted to ensure she was safe. Ben understood, and was grateful that the Nursing Staff wanted to keep a close eye on his mother, **but felt if there was a Dementia Nurse present to sit with her, she could have**

	been moved which would have made her stay in the Department more comfortable and relaxed rather than paranoid and anxious, it would have also been of great support to him whilst visiting his mother and also the Nursing Staff. Linda was transferred to Menlli Ward, Ruthin Hospital on 27th February, 2019. Whilst Linda was in Ruthin Hospital Ben identified that there was no specific Dementia Care or appropriate activities for patients with Dementia. The ward layout is typical of a standard ward with rows of beds opposite each other with a bed side locker. **Linda was constantly going into other patient's lockers, Ben asked if it could be moved which staff did each time he asked but when he would visit his mother the following day the locker was back in the original place.** Ben also identified that the Day Room is a large room and thought further use could be made of it. Ben's main concern was the lack of Dementia Care and Support for Patients and Nursing Staff. Ben is aware that Llandudno Hospital have a Dementia Care Worker and would like to see them placed in the other Community Hospitals and for more of them within the ED Departments. **Action.** PALS Officer, Llinos Roberts discussed Linda and Ben's Story with the ED Matron, Glan Clwyd Hospital and with the Ward Manager and Matron of Ruthin Community Hospital. ED Matron, stated although she understood and could totally understand why Ben requested his mother to be moved, she felt that Linda was appropriately placed in a bed near the Nurses Station due to her fractured neck of femur and being high risk of absconding. On this occasion they thought it was in the patient's best interest. In relation to a Dementia Sticker being placed on the Patients Wrist Band rather than over the bed; Matron stated that some patients have medical alerts printed on their wrist band having more alerts printed could risk medical alerts such as allergies being missed. Menlli Ward, Ruthin Hospital Ward Manager appreciated the PALS officer for raising Ben's story with them. As a result of Ben and Linda sharing their experience they will be advertising a Dementia Care worker post within the next month, the post will be shared between Ruthin and Denbigh Hospitals. They consider this to be a positive step in the right direction to provide patients

	with adequate Dementia Care and will also provide them as Health Care Professionals with the appropriate tools to improve care and identify specific requirements for Dementia patients. Occupational Therapists are also going to carry out daily activities with patients in the Day Room. Llinos met with Ben to update on the outcome of their sharing their experiences. Ben was satisfied with the response and thought that the Dementia Care worker and the daily activities was a positive step forward. PALS Officer, Llinos thanked Ben and Linda for approaching the PALS Team with their story.

Key themes emerging:	Lack of adequate Dementia Care within Acute and Community Hospitals.
Lessons learnt:	Discussed with EDOU, Matron. Discussed with Menlli Ward, Ruthin Hospital Ward Manager and Matron. Action taken / Lessons Learnt: Ward Manager and Matron have identified the lack of Dementia Focused Care and Environment within the Community Hospital. Since Linda's admission to hospital the following improvements have been made to enhance patients' care: • Patient Activities increased. • Dementia Care Worker – appointed August 2019. • Occupational Therapist is doing daily activities in the Day Room. Some patients are being encouraged to prepare their own breakfast to promote independence (Functional Friday), • Physiotherapist doing physical therapy with patients of all abilities. • New Dementia friendly flooring and Cutlery to be purchased.
Proposed action:	Appointment of a Dementia Care Worker (time to be shared) between Ruthin and Denbigh Community Hospitals. Occupational Therapists to carry out daily activities in the Ward Day Room. Physiotherapist to carry out physical therapy.
Sensitive issues to be aware of:	Small Dementia sticker to be placed on the wrist band rather than a large sticker above patient's bed. (Discussed and addressed by ED Matron)

Quality Safety Experience (QSE) Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Mental Health and Learning Disability (MHLD) Services – exception report
Report Author:	Mr Steve Forsyth, Director of Nursing MHLD
Responsible Director:	Mr Andy Roach, Director MHLD
Public or In Committee	Public
Purpose of Report:	To provide an update on Mental Health and Learning Disability Services
Approval / Scrutiny Route Prior to Presentation:	Updates on Mental Health and Learning Disability Services are approved by Divisional Directors. The paper has been signed off by the Director of MHLD
Governance issues / risks:	Risks highlighted in this report include: • Cemlyn Ward, Cefni Hospital • Heddfan doors
Financial Implications:	The service is striving to deliver 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 Mental Health and Learning Disability Services, specifically as requested in relation to: • Compliance with Mental Health Measure • Lessons Learned from incidents • HIW outstanding actions • Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan 2. The risks that are identified are being managed through locality structures and overseen by Divisional Directors

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	√	1.Balancing short term need with long	√

health and well-being for all		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 Mental Health			
Equality Impact Assessment Equality Impact assessments exist for specific elements of this report			

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

Mental Health and Learning Disability Services

1. Purpose of exception report

To provide the committee members with an exception report on the quality improvement and risk management measures in place within Mental Health and Learning Disability Services

2. Summary of Significant Quality and Safety Issues

Cemlyn Ward, Cefni Hospital

There have been recent increased concerns regarding Cemlyn Ward and the numbers of Safeguarding referrals for patient on patient assaults. Locality management, supported by safeguarding colleagues, have undertaken a review of the 33 safeguarding referrals submitted since April 2019, with 15 being closed with no further action, as they did not meet the threshold with no evidence of harm.

The increase relates to 1 person, which accounted for 14 of the remaining 18 incidents. The patient's care plan and risk assessment are under regular review to ensure holistic appraisal and intervention.

A very positive meeting has been held with North Wales Police who were supportive and appreciated the challenges on Cemlyn. They were assured of the appropriate safeguards in place to ensure patient safety, whilst acknowledging the complexity of the patient needs and the fact that we can never entirely exclude any incidents form occurring.

A meeting has also taken place with the Local Authority. They were encouraged by the immediate remedial actions which have been put in place, particularly the management of acuity on the ward via assessment of risk and patient mix before each admission.

There is a plan to move the patient with the highest level of acuity to a more specialist and therapeutic provision, better suited to their complex needs. This is an immediate remedial action that is supported by North Wales Police, Local Authority and Corporate Safeguarding.

Heddfan Doors

As part of the Anti-Ligature programme all bedroom doors were replaced across the Adult and Older Adult Wards in the Heddfan Unit from July 2017 until completion in February 2018.

There has been reported incidents of door failure and attempts to identify the source of the door failure mechanism, and modifications have been made to the different components whether this be the door itself, the component within the door, the anti-barricade mechanism and now the doorframe.

A series of improvement works was undertaken to the doors and door components following a series. Following a 'sign off' of the doors in April 2019, it was agreed with Estates supported by clinical staff, to carry out a weekly audit on the doors.

On 22.08.19 a decision was made to reinstate the anti barricades with interim control measures in place. With the new controls in place, the risk rating has reduced to 15. Once final controls are complete i.e. fit for purpose, fully functioning doors, the risk score is expected to 5.

On 10.09.19 the audit of doors evidenced that all doors in use are fully repaired and functional. Despite this latest audit the risk remains at 15 due to the awareness that the risk of entrapment does not always correlate to fully functioning bedroom doors.

On 12.09.19 a meeting took place with estates where it was agreed that all bedroom doors on Heddfan will be replaced, there are currently 4 decommissioned doors.

2.1 Mental Health (Wales) Measure (MHM)

Summary of Significant Issues:

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 for Parts 1a&1b. Parts 2 & 3 remain compliant.

Current Performance Rates:

MHLD Divisional August 2019 Unvalidated	**Total**	**Within Target**	**Compliance**
Part 1a ~ Assessments Undertaken (target 80%)	849	541 within 28 days	63.7 %
Part 1b ~ Interventions Undertaken (target 80%)	231	153 within 28 days	66.2%
Part 2 ~ Care & Treatment Plan (target 90%)	5929	5429 with valid CTP	91.6%
Part 3 ~ Total Assessments (target 100%)	14	14	100%

MHLD Divisional July 2019 Validated	**Total**	**Within Target**	**Compliance**
Part 1a ~ Assessments Undertaken (target 80%)	1031	664 within 28 days	64.4 %
Part 1b ~ Interventions Undertaken (target 80%)	304	211 within 28 days	69.4%
Part 2 ~ Care & Treatment Plan (target 90%)			90.2%
Part 3 ~ Total Assessments (target 100%)			100%

It should be noted that the validated position will always provide data one month in arrears.

In order to improve MHM performance, there are a number of initiatives that are producing results, for example, some areas are using additional staffing during normal working hours, others have developed new ways of working in a traditional Primary Care service model, such as weekend clinics/7 day working. Achievement of part 1a and 1b of the mental health measure is profiled for April 2020.

Improvement Plans:

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. The Division is benchmarking nationally against Could Not Attends (CNAs) and Did Not Attends (DNAs) to ensure we are offering a fair and consistent service within Primary Care in line with guidance and national standards.

The Division are undertaking a number of actions to improve the compliance rates for Parts 1a & 1b which can be seen in the table below:

Actions Parts ~ 1a & 1b	Outcomes	Timeline
Patients 'treated in turn' has been widely adopted which has had a negative impact on performance but, is clinically the right action for patients.	Proactive management of caseload to ensure patients are seen as quickly as possible. Improved quality and safety.	Backlog and waiting list trajectory to clear March 2020
Timely weekly reporting direct to area teams and a weekly 'deep dive' analysis to focus on potential breaches. We have also standardised intervention outcomes & reporting. Thus, ensuring CNA & DNA are accurately and timely recorded.	Correct & validated information ensuring Teams are timely informed and engaged and also can implement any remedial actions quickly.	Current and ongoing action
MHM Lead(s) are supporting areas to increase focus and traction on specific issues and action plans. We have closer monitoring & scrutiny of referral activity which also informs the weekly targeted intervention meetings.	Correct & validated information. Teams timely informed and engaged.	The solution to target achievement is a complete service transformation which is currently been worked through via the strategy implementation.

We have undertaken piloting TAG, hold weekend & additional clinics and have strongly focused on recruitment and workforce issues such as: • STR workers are now working through the interventions backlog • Secured additional funding for extra posts • Clinical & Social care staff deployed to focus on areas performing below target	Skilled workforce deployed to improve activity and compliance and provide a community asset based approach which supports earlier intervention and GP based consultations.	Compliance with part 1a and 1b profiled for April 2020
Increased Senior Manager focus to lead a Focus Group to address performance and continually develop and implement the agreed Divisional and local action plans and to provide leadership to improve targets.	Developed and implemented action plans to improve performance against 80% target.	The solution to target achievement is a complete service transformation for this identified group which is currently been worked through via the strategy implementation.

For Part 2, the continued attention, hard work and mitigating actions taken by the staff means we are still performing on plan and with sustained focus, the Division expects to remain compliant.

Actions being taken to sustain Part 2 ~ Care & Treatment Plan can be seen in the table below:

Actions ~ Part 2	Outcomes	Timeline
We have detailed & timely reports disseminated to teams and individual care coordinators by undertaking a weekly 'deep dive' analysis to focus on potential breaches and caseload validation. These support the weekly targeted intervention meetings.	Correct & validated information ensuring Teams are timely informed and engaged and can quickly implement any remedial actions.	We are performing on plan and with sustained focus, the Division expects to remain compliant for Part 2.
The Mental Health Measure Leads are aligned to local areas to support improved performance and overall quality of services to patients. They undertake regular and extensive data cleansing & caseload validation and also, provide close and regular monitoring of activity and compliance rates.	Proactive management of caseload ensuring patients receive a timely updated care plan.	We are performing on plan and with sustained focus, the Division expects to remain compliant for Part 2.
Increased Senior Manager focus to lead a Focus Group to address performance and continually develop and implement the agreed Divisional and local action plans and to provide leadership to improve targets.	The plan is focused to provide a standardised approach to increase compliance and improve quality & safety.	We are performing on plan and with sustained focus, the Division expects to remain compliant for Part 2.

We are further exploring ways to increase our establishment to reflect demand/backlog and have secured additional WG funding to recruit additional posts which is progressing urgently. Vacancies are managed swiftly as they arise and where necessary we have authorised bank cover / backfill.	Recruitment to vacant posts and cover arrangements in place, also new additional WG funded posts to support activity are progressing.	We are performing on plan and with sustained focus, the Division expects to remain compliant for Part 2.

Part 3 remains compliant. Processes are embedded to identify any breaches before they occur and so can be rectified immediately.

2.2 Lessons Learned from incidents

The health board have a standard reporting framework for incidents and key issues following the Putting Things Right (PTR) Regulations. Further examination of datix, including themes and trends are reported through agreed governance structures via divisional QSEEL.

Learning through Concerns

The tables below provide data on Welsh Government reported incidents for the years 2017/2018, 2018/2019 and 2019/2020 to date. The highest number of incidents (by category) is the unexpected death whilst under MHLD services. This category will include those patients who die from natural causes, however, currently we are still required to report under this category.

The Delivery Unit and Welsh Government (WG) have been working together to re-shape the existing serious incident framework. The current proposed approach is to move towards a framework that gives more ownership and accountability to HBs and Trusts, including what should be either reported and/or investigated. Whilst there is consensus about moving away from a trigger list approach, consideration is being given to supporting the framework with a small number of “must reports” and WG are seeking input from various specialist groups into what those might be.

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Total
Abscondment of detained patient assessed as high risk	0	0	0	0	1	0	3	2	2	2	0	0	10
Any serious act of Violence or Aggression	0	1	1	0	1	0	0	0	0	0	1	0	4
Grade 3 or above healthcare associated pressure ulcer develops	0	0	0	1	0	0	0	1	0	0	0	0	2
Mental Health - Attempted suicides as inpatients	0	1	1	1	0	0	0	0	0	0	0	0	3
Other type of incident	0	0	1	0	0	2	1	1	1	0	1	0	7
Patient fall resulting in harm/death to patient	1	1	0	1	0	2	1	2	2	0	1	0	11
Patient under 18 admitted to Adult Mental Health facilities	6	1	2	3	2	2	3	2	2	1	0	1	25
Suicide(or attempted) or homicide committed by an NHS MH patient	0	4	2	0	0	1	6	1	0	0	0	1	15
Unexpected Death whilst under the direct care of a health prof.	8	6	12	7	10	14	9	3	10	14	12	9	114
Total	15	14	19	13	14	21	23	12	17	17	15	11	191

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
Abscondment of detained patient assessed as high risk	1	0	1	1	0	1	0	0	1	1	1	1	8
Any serious act of Violence or Aggression	0	1	1	0	1	1	1	0	0	0	0	0	5
Grade 3 or above healthcare associated pressure ulcer develops	0	0	0	2	0	1	1	1	1	0	0	0	6
Mental Health - Attempted suicides as inpatients	1	0	1	0	3	2	2	2	0	0	1	1	13
Other type of incident	2	0	0	0	0	0	0	1	0	0	0	1	4
Patient fall resulting in harm/death to patient	2	1	0	0	1	0	1	1	0	0	1	0	7
Patient under 18 admitted to Adult Mental Health facilities	0	0	0	1	0	0	1	0	0	0	0	0	2
Sensitive Issue	1	0	1	0	0	0	0	0	0	0	0	0	2
Suicide(or attempted) or homicide committed by an NHS MH patient	1	0	0	1	1	1	4	2	2	1	0	2	15
Unexpected Death whilst under the direct care of a health prof.	12	5	9	17	7	10	11	11	8	10	6	16	122
Total	20	7	13	22	13	16	21	18	12	12	9	21	184

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Total
Abscondment of detained patient assessed as high risk	0	0	0	4	1	5
Any serious act of Violence or Aggression	0	1	0	0	1	2
Major Harm Caused	0	0	0	1	0	1
Mental Health - Attempted suicides as inpatients	2	0	1	0	0	3
Patient fall resulting in harm/death to patient	1	5	1	1	2	10
Sensitive Issue	0	0	2	0	0	2
Suicide(or attempted) or homicide committed by an NHS MH patient	0	6	0	1	1	8
Unexpected Death whilst under the direct care of a health prof.	11	11	7	7	10	46
Total	14	23	11	14	15	77

During April – June 2019 the Division successfully sent 137 closures to Welsh Government generating a significant amount of learning over a short period of time. During the process of closure the following 6 themes were identified, current work being undertaken to mitigate risks associated with the learning is identified below:

1 Discharge Planning

A Central Locality review of the Acute Care Pathway is underway with a focus on the move towards 72 hour follow up (rather than the current 7 day) that has been highlighted by the 2018 National Confidential Inquiry into Suicides and Safety in Mental Health.[1] The report states: “There were 227 suicides in the 3 months after hospital discharge in 2016, 17% of all patient suicides, a fall since 2011. The highest risk was in the first 2 weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.”

The review is looking at the Acute Care Meetings where progress and actions for completion from admission to discharge are assessed. A proposed redesign of the Acute Care Pathway will facilitate the gaining of information for a daily visual board review template to chart progress towards discharge and outstanding discharge actions using a traffic light system. Once implemented fully within the Central Locality the Division intends to extend the process across the Division.

2 Risk formulation and risk management

The 2 day Welsh Applied Risk Research Network (WARRN) training has been delivered across the Division. The training was implemented to improve standards of risk assessment and risk management across the Division. In addition to this, the Central locality has launched in house refresher risk formulation and management

[1] https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-69-Mental-Health-CORP-annual-report-v0.4.pdf

training. Options to roll the refresher training across all localities are currently being explored.

3 Single Point of Access (SPOA) decisions to downgrade urgent referrals

Following incidents which highlighted the issue with the SPOAA process, work has been undertaken to improve the processes and procedures when referrals are downgraded from urgent to routine. The SPOAA minutes are now saved onto a SharePoint drive which is accessible and documents the rationale for all decisions and how that decision has been communicated to the referrer. All referrals have a front sheet which includes the discussion held in the meeting and any actions taken. Duty workers now attend SPOAA and feedback on all assessments agreeing actions to be taken, this is also documented.

4 Timely allocation of care coordinator

Through the investigation of Serious Untoward Incidents, the Division has identified issues with timely allocation for Care coordination due to demand and capacity within the teams. The Quality and Workforce sub-group is currently reviewing the role of the community care hubs within primary care so that mental health assessment and treatment will commence at the earliest opportunity in a primary care setting but is coordinated by specialist Mental Health practitioners via an Multidisciplinary Team (MDT) in Primary Care linking in to tier 1 and tier 2 services as appropriate. Two pilot projects are to be commenced in Anglesey and Wrexham whose aim is to reduce the number of inappropriate requests for assessment and care coordination to ensure that secondary care services have the capacity to meet relevant requests for care coordination in line with the Mental Health Measure requirements.

5 Quality of documentation/record keeping

The quality of documentation and record keeping is a re-occurring theme within Serious Untoward Incidents across the division. This concern has been raised in various forms i.e. incidental to the incident and as a care and service delivery problem that has had an impact on patient care. Focused work is being undertaken across the Division to review the ongoing quality of documentation and record keeping including relaunching the Good Record Keeping Guidance (BCUHB 2017), annual mental health measure audits, case file audits during planned supervision, monthly quality and safety audits (HCMS), monthly Matron Walkabout audits. Consideration is being given to the development of record keeping clinics to improve individual performance and confidence.

6 Multiple case notes

The Integrated Case Note Standard Operating Procedure (SOP) has been reviewed and is progressing through the Policy Group. The purpose of the SOP is to ensure the creation and maintaining of integrated case notes across the MHLD Division. The SOP identifies that Contact with Patients will be recorded chronologically irrespective of the nature of contact to ensure that an accurate current position, reflecting all aspects of care is readily available and clearly identifiable. This allows for the improved sharing of information between clinical disciplines and underpins the ethos

of multi-disciplinary working. Once finalised in October, the SOP will be redistributed across the Division.

A newsletter identifying the themes from serious untoward incidents has been shared with all staff via local Today We Can (TWC) meetings across the Division.

Learning Project

Through the process of closing the legacy WG, reportable incidents the MHLD Governance Team identified an opportunity to develop a 4-stage process that aims to reduce the recurrence of incidents with the above noted themes.

Stage 1 - Thematic review of 137 closures to identify the prevalence of the above noted themes
Stage 2 - Identify additional methods of dissemination of learning to ensure learning influences both care delivery and service design
Stage 3 - Review of the effectiveness of Serious Incident action plans generated from the 137 closures
Stage 4 - Incorporate the learning and actions in the cycle of audit across the Division

The project is currently at stage 1, the thematic review of 137 closure forms that has identified the prevalence of the themes noted above and any other additional areas requiring a Division wide focus. The official launch of the project is in November at the MHLD Quality and Safety Learning event. Speakers include MHLD staff, H M Coroner, MD of Suicide Bereavement UK and the family of a person who died will present their personal story.

Learning lessons through the Coronial Process

HM Coroner North Wales (East & Central) wrote to the Division to share his concerns regarding the localities message taking and response systems. In response, the Division has undertaken a considerable amount of work to ensure there is a robust and auditable system in place. A flow chart has been shared across every Community Mental Health Team (CMHT) and community base (including learning disabilities and substance misuse services) that clearly identifies the responsible officer's duties at the end of each day to ensure every message taken has received an appropriate documented response. In addition to this contact phone numbers on google relating to mental health facilities are being amended. The Division has instructed that all out of hours contact numbers have bilingual answerphone messages that provide callers with emergency out of hour's numbers, signposting them to the relevant support services as required. The Division is developing an audit tool and an audit will be undertaken, pan division, every three months, the outcome of which will be shared with the Coroner regularly over the next 12 months.

Following comprehensive serious incident reviews and formal feedback from HM Coroner, issues were identified with those patients who experience co-occurring substance misuse and mental health problems. In April 2019 the Division implemented the NHS Wales & Welsh Government Service Framework to Meet the

Needs of People with a Co-occurring Substance Misuse and Mental Health Problems, to ensure that those with substance misuse and mental health problems get the right support at the right time and prevent people falling between services.

The Division set up a task and finish group with an agreement that people will be jointly cared for and supported and that services within the Division will work jointly to the co-occurring framework ensuring coproduction of care plans etc. Over time, four models of care have evolved in which the delivery of services to people with a co-occurring substance misuse and mental health problem could potentially be delivered. The agreed model within BCUHB is described below. The Task and Finish Group have identified five core principles derived from the Framework and work is underway to ensure the Division is meeting those core principles which are:

- Early recognition and prevention
- Competent, training workforce
- Effective clinical leadership
- Monitoring and measuring performance
- Corporate governance and accountability

Model of treatment	Description	Issues for Consideration
1. Joint liaison/ collaborative approach	The care of patients is jointly managed by both services	• Joint working required between mental health and substance misuse services • Joint responsibility • Ensures the skills and expertise of both spheres of health care is utilised

The Division learns from Prevention of Future Death Reports (Regulation 28) issued via the Coronial process to other Health Boards in Wales. A regulation 28 issued to Cardiff and Vale in relation to post falls management has seen the identification of six recommendations within the MHLD Division. Audits of neurological observations post fall have been undertaken identifying an improvement in compliance with undertaking neuro observations post fall from 85% in 2017/18 to 93% in 2018/19. Falls walls have been implemented across the Division providing user friendly information to frontline staff on the actions required post fall, these include actions to assess any clinical harm and actions to reduce the risk of recurrence.

Learning from Suicide and Self-Harm Data

Public Health Wales provide annual updates of suicide and self-harm data to the North Wales Suicide and Self-Harm Prevention group. The next report is scheduled to be completed in December 2019.

The Division has commenced work with Public Health Wales to incorporate more data pertaining to mental health patients within this report, using sources available to

this Division. The report will include: Incidence of suicide, Suicide rates in Wales, Suicide rate in Betsi Cadwaladr University Health Board, Suicide rate in Betsi Cadwaladr UHB Areas, Suicide rates in Betsi Cadwaladr UHB unitary authorities, Suicide rates in males and females, Age-specific suicide rates, Suicide and deprivation, Suicide methods in Betsi Cadwaladr UHB and Wales, Suicide locations in Betsi Cadwaladr UHB, Suicide and healthcare in Betsi Cadwaladr UHB and Wales (including data pertaining to inpatients where available and information on individuals in contact with specialist mental health services in the previous 12 months via Divisional database), Suicide in children and young people, Suicide clusters, Self-harm in Betsi Cadwaladr UHB (including admissions for self-harm and reported incidents of self-harm on NHS sites).

The division has recently undertaken local thematic reviews in terms of confirmed suicides; this will be further reviewed, and linked into the National Confidential Inquiry into Suicides and Homicides together with the work being undertaken by Public Health Wales.

In terms of missing patients, there were nine incidences of AWOL patients reported to Welsh Government between August 2018 and July 2019. All patients were returned to the units without harm to themselves or others.

The Division has a ratified policy (AC008) that sets out the procedure to be followed when an inpatient from a mental health ward is missing, or a community patient subject to supervised community treatment, or conditional discharge who is deemed to be at high risk to themselves or others, patients known to community Mental Health or Learning Disability (MH & LD) services who have gone missing and is deemed to be vulnerable and high risk.

Data from the Harms Dashboard is discussed on a weekly basis at locality TWC meetings. This includes Hospital Acquired Pressure Ulcers (HAPU), falls, infection control and medication errors. Medication errors is one element of an audit of all three localities to be carried out by the Head of Mental Health Pharmacy in December 2019. The full report will be scheduled for completion before April 2020. The Divisional Medicines Management sub-group are tracking progress and reported to Divisional QSEEL.

There were no Child Adolescent Mental Health Services (CAMHS) to adult transition incidents of note over the past 12 months. However, the Division has worked with CAMHS colleagues to improve the service transition from CAMHS to adult services by planning early, listening to young people, providing appropriate and accessible information to young people, and focusing on outcomes and joint commissioning. Co-production of care plans moving to adult services is essential to ensure compliance with part 2 of the MHM Wales Care Treatment Plan (CTP) requirements. The process is documented in Policy MHLD0020.

2.3 Healthcare Inspectorate Wales (HIW) – outstanding actions

External Regulation: Healthcare Inspectorate Wales Reports and Actions.

The most recent HIW inspection was at the Ablett Unit on 16-18 January 2019. The All Wales Thematic Review of CMHTs was reported in February 2019 with a number of actions to be undertaken.

There are 14 outstanding actions of the total 168 (including All Wales HIW actions) that require work and these are being 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. The oldest relate to the visit to Heddfan in June 2017 (both awaiting estates funding) and the most recent covers the All Wales joint thematic review reported in February 2019.

The outstanding actions are a standing agenda item on each of the locality QSEEL meetings and are reported to Divisional QSEEL on a monthly basis.

Site	Date of visit	No of outstanding actions	Issue	Update September 2019
Heddfan	June 2017	2	Lighting in garden area Enclosing nurses station on Tryweryn	Estates have assessed the area and a business case is being developed by the Business Support Manager. There is currently no date for the works required
Division – finance	2018	2	Identification of lockers	
Hergest	September 2018	1	S136 toilet door awaiting magnetic fixings	
Central – Nant y Glyn	November 2018	2	Awaiting handwash basin in clinic room	Date awaited from with Estates
Regional – Cynnydd	January 2019	1	Awaiting extractor fan in ADL kitchen	The minor works have been completed and parts on order. Awaiting receipt of parts and a date to progress.
Division wide – All Wales thematic review	February 2019	6	Review CMHT access criteria Equitable provision of advocacy	

			inpatients and CMHTs WCCIS x 2 Delivery of Strategy	

2.4	**Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan**

The challenges we face as an organisation and a region are interconnected, and cannot be tackled by the wider Health Board or by our Mental Health Division in isolation.

Mental health services have traditionally focussed on treating symptoms of ill health and managing their emergency complications. However, this model of care is unsustainable for the future if we are to meet current and future challenges facing health and social care.

With the support of key partners and people with lived experience of mental health issues, we have co-produced Together for Mental Health in North Wales - the first 'whole system' integrated mental health strategy aimed at addressing these challenges.

Our new approach aims to ensure that people of all ages receive the right support, in the right place, at the right time, throughout their lives. This involves moving away from a clinical, specialist model of bed-based care to one which is focused on community based prevention and early intervention. Our asset-based approach will focus on people's strengths and skills rather than just the challenges that they face.

This significant, whole system change will deliver better outcomes for people across the region, as well as better value for money.

Progress within the Mental Health & Learning Disabilities Division

Over the past three years we have made real progress in improving quality of our services, as set out in our strategy. These improvements are being felt at ground level by the people who use our services. Notably:

- We have significantly reduced the number of days our patients spent at mental health units outside of North Wales. This has enabled more people to receive care closer to the support network of their friends and family, and also delivered significant cost savings

- Recent reports from unannounced inspections of the Hergest Unit (Ysbyty Gwynedd), Ablett Unit (Glan Clwyd Hospital) and Nant y Glyn Community Mental Health Service by Healthcare Inspectorate Wales show that standards of care and staff morale have improved

- A specialist Perinatal Mental Health Service has been established to support new and expectant mums who are struggling with their mental health. In 2018/19 the service supported more than 450 women

- We have implemented an end of life pathway, improved end of life staff training, and established dedicated end of life suites on our older persons mental health wards

- We have developed our approach to restrictive practice management for all older adults within BCUHB healthcare settings. As a result of our proactive approach, assaults on our mental health staff have reduced by 50% over the past five years

Delivering a whole system transformation

Despite this progress, there is still a need to go much further, ensuring that every person has the right supporting framework, life skills, and community support and can access quality services when needed.

A whole system transformation is required to ensure that people across the region receive the timely support they need.

Clear delivery plans have been developed which set out how we will achieve this transformation. These include clearly defined priorities, enablers for change, metrics and milestones.

Work to deliver on this is seeing a wide range of statutory, voluntary and third sector organisations from across the region work together in partnership in a way which simply has not happened in the past.

Governance structures have been approved which allow for strengthened collaboration, and agreement has also been reached on both the Service Model and Clinical Model.

Three Local Implementation Teams and six Quality and Workforce groups continue to work collaboratively to ensure that delivery of the strategy meets local needs, and delivers the required changes to clinical service provision.

Detailed locality plans have been developed by the Local Implementation Teams and agreed by the Together for Mental Health Partnership Board.

A strengthened approach to commissioning services is being introduced which will help ensure the effective use of resources, value for money, and delivery of outcomes.

Funding from the Welsh Government's Plan for Health and Social Care – 'A Healthier Wales' is being used to ensure a whole system approach to delivery. This includes the appointment of a Service Improvement Programme Manager and three Local Implementation Team Business Managers, who are focusing on transforming

the community and primary care elements of our delivery plans in order to alleviate demand on our more specialist services.

To deliver the significant change programme at pace, discussions are ongoing with Welsh Government over potential investment to support the pump-priming of the new service model, which would enable a period of transition to limit disruption to service delivery,

Many of the problems we face in North Wales have built up over a long time, and they will not be tackled quickly.

Despite this, we have made significant early progress in beginning to shift the focus of care to prevention and early intervention, and improving the support for people in crisis.

Based on the empowering principles of our I CAN campaign, we have:

- Developed detailed local plans through the three Local Implementation Teams to introduce new community support (Integrated I CAN Pathway) which will help build resilience and prevent people from falling into crisis. Once fully established, we expect that more people will receive the early support they need in the community, leading to reduced waiting times and improved outcomes for people who require the specialist support of our mental health services

- Introduced the first element of this pathway: I CAN Unscheduled Care, at North Wales' three Emergency Departments. I CAN Mental Health Urgent Care Centres support people in crisis who do not require medical treatment or admission to a mental health unit. Since January 2019 the service has supported more than 1,000 people and a recent social return on investment analysis found that for every £1 invested, more than £5 of social value was created

- Piloted I CAN Work in partnership with Bangor University, Welsh Government, CAIS and the Rhyl City Strategy. Based on the leading Individual Placement Support (IPS) model which is endorsed by NICE, I CAN Work aims to help people with mild to moderate mental health problems find and remain in paid employment in order to support their recovery

- Introduced I CAN Mental Health Awareness Training which is being offered free of charge to employers, community groups and individuals across the region. More than 1,500 people have signed up to receive the training.

3. Conclusions / Next Steps

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.

4. Recommendations

The Committee is asked to note:

1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to:
    - Compliance with Mental Health Measure
    - Lessons Learned from incidents
    - HIW outstanding actions
    - Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan

2. The risks that are identified are being managed through locality structures and overseen by Divisional Directors

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

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

July 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. Additional assurance will be provided on a quarterly basis with narrative in support of the rating given to a random selection of plan actions . Where a red rating is applied in any month, a short narrative is provided to explain the reasons for this and actions being taken to address.

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.

Where the RAG letter is blue instead of white in a cell, this indicates a Milestone. The letter P in a purple cell states the Action has been achieved.

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)

July 2019

Programme Health Improvement & Health Inequalities Matrix

Plan Ref	Actions	Executive strategic Lead	Submitted to Committees			Self Assessment and Milestone due indicator (M) from revised outlook report July 2019								
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP001	Smoking cessation opportunities increased through Help Me Quit programmes	Executive Director of Public Health	G	G	G	G								M
AP002	Healthy weight services increased	Executive Director of Public Health	G	G	G	G								
AP003	Explore community pharmacy to deliver new lifestyle change opportunies	Executive Director of Public Health	G	G	G	G								M
AP004	Delivery of ICAN campaign promoting mental well-being across North Wales communities	Executive Director of MH & LD	G	G	G	G								M
AP005	Implement the Together for Children and Young People Change Programme	Executive Director of Primary and Community Care	A	A	G	G		M						M
AP006	Improve outcomes in first 1000 days programmes	Executive Director of Primary and Community Care	G	G	G	G					M			M
AP007	Further develop strong internal and external partnerships with focus on tackling inequalities	Executive Director of Public Health.	G	G	G	G					M			M
AP008	Partnership plan for children progressed with a strong focus on Adverse Childhood Experiences	Executive Director Primary and Community Care		A	A	A								M

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Programme Care Closer to Home Matrix

Plan Ref	Actions	Executive strategic Lead	Submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP009	Put in place agreed model for integrated leadership of clusters in at least three clusters, evaluate and develop plan for scaling up	Executive Director Primary & Community Care	G	G	A	A		M						M
AP010	Put in place Community Resource Team maturity matrix and support to progress each CRT	Executive Director Primary & Community Care	G	G	G	G					M			M
AP011	Work through the RPB to deliver Transformational Fund bid	Executive Director of Primary and Community Care	G	G	G	G								M
AP012	Define and put in place Model for integrated Primary and Community Care Academy (PACCA) to support GP practices under greatest pressure	Executive Director of Primary and Community Care	A	A	G	G		M						M
AP013	Develop and implement plans to support Primary care sustainability	Executive Director of Primary and Community Care		G	G	G					M			M
AP014	Model for health & well-being centres created with partners, based around a 'home first' ethos	Executive Director of Primary and Community Care	A	A	A	A		M						M
AP015	Implementation of RPB Learning Disability strategy	Executive Director of MH & LD		G	G	G								M
AP016	Plan and deliver digitally enabled transformation of community care	Executive Director of Primary & Community Care	G	G	A	A								M
AP017	Develop and Implement a Social prescribing model for North Wales	Executive Director of Primary & Community Care	G	G	G	G								M
AP018	Establish framework for assessment for CHC and individual packages of care for people with mental health needs or learning disabilities	Executive Director of MH & LD	G	G	P									M
AP019	Establish a local Gender Identity Team	Executive Director of Primary & Community Care	A	A	A	A					M			

AP018 CHC: A Standard Operating Procedure has been developed outlining the key principles , roles and responsibilities for the Commissioning of Adult mental Health and Learning Disabilities. The SoP incorporates the key components from the National Framework for implementation in Wales (WAG 2014), alongside other relevant guidance and good practice, including current legislation. To support staff, flow charts have been developed for ease of reference and guidance. A training programme will be also be further developed to support staff alongside the implementation **of the SoP**

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Programme Planned Care Matrix

Plan Ref	Actions	Executive strategic Lead	Submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP020	Centralisation of complex vascular surgery services supported by a new hybrid theatre on YGC site	Executive Director of Nursing & Midwifery	P											
AP021	Implement preferred service model for acute urology services	Executive Director of Nursing & Midwifery	G	G	A	R		M						M
AP022	Business case, implementation plan and commencement of enabling works for Orthopaedics (refer to estates section/ plan)	Executive Director of Nursing & Midwifery	G	G	A	A		M						
AP023	Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists	Executive Director of Nursing & Midwifery	A	A	A	R		M						
AP024	Rheumatology service review	Executive Director of Primary & Community Care	G	G	A	A					M			
AP025	Systematic review and plans developed to address service sustainability for all planned care specialties (RTT).	Executive Director of Nursing and Midwifery	G	G	A	A		M						
	Implement year one plans for Endoscopy	Executive Director Health Sciences	G	G	A	R								
	Systematic review and plans developed to address diagnostic service sustainability		G	G	A	R								M
	Systematic review and plans developed to address service sustainability	Executive Director Nursing & Midwifery	G	G	A	A								M
AP026	Fully realise the benefits of the newly established SURNICC service	Executive Director Primary and Community Care		G	A	G					M			
AP027	Implement the new Single cancer pathway across North Wales	Executive Director of Therapies & Health Sciences	A	R	A	G								
AP028	Develop Rehabilitation model for people with Mental Health or Learning Disability	Executive Director of Mental Health & Learning Disabilities		G	G	G								M

AP021 Urology: The urology business case is under active preparation however it will not be complete by the end of September. An All Wales approach is now being developed for robotic assisted surgery which has had some impact on timescales. Capacity to write the case has now been strengthened. A separate update on robotic assisted surgery is provided for this meeting.

AP023 Eye Care Measure: Work is proceeding assisted by the recent appointment of a project manager using allocated funds from Welsh Government. The business case is on track for completion in November 2019

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Programme Unscheduled Care Matrix

Plan Ref	Actions	Executive strategic Lead	submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP029	**Demand** Improved Urgent care out of hours / 111 service	Executive Director Nursing and Midwifery	G	G	G	G					M			
AP030	**Demand** Enhanced care closer to home / pathways	Executive Director Primary and Community Care	G	G	G	A		M			M			M
AP031	**Demand** Workforce shift to improve care closer to home	Executive Director Nursing and Midwifery	G	G	G	A		M						
AP032	**Demand** Improved Mental Health crisis response	Executive Director of MH & LD	G	A	A	A		M						M
AP033	**Demand** Improved Crisis intervention services for children	Executive Director Primary and Community Care	A	A	G	A								M
AP034	**Flow** Emergency Medical Model	Executive Director Nursing and Midwifery	G	G	A	G		M						
	Flow Management of Outliers	Executive Director Nursing and Midwifery	Grey	Grey	Grey	G		M						
AP035	**Flow** SAFER implementation	Executive Director Nursing and Midwifery	G	A	A	A		M			M			
AP036	**Flow** Ablett / PICU for Mental Health (linked to estates section/ plan)	Executive Director of MH & LD	G	A	A	A								M
AP037	**Flow** Early Pregnancy Service (emergency Gynaecology)	Executive Director of Public Health	G	G	G	G		M			M			
AP038	**Discharge** Integrated health and social care	Executive Director Nursing and Midwifery	A	A	A	A		M						M
AP039	Stroke Services	Executive Medical Director	A	A	R	A								

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Programme Workforce Matrix

Plan Ref	Actions	Executive strategic Lead	submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP041	Establish an integrated workforce improvement infrastructure to ensure all our work is aligned	Executive Director WOD	G	G	G	G		M						
AP042	Build on QI work to develop the BCU improvement system and delivery plan for efficient value based healthcare	Executive Director WOD	G	G	G	G		M						M
AP043	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	Executive Director WOD	A	A	A	A		M						M
AP044	Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture	Executive Director WOD	G	A	A	A		M			M			M
AP045	Develop an integrated multi professional education and learning Improvement Programme in liaison with HEIW	Executive Director WOD	A	G	G	G		M			M			
AP046	Develop a Strategic Equality Plan for 2020-2024	Executive Director WOD	G	G	A	G		M						
AP047	Deliver Year One Leadership Development programme to priority triumvirates	Executive Director WOD	G	A	A	A		M			M			M
AP048	Develop an integrated workforce development model for key staff groups with health and social care partners	Executive Director WOD	G	G	G	G					M			M
AP049	Provide ‘one stop shop’ enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services	Executive Director WOD	A	A	A	A		M						M
AP050	Develop and Deliver Year one Communications Strategy to improve Communications and enhance BCUHB reputation	Executive Director WOD	A	G	G	G		M			M			M

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Programme Digital Health Matrix

Plan Ref	Actions	Executive strategic Lead	submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP051	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	Executive Medical Director	G	G	G	G		M						M
AP052	Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	Executive Medical Director	A	A	R	R		M			M			M
AP053	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)	Executive Medical Director	G	G	G	G		M						M
AP054	Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	Executive Medical Director	G	G	G	G		M						
AP055	Support the identification of storage solution for Central Library	Executive Medical Director	A	A	A	A		M						
AP056	Transition program to review the management arrangements for ensuring good record keeping across all patient record types	Executive Medical Director	G	G	A	A								M
AP057	Delivery of information content to support flow/efficiency	Executive Medical Director	A	A	G	G		M						M
AP058	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	Executive Medical Director	G	G	A	A								M
AP059	Provision of infrastructure and access to support care closer to home	Executive Medical Director	A	A	A	A								M
AP060	Support Eye Care Transformation	Executive Medical Director	G	G	G	G								M
AP061	Implement Tracker 7 cancer module in Central and East.	Executive Medical Director	A	A	G	G		M						

WCCIS: Due to delays in development of this product and the order of the roll out across Wales BCU is no longer in a position to test the implementation during 2019-20. Discussions are continuing nationally to confirm revised programme for roll out and adoption of the product in Health.

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Programme Estates Strategy Matrix

Plan Ref	Actions	Executive strategic Lead	submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019							
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP062	Statutory Compliance / Estate Maintenance	Executive Director Planning and Performance	G	G	G	G								M
AP063	Primary Care Project Pipeline		G	G	G	G								M
AP064	Well-being Hubs		G	G	A	A								M
AP066	Ruthin Hospital		G	G	G	G								M
AP067	Vale of Clwyd		G	G	G	G								M
AP068	Orthopaedic Services		G	G	G	G								M
AP069	Ablett Mental Health Unit		G	G	G	G								M
AP070	Wrexham Maelor Infrastructure		R	R	R	R		M						
AP071	Hospital Redevelopments		G	G	G	G								M
AP072	Central Medical Records		G	G	G	G								M
AP073	Residencies		G	G	G	G								M
AP074	Integrated Care Fund (ICF) Schemes		G	G	G	G								

AP070 -The Programme Business Case has been approved by the Executive Team and will be presented to the August Finance and Performance Committee.

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Appendix A: Further Information

The Annual Plan is included on page 423 of the July 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 and Experience (QSE) Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Integrated Quality and Performance Report
Report Author:	Dr Jill Newman, Director of Performance Mr Edward Williams, Head of Performance Assurance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning and Performance
Public or In Committee	Public
Purpose of Report:	This paper provides the QSE Committee with detail of the latest performance aligned to the NHS Annual Delivery Framework for Key Performance Indicators which sit within its remit. Where performance is below the national target an exception report is provided to indicate actions being take to improve performance.
Approval / Scrutiny Route Prior to Presentation:	The content has been prepared by exception report leads following a process to obtain sign off with Executive sponsors. Overall editorial scrutiny has been applied by the Director of Performance
Governance issues / risks:	The Executive Summary highlights the issues of greatest concern to the Committee
Financial Implications:	The financial benefits arising from high quality safe care are recognised and the cost of poor performance both to the individual patient, staff morale, organisational reputation and financial cost is integral to improving the performance of the Health Board
Recommendation:	The Committee are asked to note the current performance and consider the actions being taken to deliver improved performance. The committee are asked to determine areas of concern for escalation to the Board.

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

Performance is part of the Special Measures Improvement Framework

Equality Impact Assessment

The report considers the performance against the Operational Plan of the Board which has had an EqIA carried out

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

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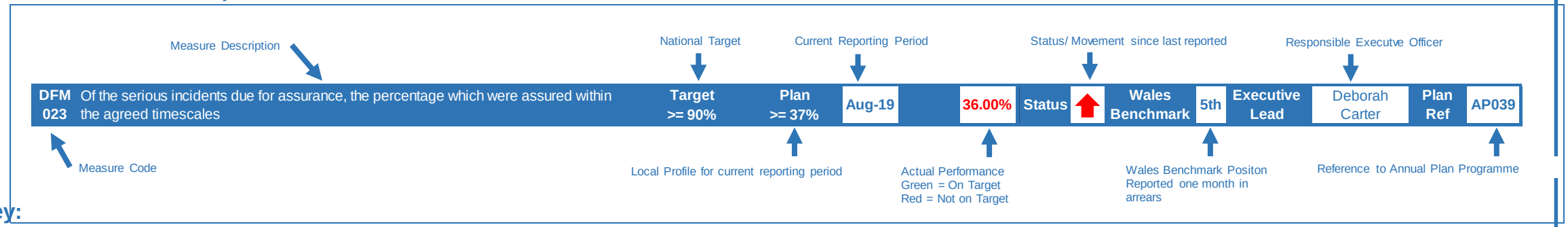
About this Report

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

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. Measures are required by NHS Wales Delivery Framework, but are not linked to Actions in the Operational Plan*

About this Report

Section 3: Report Content for 2019/20

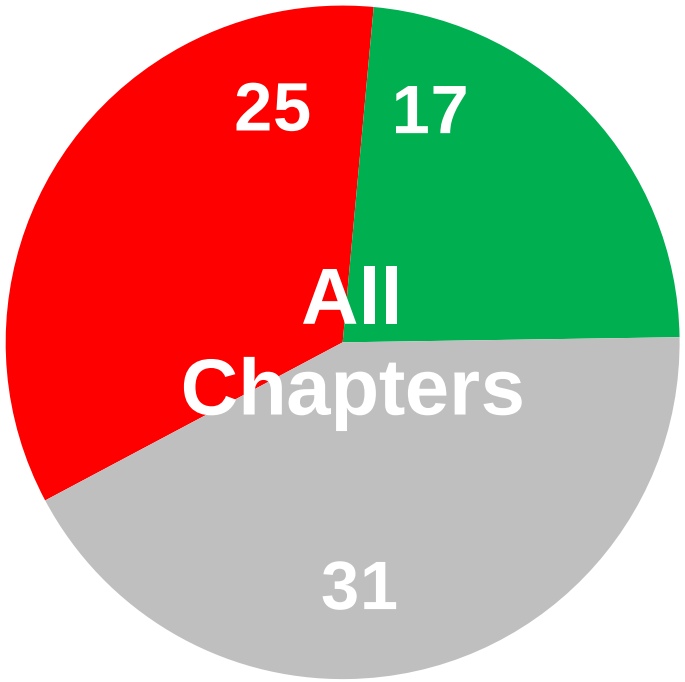
Profiles
The Executive sponsor has confirmed the profile of performance expected to be delivered during the year based on the actions and resourcing set out in the operational plan. The report will track performance against this profile . It is noted that profile set will reflect the reporting requirement 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. This month the health board have received the national targets expected for delivery of the infection prevention and control indicators and have included these in the report.

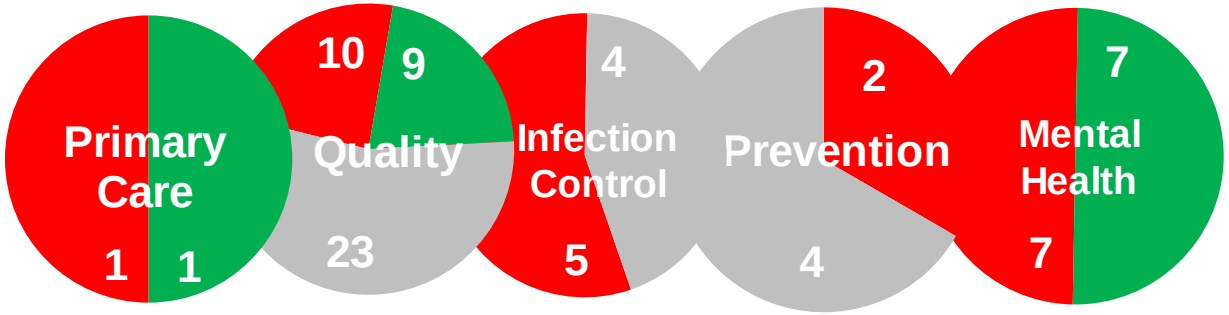
Escalated Exception Reports
When performance on a measure is worse than expected, the Lead for that measure is asked to provide an exception report to assure the relevant Committee that they have a plan and set of actions in place to improve performance, that there are measurable outcomes aligned to those actions and 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 the Quality, Safety and Experience Committee (QSE) of the Board, there may be instances where they need to be 'escalated' to the Board. The timings of the Board and its committees does mean on occasions the Board will have received timely information on the performance compliance ahead of the QSE committee scrutinising the performance. This is the case with a number of indicators in this report.

Performance Trends
Where appropriate run charts or 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 August 2019 where the measure and profile is reportable monthly.
This report also includes the local indicator ; Healthcare Acquired Pressure Ulcers and provides disaggregation of the Health Care Acquired Infection data to demonstrate the split between hospital and community recorded infections and disaggregation of S.aureus indicator to show numbers of MRSA and MSSA infections and number of C.difficile infections which contribute to the overall rate for both national measures.
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.

Overall Summary Graphic Summary





Most Improved

Measure	Status		(Target)
Survey Results : Dignity and Respect	96.60%	↑	Improve
Survey Results: Satisfaction with GP Care	92.50%	↑	Improve
Survey Results: Satisfaction with Hospital Care	94.60%	↑	Improve
Incidents Assured with agreed Timescales	47%	↑	>= 90%

Of Most Concern

Measure	Status		(Target)
Cumulative Number of Klebsiella	59	↓	<= 38
Psychologiacal Therapy within 26 Weeks	19.85%	↓	>= 80%
Neurodevelopment Assessment within 26 Weeks	37.21%	↓	>= 80%
MH Assessments within 28 Days (Combined)	66.32%	↓	>= 80%

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Executive Summary

It is noted that the completeness of this month's report has been adversely affected by the major incident which affected national data systems. Once this data is recovered it will be included in the November 2019 report.

- This report demonstrates continuing improvement in responding to serious incidents with reduction in both the number of open incidents and the volume of these that are overdue. This demonstrates the benefits arising from the revised governance and review process and is important in developing a culture of learning from incidents.
- The Quality Improvement Strategy of the Health Board includes: infection prevention, falls, healthcare acquired pressure ulcers (HAPU) and medicines management. The revised ward dashboard is improving visibility of performance for front-line staff and helping engage staff in continuous improvement driven through the improvement collaboratives. This month the revised national indicators for infection prevention have been received. To aid understanding of the implications of these, the health board are using both the national target rate and the number of patients affected. The health board are also working through the origins of infections and finding the majority are arising in community rather than hospital settings. The triangulation of data from the falls and HAPU collaboratives do not show any geographical hotspots within this months data, longitudinal data is being used to assess wards where incidence is higher than expected. This links to the work on ward accreditation which is also delivering a culture of continuous improvement.
- Of particular concern within this report is the volume of procedures postponed at short notice. This is recognised as a poor patient experience and also inefficient use of resources. Analysis has been completed at location, consultant and reason for postponement level, which is informing the development of an action plan managed via the Planned Care Improvement Group.
- The level of staff vacancies is affecting compliance with staffing levels and continues to present a risk to the quality of care delivered. Newly trained nurses are expected to be in post from October.
- The report highlights the improvement made in the overall delivery of access to Children and Adolescent Mental Health Services, which will be further improved following receipt of investment to improve early intervention. Investment has also been received to support Neuro-development services, which have seen a significant increase in demand. Future reports will include detail of improvement actions being taken in these services. Overall performance on Mental Health Measure is adversely affected by performance in adult services. Actions being taken to improve this reflects the high volume of patients who are discharged on assessment and therefore could be supported prior to referral.

Chapter 1 – Quality Graphic Summary

Note: Many of the Measures in this chapter are reported on a quarterly, Bi-annual or Annual basis. Those presently unavailable are shown as grey in the pie-charts.

The Quarter 1 position for some measures isn't currently available due to various issues including the national major IT incident which resulted in failure of data servers. Recovery of this data is underway. These issues have occurred on national systems, thus affected all Health Boards and are beyond our control.

We have been assured that data will be available in time for the next sitting of the Committee, in November 2019. Measures affected include Childhood Immunisation, Medicines Management and Research.

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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
Sepsis Six Bundle: Inpatients	**100%**	→	100%
Sepsis Six Bundle: Emegrgency Department	**54.90%**	↑	>= 74%
Preventable Hosptial Acquired Thrombsis			N/A Q
Opiod Average daily quantities per 1,000 patients	**4815.01**	↓	<=4,960
Antipsychotic Prescriptions for Over 65s			<= 7.04

Measure	Status		(Target)
Antibacterial Items er 1,000 STARPUS	**259.80**	↑	<= 275.5
Combined 4 Antibacterial items prescribed	**12.68**	↓	<= 14.32
Patient Safety Solutions Wales Alerts and Notices			<= 5
Serious Incidents Assured within timescales	**47.00%**	↑	>= 90%
Serious Incidents: Patient Falls	**12**	↑	<= 11
Serious Incidents: Pressure Ulcers	**6**	↓	0
Total Number of Healthcare Acquired Pressure Ulce	**217**	↓	AP
Total Number of New Never Events	**0**	→	0
Universal Mortality Reviews within 28 Days	**85.80%**	↓	>= 95%
Crude Mortality Rate (Under 75 years of age)	**0.71%**	↑	<= 0.70%
New Medicines made available	**100.00%**	↑	100%

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Chapter 1 – Quality Summary Page 2

Measure	Status		(Target)
Number of Clinical Research Studies			+2.5%
Number of Commercial Research Studies			+1.25%
Number recruited to clinical studies			+2.5%
Number recruited to commercial studies			+1.25%
Survey Results: Satisfaction with Health Services			Improve
Number of Postponed Procedures (Non-clinical)	**2,242**	↑	Reduce
Evidence of Responding to service user experience			N/A
Concerns Replies within 30 Days	**43.00%**	↑	>= 75%
Over 65's with Dementia registered with GP			Improve
Survey Results: Dignity and Respect	**96.60%**	↑	Improve
Survey Results: Satisfaction with GP care	**92.50%**	↑	Improve

Measure	Status		(Target)
Survey Results: Satisfaction with Hosptal Care	**94.60%**	↑	Improve
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)	**84.00%**	↓	>= 95%
Ward Staff Skill Mix (Nursing)	**55.00%**	←	>= 60%

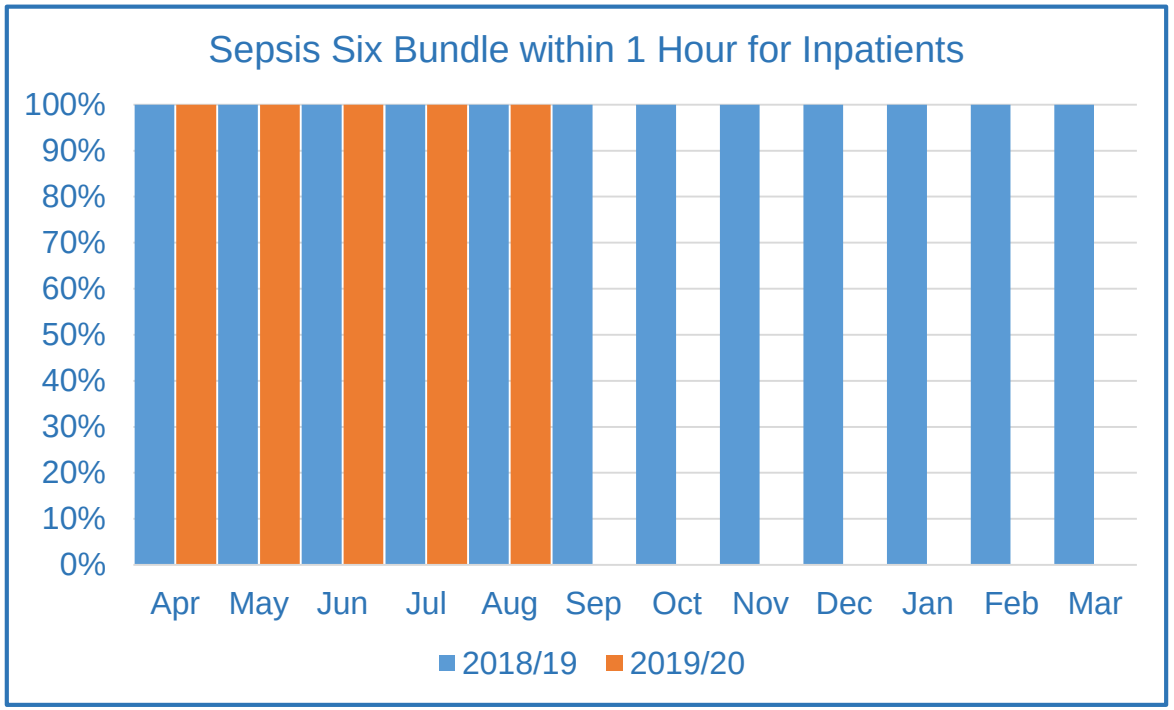
Integrated Quality and Performance Report
Quality, Safety & Experience Committee Version

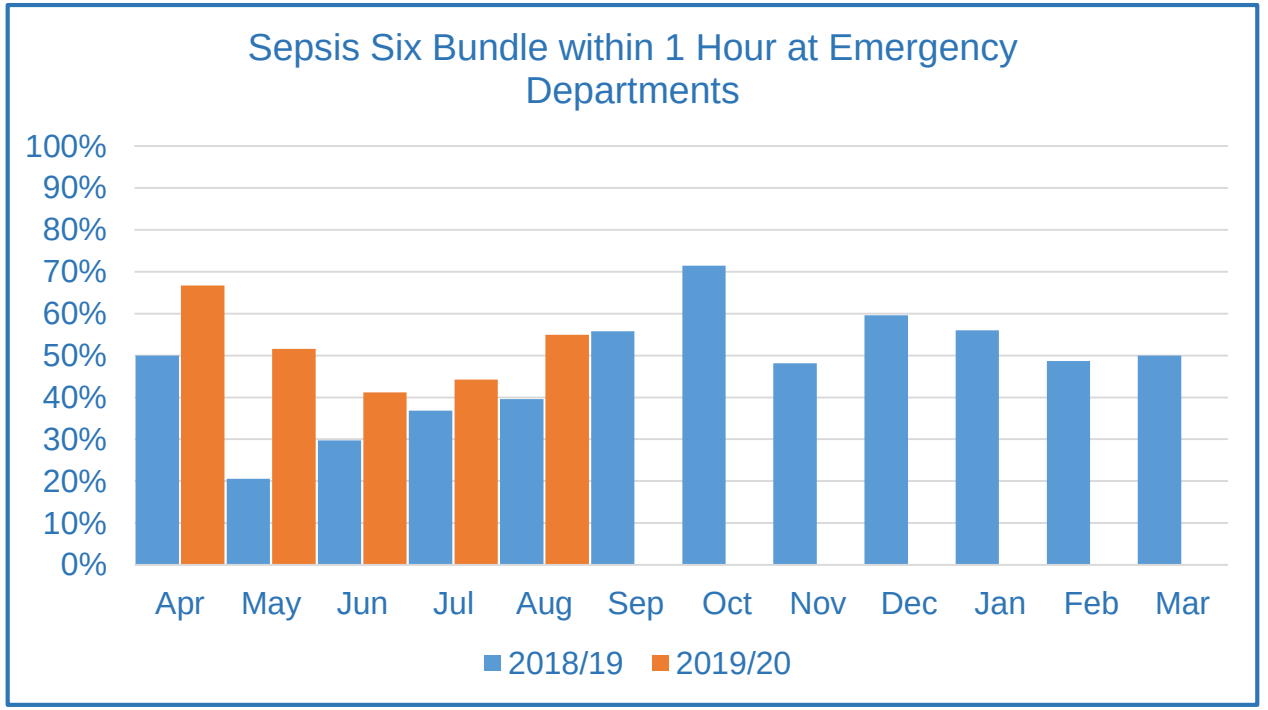
September 2019

Chapter 1 – Quality

Sepsis Six Graphs

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%	Aug-19	100%	Status		Wales Benchmark	1st	Executive Lead	David Fearnley	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 >= 74%	Aug-19	54.90%	Status		Wales Benchmark	4th	Executive Lead	David Fearnley	Plan Ref	AP039





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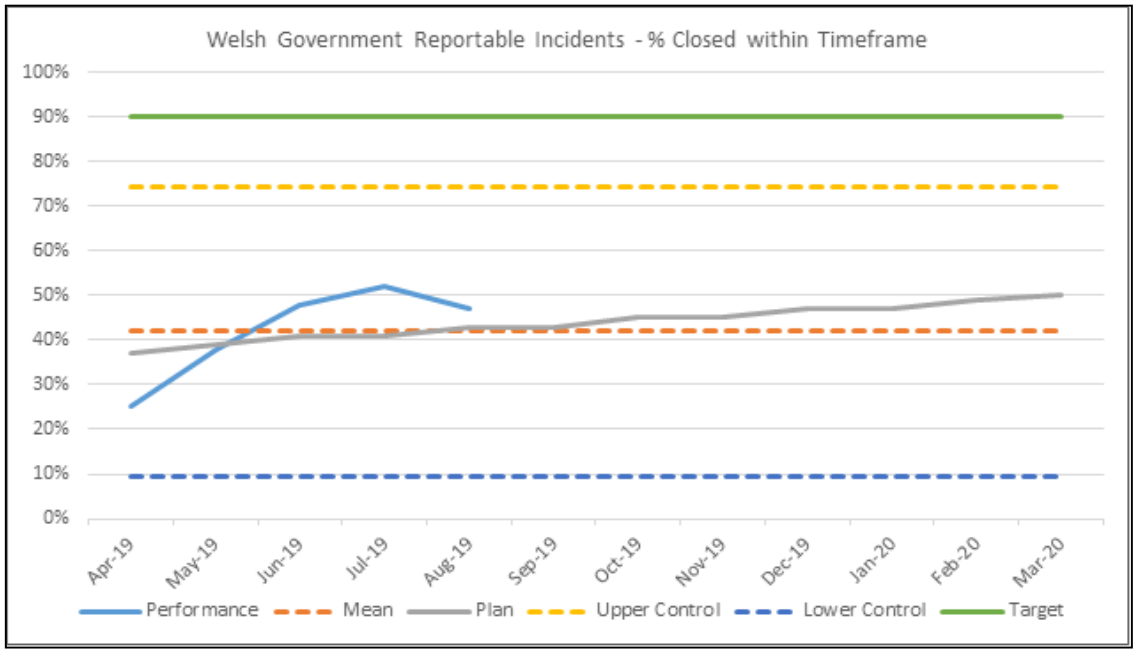
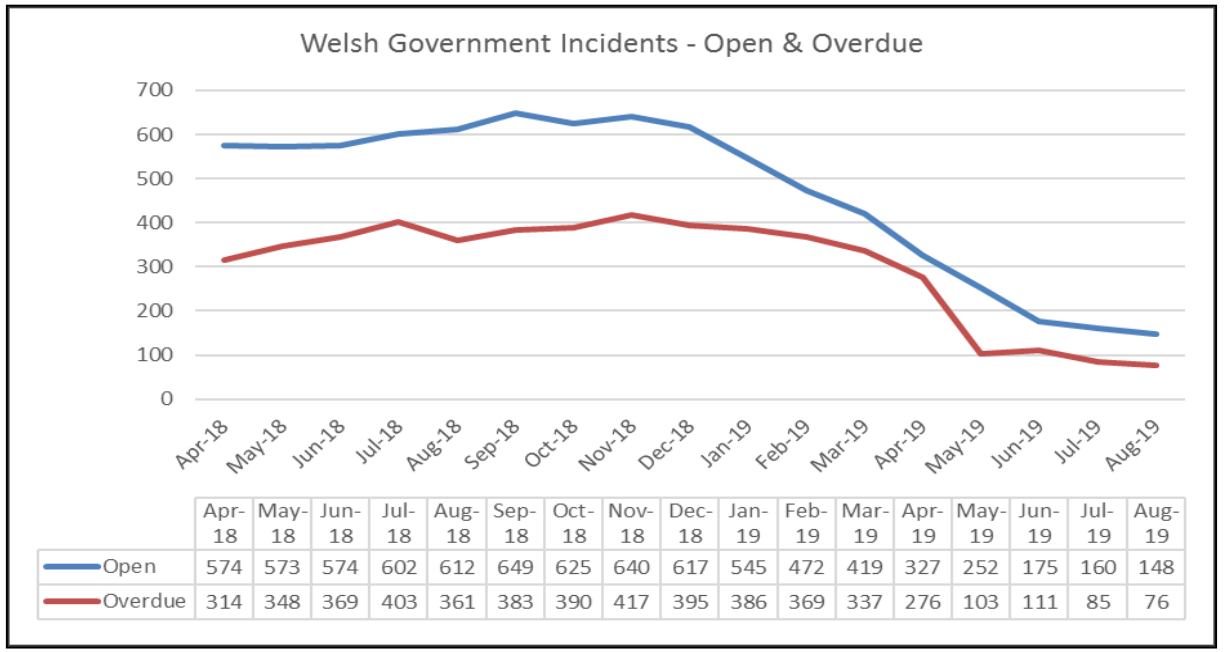
Sepsis Six Bundles

Actions	Outcomes	Timeline
1. Sepsis collaborative (ED Depts.) Day 4 of the sepsis collaborative took place on 5th Sep 2019	• Improve understanding of issues and develop action plans to rectify problems as identified • Improved ownership around sepsis and helps staff to aspire to be best they can • Reduction in mortality is being seen now, particularly on the Ysbyty Glan Clwyd (YGC) site as a result of on going improvement work.	April 2020 (predicted)
2. Sepsis dashboard Sepsis dashboard is active and in use across all sites by ED depts. It is now being used to inform of progress during ED DRIPS meetings. DRIPS stands for 'Data, Review the cases, Improvements, Plot the dots, Share and Celebrate'. Work is currently in progress again to evolve further by inclusion of new data sets.	• Provision of live data to inform staff of progress and help identify areas of weakness that need improvement	November 2019
3. Introduction of DRIPS meetings (ED depts.) All acute site ED depts. Are now running DRIPS meeting to review progress and make improvements to early sepsis treatment	• Improve understanding of issues and develop action plans to rectify problems as identified • Improved ownership around sepsis and helps staff to aspire to be best they can	April 2020 (predicted)

Chapter 1 – Quality Incidents Graphs

DFM 023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Target >= 90%	Plan >= 43%	Aug-19	47.00%	Status	Wales Benchmark	2nd	Executive Lead	Deborah Carter	Plan Ref	AP039





	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	May-19	Jun-19	Jul-19	Aug-19
Open	574	573	574	602	612	649	625	640	617	545	472	419	327	252	175	160	148
Overdue	314	348	369	403	361	383	390	417	395	386	369	337	276	103	111	85	76

Why we are where we are: There is a continued effort to reduce the number of Welsh Government reportable incidents open. This has seen an improvement week on week, with the number open as at 28/08/19 being 148, of these 76 are overdue. There is a focus on the management of incidents and this is increasing the timeliness of managing of incidents more effectively. The weekly incident review meetings continue to scrutinize progress as well as detail of incidents. Closure is dependent upon appropriate investigation. Changes in service governance arrangements is expected to impact positively on performance of WG reportable incidents going forward

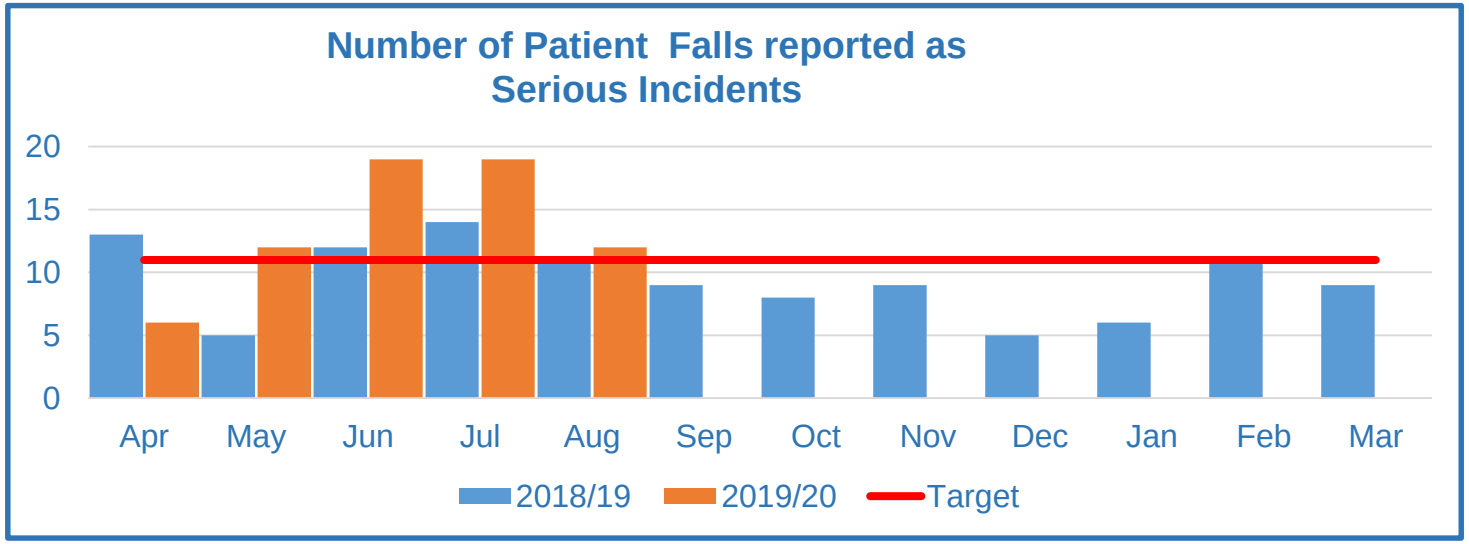
Chapter 1 – Quality Incidents - Report

Actions	Outcomes	Timeline
1. The weekly incident review meeting in place which is ensuring a more focused approach to managing major and catastrophic incidents. This meeting is also used to focus on overdue incidents which have been reported to Welsh Government	Reduction in the number of incidents significantly overdue for closure	New trajectories have been issued to each of the Divisions with expectation that they will be in line with these by 31st August 2019
2. Review of model for corporate and governance teams to allow greater support to the wider incident management	1. Reduction in the number of major/catastrophic incidents	August 2019
	2.Improvement in the total number of overdue Welsh Government Incidents	August 2019
	3. Improvements in the standard/quality of closure forms being submitted	August 2019
	4.Single senior lead for incidents management across BCUHB	Dec 2018

Chapter 1 – Quality

Serious Incidents: Patient Falls Graphs

LM02 3a	Number of Patient Falls reported as Serious Incidents	Target <= 11	Plan <= 11	Aug-19	12	Status	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP



Harms resulting from patient falls in August 2019:

- Fractured Humerus x1
- Fracture Neck of Femur (hip) x6
- Fractured Ankle x1
- Spinal Injury x1
- Subdural haemorrhage x2
- Unknown x1

Why we are where we are: 12 incidents of patient falls (resulting in harm) have been reported to Welsh Government in August 2019 (compared to 19 reported in July 2019). Location of incidents for August shows no geographical hot spots with each incident happening on a different ward as follows:

- Llandudno Hospital (Llewelyn ward & Morfa ward) reported 2
- Ysbyty Penrhos Stanley (Cybi ward) reported 1
- Ysbyty Eyri (Peblig ward) reported 1
- Wrexham Maelor (Bersham ward, Evington Ward, Emergency Dept & Radiology Dept.) reported 4
- Wrexham Maelor (Community Onnen ward) reported 1
- Mental Health & Learning Disabilities Services (Bryn Hesketh* & Conwy SMS) reported 2
- Ysbyty Glan Clwyd (ward 8) reported 1

**Bryn Hesketh is part of the Falls Collaborative*

Serious Incidents: Patient Falls

Actions	Outcomes	Timeline
1. Health Board Inpatient Falls collaborative and Faculty established – Faculty multidisciplinary	To reduce inpatient falls by 15% for collaborative wards	30th November 2019
2. The collaborative will develop a toolkit of evidence based interventions that are individualised to meet the needs of inpatients following risk assessment. Based on evidence/information from group learning sessions	Interventions will be evidenced based and tailored to patient individual needs	31st December 2019
3. Falls Faculty- projects include review Datix reporting, educational & intranet resources, equipment, criteria lying & Standing Blood Pressure monitoring, reduction of patient deconditioning	Standardisation of processes, resources and accessibility to information and equipment	31st December 2019
4. Masterclass held 5th September 2019	Test of change includes all wards reviewing and completing E learning package -educational resources, post falls protocol	30th September 2019

Chapter 1 – Quality

Serious Incidents: HAPU (Healthcare Acquired Pressure Ulcers) - Report

LM02 3b	Number of Healthcare Acquired Pressure Ulcers reported as Serious Incidents	Target 0	Plan 0	Aug-19	6	Status ↓	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP

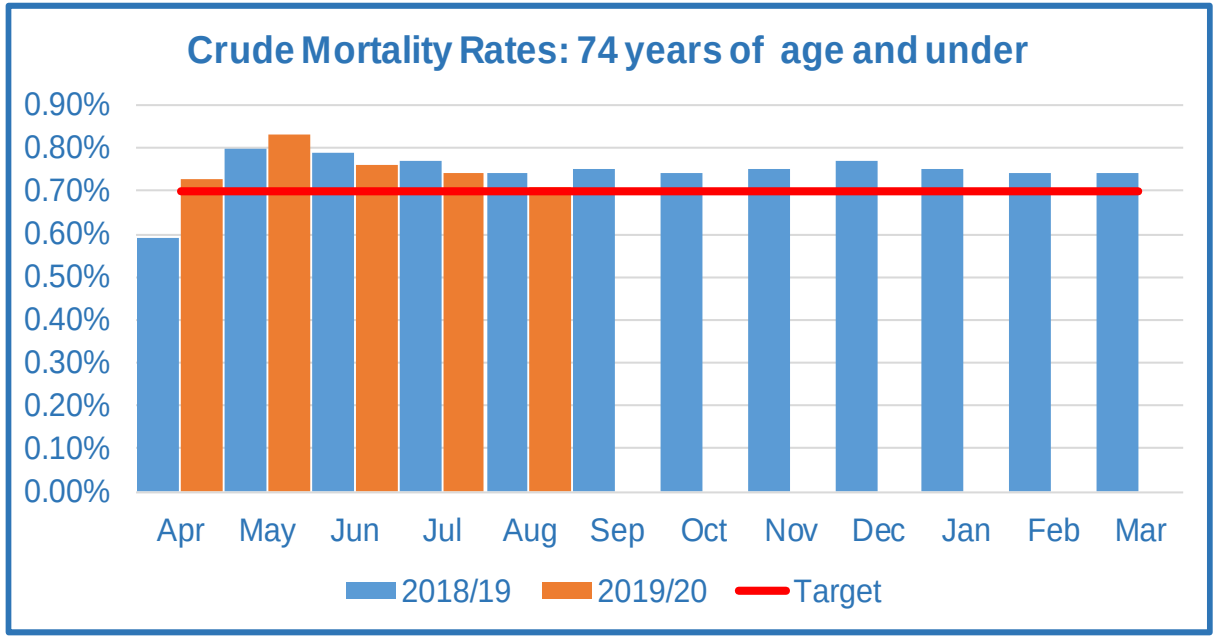
LM02 3c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	Target AP	Plan AP	Aug-19	217	Status ↓	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP

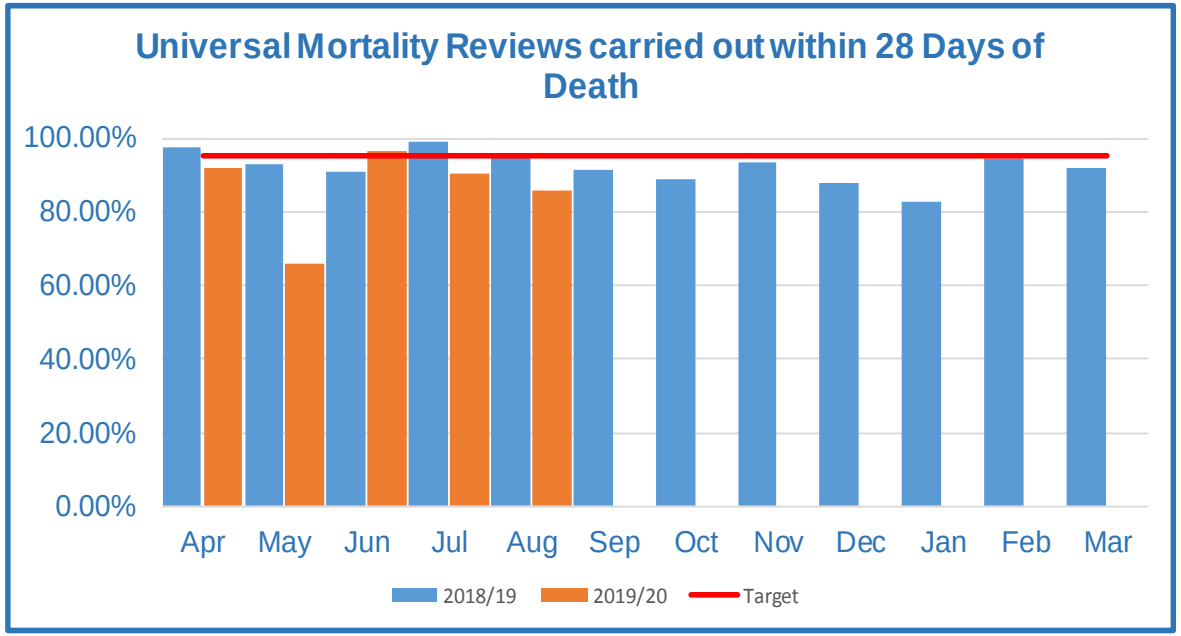
Why we are where we are: For August 2019 a total of **6** HAPU reported to Welsh Government for patients within the care of the Health Board and following investigation.

- Wrexham Maelor – Cunliffe ward reported 1 x unclassified/unstageable
  Morris Ward reported 2 x grade 3
  Glyndwr ward reported 1 x unclassified/unstageable
- Ysybty Gwynedd - Hebog ward reported 1 x grade 3
- High Pastures Nursing Home reported 1 x grade 3

Actions	Outcomes	Timeline
1.HAPU Masterclasses will include revised all Wales risk assessments Nutrition, Continence, Manual Handling & Tissue Viability WHC Implementation required by 30th November 2019 for the Nutritional risk assessment and 1st May 2020 for all other risk assessments	Revised all Wales documentation is included in All Wales Tissue Viability documentation will require simultaneous implementation	Masterclasses October/November 2019 go live date for all risk assessments 2nd December 2019
2.All Wales review tool now incorporated in BCU Datix incident reporting system	To enable reporting of data for improvements, more timely investigation and sharing of lessons learned when HAPU grade 3 and above developed	1st September 2019
3. Increased focus of clinical teams around HAPU with targeted support from TVN Service. Scrutiny meetings in each area to review and monitor	Increased focus by leadership teams to support clinical teams to undertake corrective actions	Weekly in all areas this will be reviewed following go live of masterclasses

DFM 027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	Target >= 95%	Plan >= 95%	Aug-19	85.80%	Status ↓	Wales Benchmark	2nd	Executive Lead	David Fearnley	Plan Ref	AP039
DFM 028	Crude hospital mortality rate (74 years of age or less)	Target Reduce	Plan <= 0.70%	Aug-19	0.71%	Status ↑	Wales Benchmark	4th	Executive Lead	David Fearnley	Plan Ref	AP039

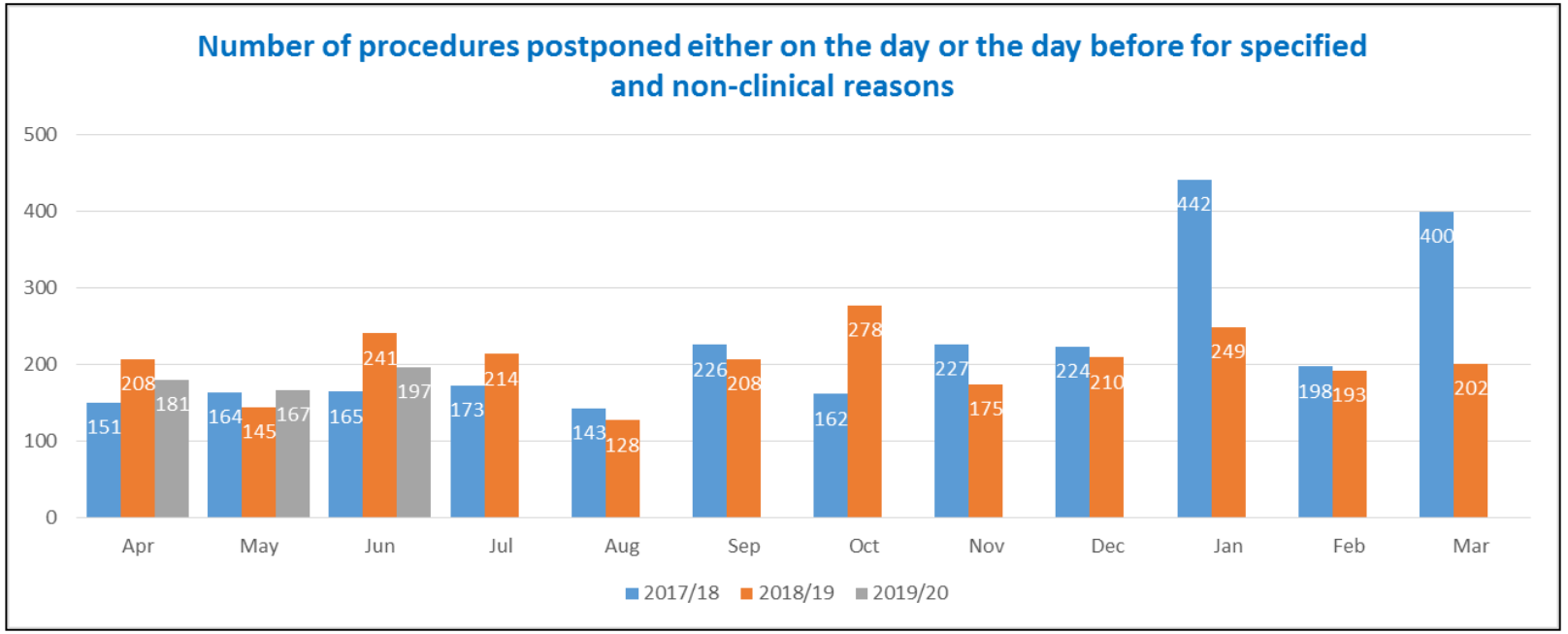




Why we are where we are: Further works need to be undertaken to understand why performance in stage 1 UMR completion has deteriorated. The main area to focus the review of stage 1 issues is Wrexham Maelor site and will be completed over the next 7-14 days.
Crude Mortality in under 74 years of age is performing at expected levels and completed review of crude mortality shows no statistically significant variation in our figures which would raise any concern.

Actions	Outcomes	Timeline
1. DATIX Mortality module implementation • YGC are actively using system to complete stage 1 process • YG are going live in usage of system Oct 2019 for stage 1 • Wrexham are predicted to start using December 2019 for stage 1 • Stage 2 spread will take place during 2020	• Will improve the completion of stage 1 for all deaths • Improve timeliness of stage 1 and 2 process • Better reporting functionality, specialities will be able to use for Mortality & Morbidity reviews also.	2019 and 2020 calendar year
2. Introduction of Medical Examiner (ME) role • Predicted introduction of ME is April 2020 • Several doctors are now actively completing online modules in order to apply for interview stage and attending further training in London	• Provision of impartial scrutiny of all deaths in BCUHB • It is predicted that once ME post are live in BCUHB we are expecting a slight increase in stage 2 conversion • ME process will take over the stage 1 element of the mortality reviews so Drs currently undertaking that will no longer be involved	April 2020 (predicted)
3. Sepsis collaborative Emergency Departments (ED) • Day 4 of the sepsis collaborative took place on 5th September 2019	• Improve awareness of sepsis • Improve identification of sepsis through improved policies and procedures • Live data capture so we can see compliance every hour with sepsis 6 delivered within an hour of triple trigger or suspicion of sepsis diagnosis	April 2020 (predicted)

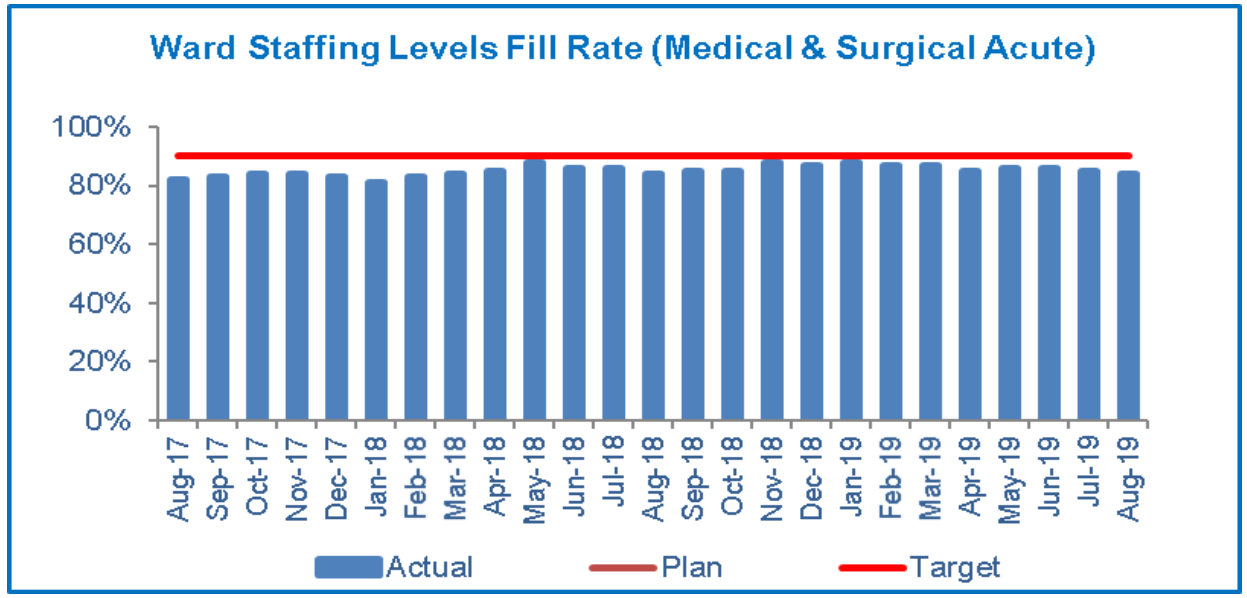
DFM 038	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	Target Reduce	Plan Reduce	12 Months to Apr-19	545	Status	Wales Benchmark	5th	Executive Lead	David Fearnley	Plan Ref	AP025

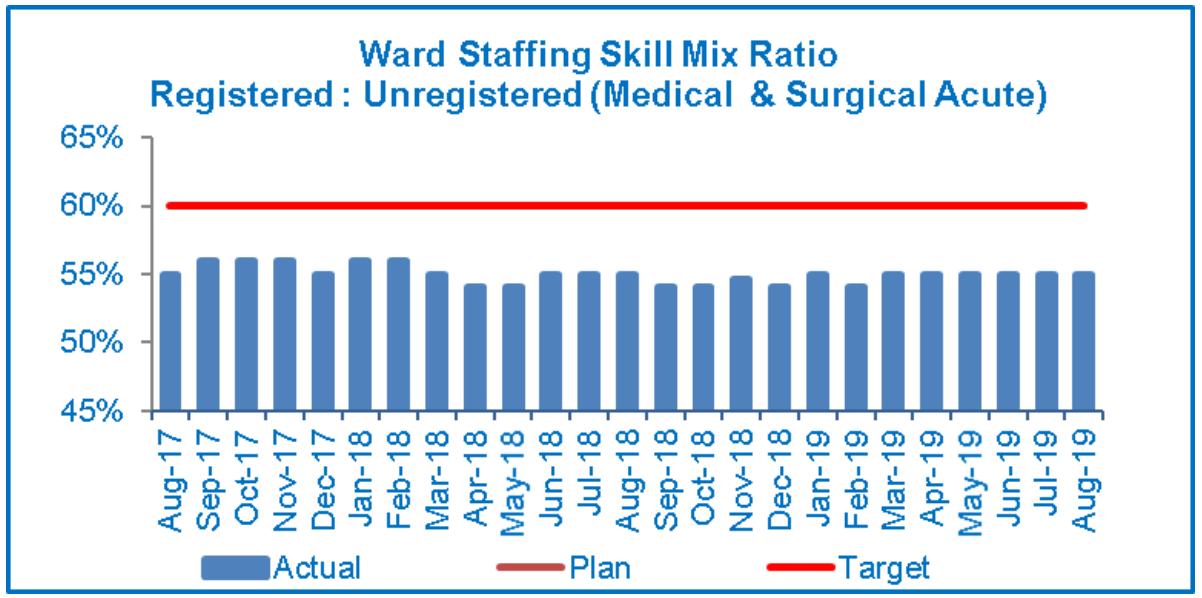


Why we are where we are:
Analysis of the reasons for postponement has been completed. This analysis shows that cancellation due to the patient being unfit due to illness is the highest volume, however other reasons create opportunities for improvement in pre-operative assessment and operational planning. The locations with the highest volume of cancellations are day case theatre 1 and the eye theatres in Wrexham and theatre 2 in Ysbyty Gwynedd. An action plan is being developed which will be managed through the Planned Care Improvement Board to address this.

Actions	Outcomes	Timeline
1.Analysis of Postponed procedure by site and speciality.	Better understanding of cancellation reasons by speciality	August'2019 This action is completed. The report has now been shared with local HMT
2. Agree Improvement trajectory at site level.	Speciality and site level reduction target for Postponed surgery in place	31/09/2019 This KPI is part of Current Theatre Improvement PID, therefore will have improvement trajectory signed off.
3.Develop escalation process for short notice cancellation and implement.	Robust escalation process in place to avoid short notice cancellations	31/09/2019 Standard operating procedure has been drafted and circulated for feedback. This will need to be signed off by Theatre Transformation Group in September prior to implementation.
4.Weekly report on Postponed Procedures.	Real time monitoring in place	August'2019 Weekly report is available on share point. This is now also part of weekly RTT performance report.

WGM 001	Ward Staff Fill Rate Percentage	Target >= 95%	Plan AP	Aug-19	84%	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	Aug-19	55%	Status ←	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	NIP



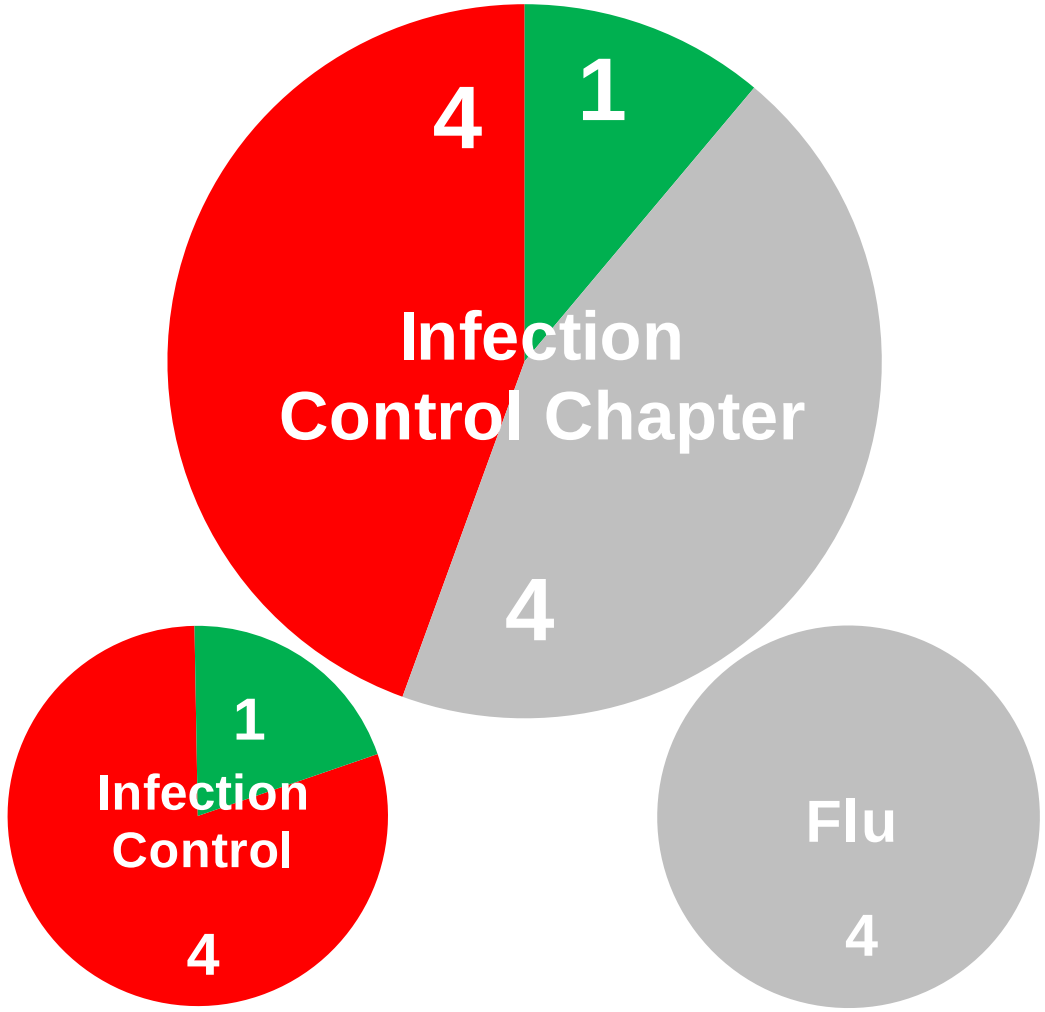


Why we are where we are: Ward staffing fill rate showing slight deterioration in August (85% to 84%). Likely explanation is holiday period therefore BCU core staff, bank and external agency availability restricted. Registered Nurse vacancies also remain high. Each site awaiting new graduates to start. Expected Sept / Oct 2019.

Actions	Outcomes	Timeline
1. Registered Nurse (RN) gaps backfilled with bank / agency. Scrutiny via Heads of Nursing (HONs) / SDNs on each acute site.	Maintain safe staffing to comply with Nurse Staffing Act and support patient safety.	Until vacancies filled. New graduates being recruited to the 3 sites during Sept / October 2019 (carried over from previous month).
2. BCUHB representation at national recruitment events.	To reduce RN vacancies. (Latest Pipeline report shows a deterioration in RN vacancies).	Ongoing.
3. BCUHB hosting recruitment event / open day for new graduates 14th September.	To reduce RN vacancies.	Due to graduate March 2020. Initially employed as Band 4s whilst awaiting NCM registration. Then require preceptorship period.

Chapter 2 – Summary

Infection Control



Measure	Status		(Target)
Cumulative Rate: E.Coli	85.63	↓	<= 67
Cumulative Rate: S.Aureus	27.75	↑	<= 20
Cumulative Rate: C.Difficile	25.69	↓	<= 22
Cummulative Number: Klebsiella sp	59	↓	<= 38
Cumulative Number: P.aeruginosa	13	↑	<= 10
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 (Apr-19 to Date)	Target <= 67	Plan <= 194	Aug-19	85.63	Status	↑	Wales Benchmark	3rd	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 (Apr-19 to Date)	Target <= 20	Plan <= 60	Aug-19	27.75	Status	↑	Wales Benchmark	3rd	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1b1	Cumulative Number of laboratory confirmed MRSA cases (Apr-19 to Date)	Target 0	Plan 0	Aug-19	7	Status	↑	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1b2	Cumulative Number of laboratory confirmed MSSA cases (Apr-19 to Date)	Target <= 139	Plan <= 53	Aug-19	75	Status	↑	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population (Apr - 19 to Date)	Target <= 22.13	Plan <= 22	Aug-19	25.69	Status	↓	Wales Benchmark	3rd	Executive Lead	Deborah Carter	Plan Ref	AP039
LM02 1c	Cumulative Number of laboratory confirmed C.difficile cases (Apr-19 to Date)	Target <= 153	Plan <= 60	Aug-19	74	Status	↓	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021d	Cumulative Number of laboratory confirmed Klebsiella sp bacteraemia cases (Apr-19 to Date)	Target <= 106	Plan <= 38	Aug-19	59	Status	↓	Wales Benchmark	6th	Executive Lead	Deborah Carter	Plan Ref	AP039
DFM 021e	Cumulative Number of laboratory confirmed P.aeruginosa bacteraemia cases (Apr-19 to Date)	Target <= 27	Plan <= 10	Aug-19	13	Status	↑	Wales Benchmark	4th	Executive Lead	Deborah Carter	Plan Ref	AP039

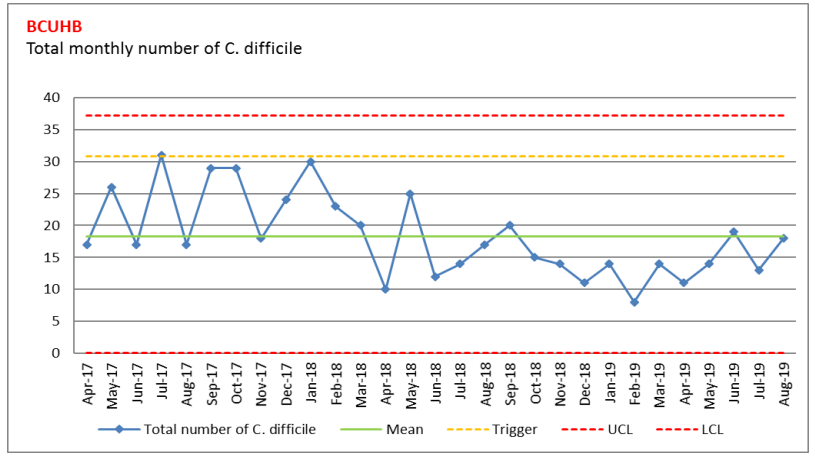
Why we are where we are:

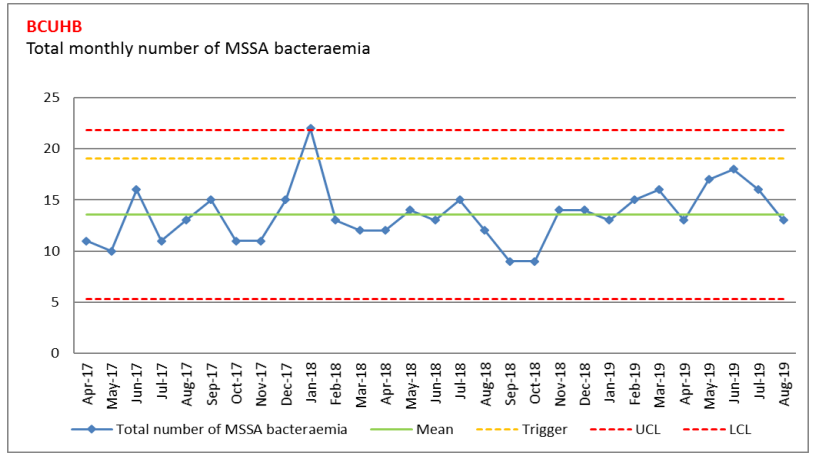
There is expected monthly variation in all of the key infections, and this is not a cause for concern. Overall the numbers of infections are decreasing when compared to previous years albeit not months.

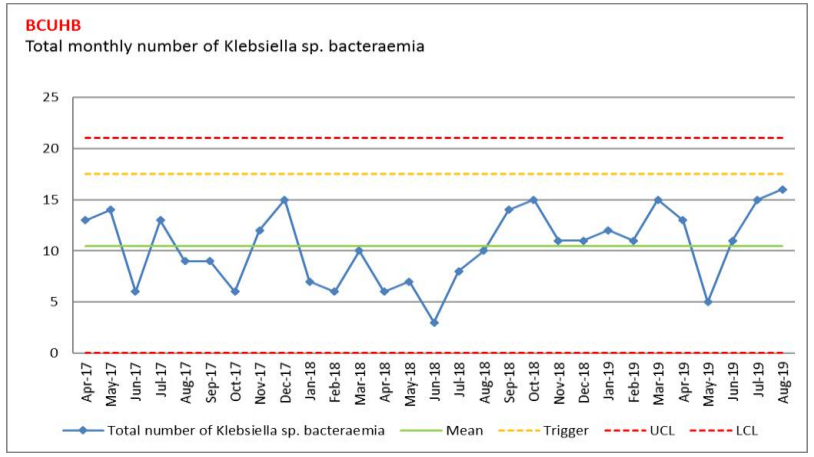
Any increase in Gram Negative/Multi Resistant Organisms and MSSA is also a national concern, and none of the Welsh Health Boards are on track to achieve the 2019/20 trajectories for gram negative infections or MSSA.

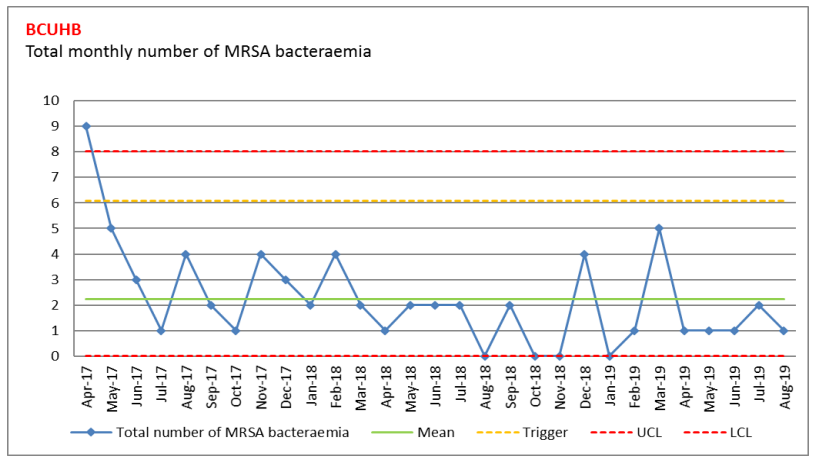
The majority of Blood Stream Infections (BSIs) **are not** Hospital Onset but Community Onset.

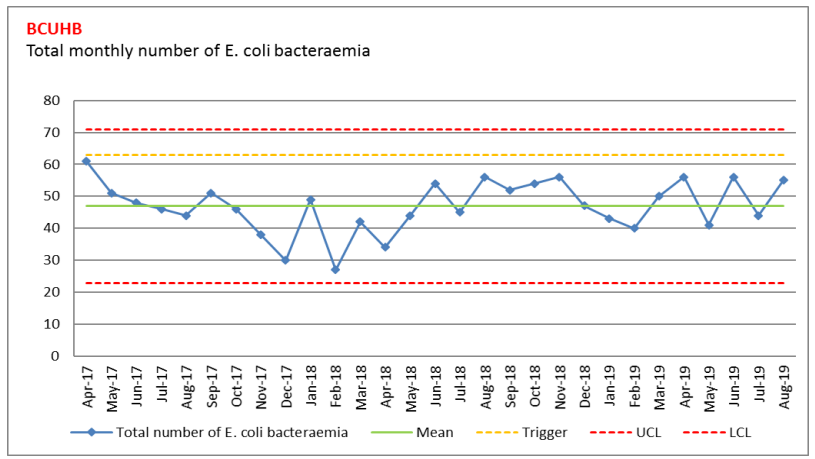
Where we do have Hospital Onset or Healthcare Associated infections, these are at times the consequence of treatment, for example, clostridium difficile related to correct antimicrobial stewardship and therefore unavoidable.

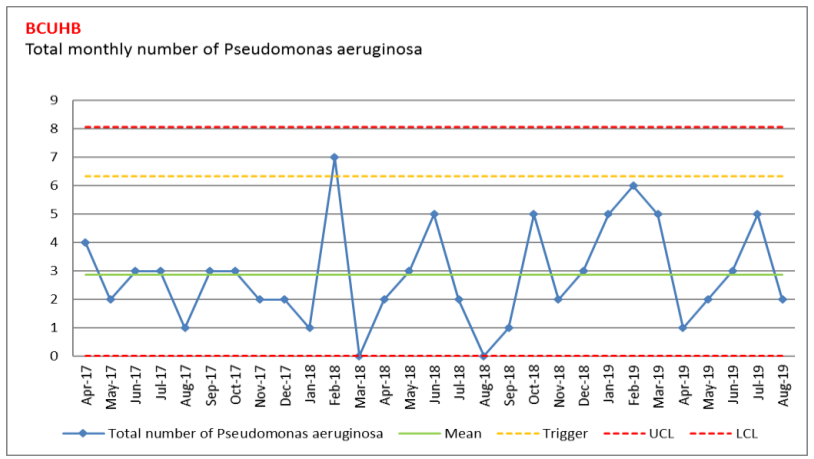

BCUHB
Total monthly number of C. difficile
Total number of C. difficile
Mean
Trigger
UCL
LCL


BCUHB
Total monthly number of MSSA bacteraemia
Total number of MSSA bacteraemia
Mean
Trigger
UCL
LCL


BCUHB
Total monthly number of Klebsiella sp. bacteraemia
Total number of Klebsiella sp. bacteraemia
Mean
Trigger
UCL
LCL

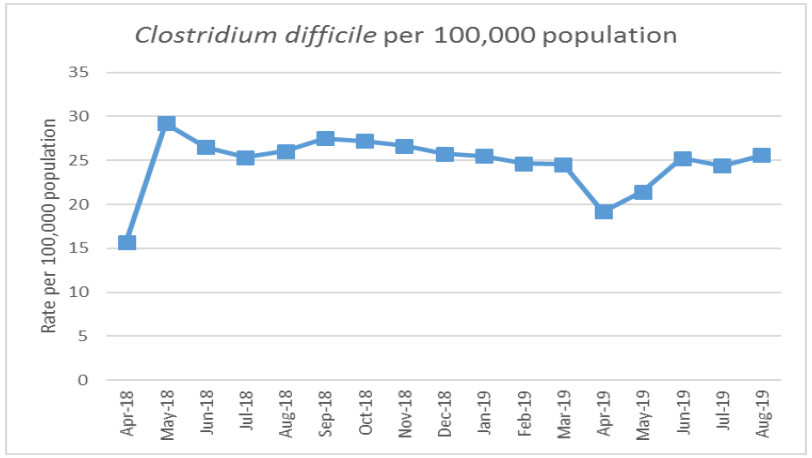

BCUHB
Total monthly number of MRSA bacteraemia
Total number of MRSA bacteraemia
Mean
Trigger
UCL
LCL

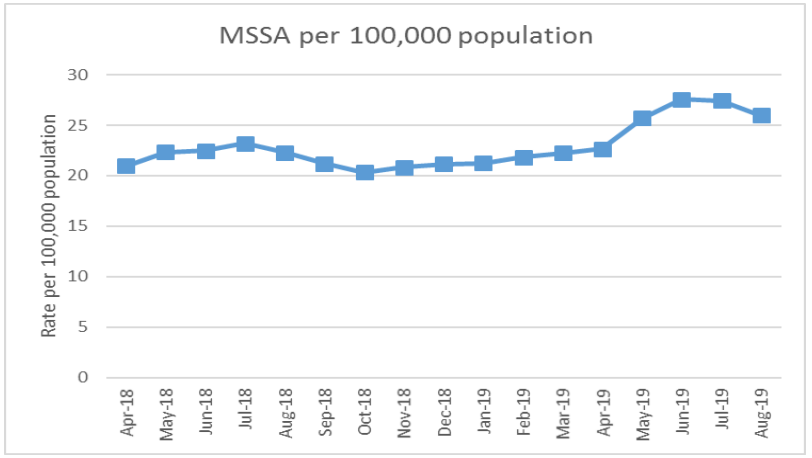

BCUHB
Total monthly number of E. coli bacteraemia
Total number of E. coli bacteraemia
Mean
Trigger
UCL
LCL

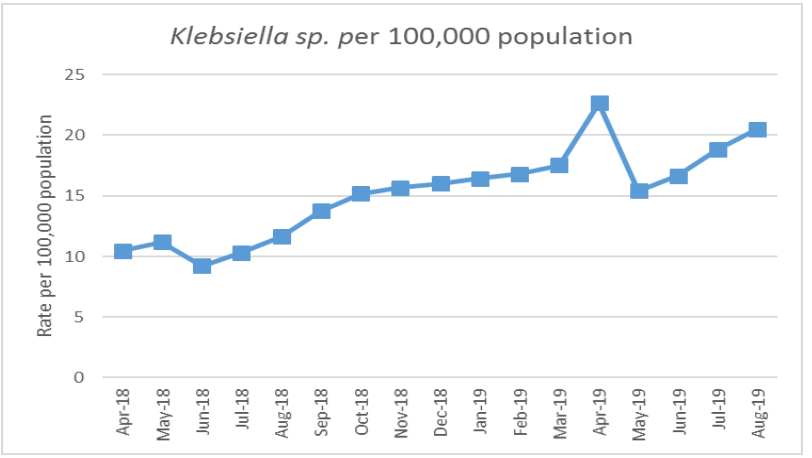

BCUHB
Total monthly number of Pseudomonas aeruginosa
Total number of Pseudomonas aeruginosa
Mean
Trigger
UCL
LCL

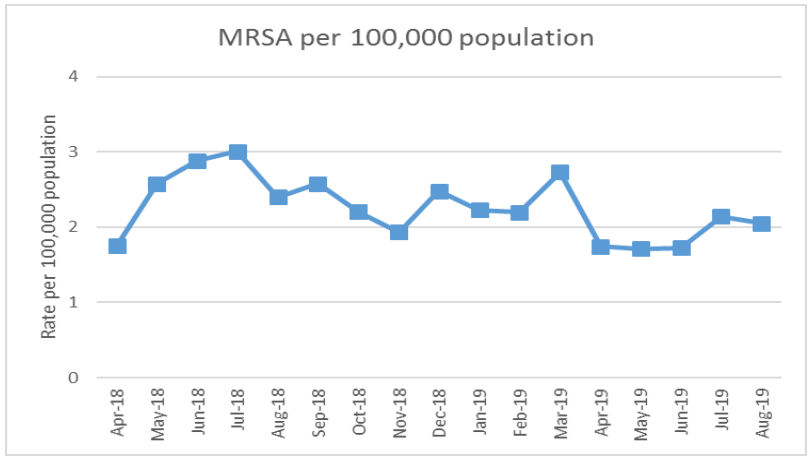
Chapter 2 – Infection Control

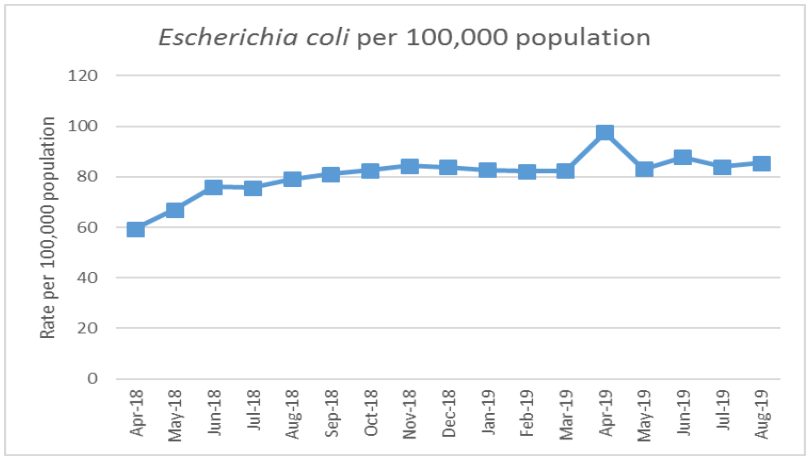
Graphs –Rate of infections

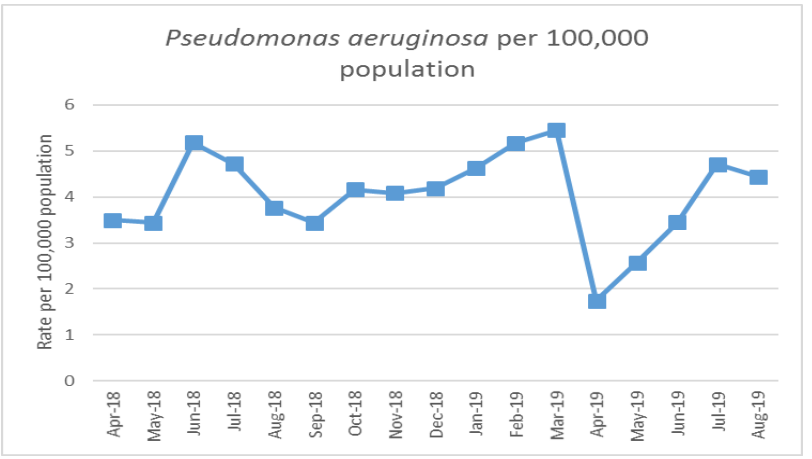












Chapter 2 – Infection Control Report

Actions	Outcomes	Timeline
1. Continue with the deep dives which are carried out on every infection with the 6 trajectory infections	From this process we are able to establish trends, onset area, and if the infection is healthcare related and avoidable. If so a post infection review is carried out following the local scrutiny meeting and reported at local IPGs, SIPG and Exec Led reviews were learning and actions are discussed and carried out.	Continuous
2. Antimicrobial stewardship is discussed with antimicrobial pharmacy colleagues and relevant clinicians were this is thought to be the root cause of infection.	A post infection review is carried out on all clostridium difficile infections. Antimicrobial stewardship in the community setting is crucial in reducing the incidence of multi resistant organisms, particularly e Coli/gram negative infections which are on the increase.	Continuous
3. Need to deliver robust environmental cleaning delivered by facilities department and deep clean team, and an uninterrupted HPV programme by having allocated staff and a decant area. To do this we need to reduce the C4C audits.	This will reduce the bio burden of microorganisms in the healthcare environment and the risk of environmental cross infection. Staff will know what they are responsible for cleaning and with what product. This will also realise time to care by clinician's. Environmental associated cross infections will be significantly reduced.	December 2019
4. A benchmark audit is to take place in September 2019 to understand the prevalence of urinary catheters and associated infections.	Will understand the snapshot of urinary catheters and associated infections. This will prompt the removal of unnecessary catheters and the associated risks of infection. Re audit Spring 2020.	Spring 2020
5. Increase the visibility of the IP team and senior clinicians in terms of quality support visits, audit and introduction of the Link Practitioner programme in September 2019.	Timely support and actions to respond to any IP gaps in practice, cleaning and the environment.	December 2019

Chapter 2 – Summary

Prevention

Measure	Status		(Target)
Smoking Cessation: Pregnant Women			Improve
Immunisation: 3 doses of 6 in 1			>= 95%
Immunisation: 2 doses of MMR			>= 95%
Healthy Child Wales Programme			Improve
Smoking Cessation: % Service Use	**1.91%**	↑	>= 5%
Smoking Cessation: Validated as Quit	**37.03%**	↑	>= 40%

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Quality, Safety & Experience Committee Version

September 2019

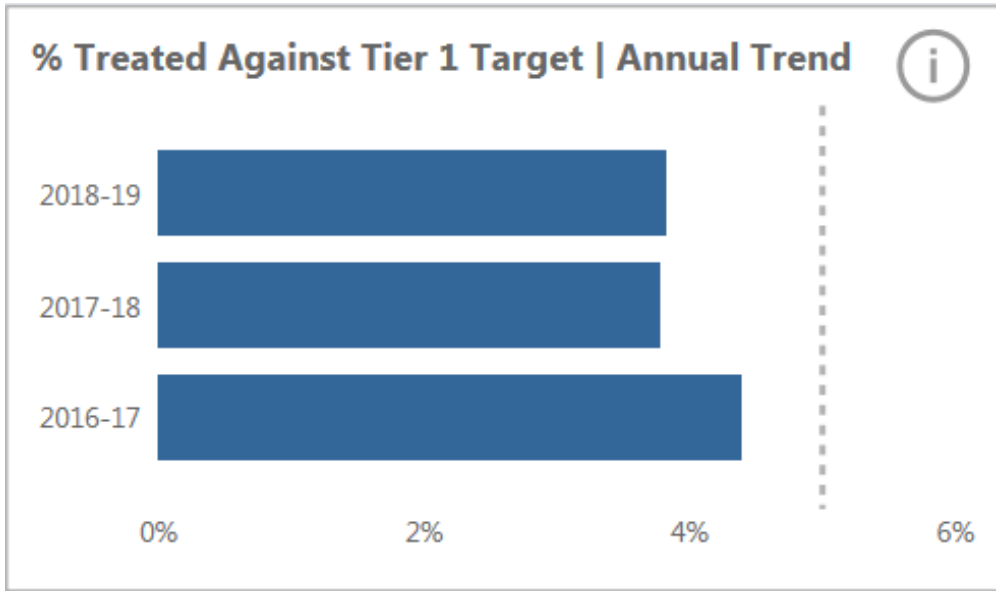
Chapter 3 – Prevention

Smoking Cessation

DFM		Target	Plan	Qtr1			Wales		Executive		Plan	
006	The percentage of adult smokers who make a quit attempt via smoking cessation services	>= 5%	>= 3.9%	19/20	1.91%	Status ↑	Benchmark	*	Lead	Teresa Owen	Ref	AP001

DFM		Target	Plan	Qtr1			Wales		Executive		Plan	
007	The percentage of those smokers who are CO-validated as quit at 4 weeks	>= 40%	>= 38.0%	19/20	37.03%	Status ↑	Benchmark	*	Lead	Teresa Owen	Ref	AP001

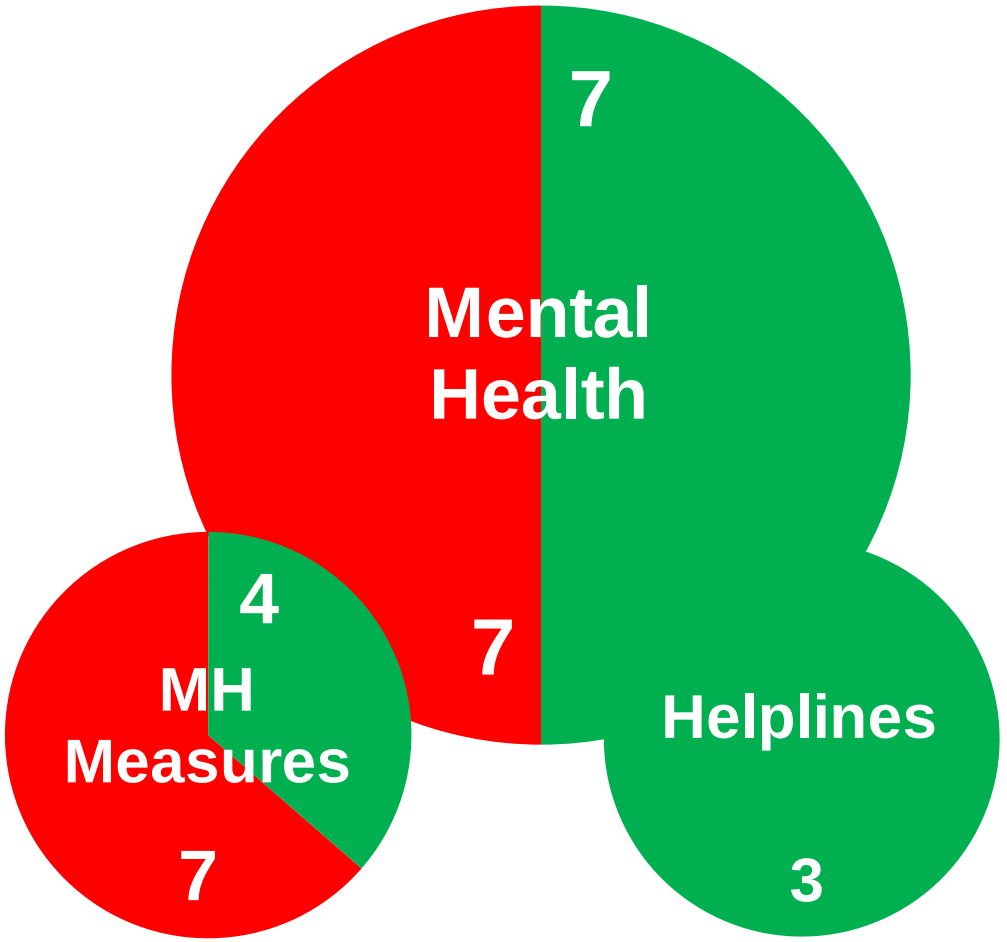
Service	Treated Smokers	% Treated	Quit Smokers*	Quit Rate
All	4,037	1.91%	1,495	37.03%
HMQ for Baby	238	0.11%	71	29.83%
HMQ in Hospital	272	0.13%	151	55.51%
Pharmacy L3	2,261	1.07%	709	31.36%
Stop Smoking Wales	1,266	0.60%	564	44.55%



Why we are where we are: The percentage of adult smokers who make a quit attempt via smoking cessation' has been set locally at 3.9% over the year period. Assuming that the reported % treated of 1.915% for August refers to the running total for the year to date then we are on target (3.9/12months x 5 months = 1.625%) and slightly under for the national target (5/12 months x 5 months = 2.083%). In August a number of unplanned absences through sickness were seen in the SSW and HMQ for Baby services which impacted heavily on the number of quitters seen. The majority of staff who were off sick have now returned back to their normal hours.

Actions	Outcomes	Timeline
1. The Stop Smoking Wales service is transferring across to the health board on 01 October 19	Will provide an opportunity for closer integration of smoking cessation services, particularly between hospital and community.	Transfer on 1st October 2019 This should start to have a positive impact on targets by end Quarter 4.
2. BCUHB Pharmacy are currently undertaking work to reduce the number of self-reporting quitters in the system, which are not recorded as a CO-validated quit, in favour of CO-validated quits.	This work should see a rise in overall CO-validated quits in Q3 and 4 given the footfall seen in Pharmacy Level 3 services.	Ongoing

Chapter 4 - Summary



Mental Health

Measure	Status		(Target)
26 Week Wait: Adult Specialist Mental Health Psychological Therapy	19.85%	↓	>= 80%
26 week Wait: Children and Young People Neurodevelopment Assessment	37.21%	↓	>= 80%
MHM1a - Assessments within 28 Days (Combined)	66.32%	↓	>= 80%
MHM1b - Therapy within 28 Days (Combined)	70.71%	↓	>= 80%
MHM1a - Assessments within 28 Days (Adult)	64.40%	↑	>= 80%
MHM1b - Therapy within 28 Days (Adult)	69.40%	↓	>= 80%
MHM1a - Assessments within 28 Days (CAMHS)	81.20%	↑	>= 80%
MHM1b - Therapy within 28 Days (CAMHS)	76.00%	↑	>= 80%
MH Advocacy	100%	→	N/A Q
MHM2 - Care Treatment Plans (CTP)	90.30%	↓	>= 90%
MHM3 - Copy of Agreed plan within 10 Days	100%	→	100%
Helplines: CALL	250.3	↑	Improve
Helplines: DAN	11.1	↑	Improve
Helplines: Dementia	46.0	↓	Improve

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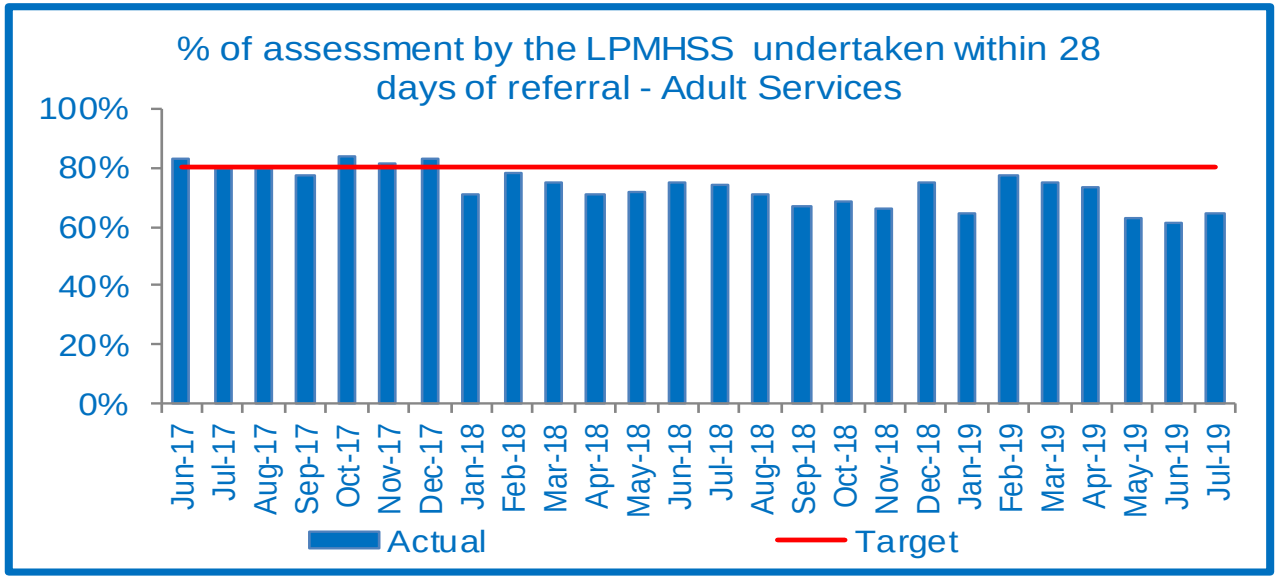
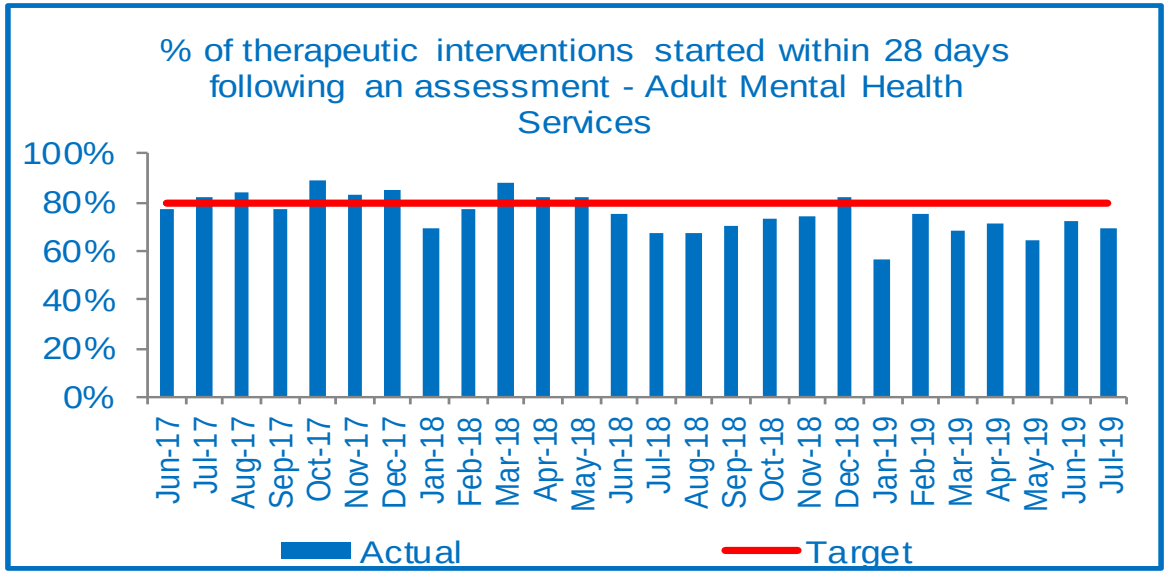
September 2019

LM060a	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 >= 72%	Jul-19	64.40%	Status ↑	Wales Benchmark	N/A	Executive Lead	Andy Roach	Plan Ref	AP027
LM061a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	Target >= 80%	Plan >= 68%	Jul-19	69.40%	Status ↓	Wales Benchmark	N/A	Executive Lead	Andy Roach	Plan Ref	AP027





Why we are where we are: 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.

The Division is benchmarking nationally against Can Not Attend (CNA's) & Do Not Attend (DNA's) to ensure we are offering a fair and consistent service within Primary Care in line with guidance and national standards.

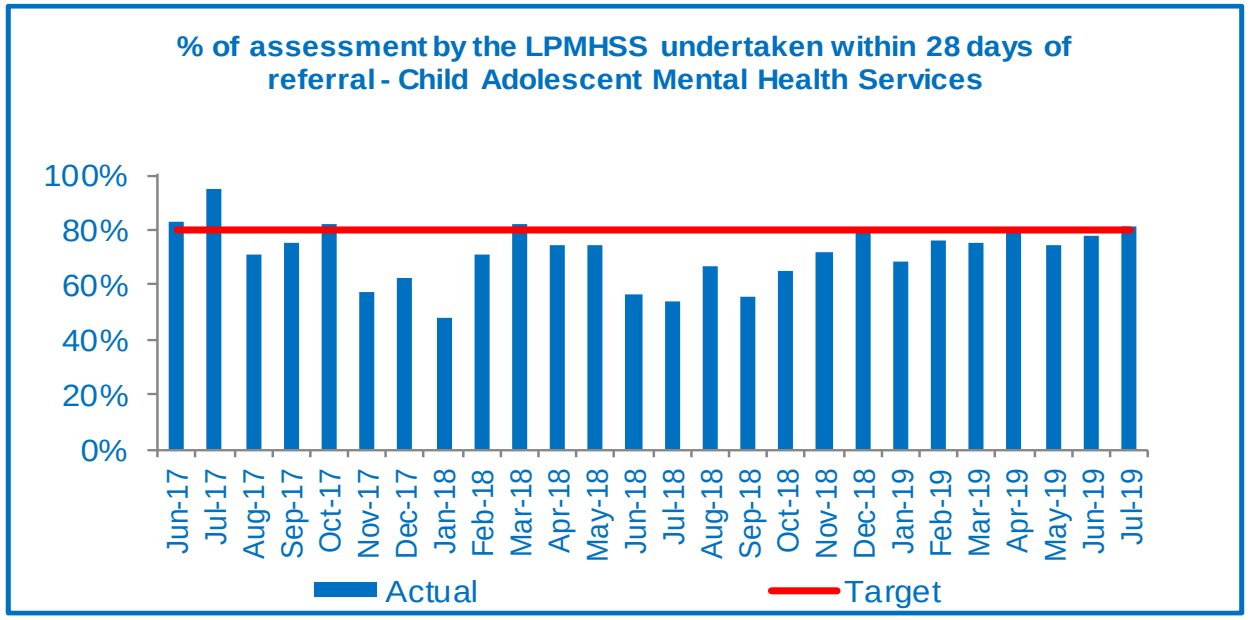
Chapter 4 – Mental Health

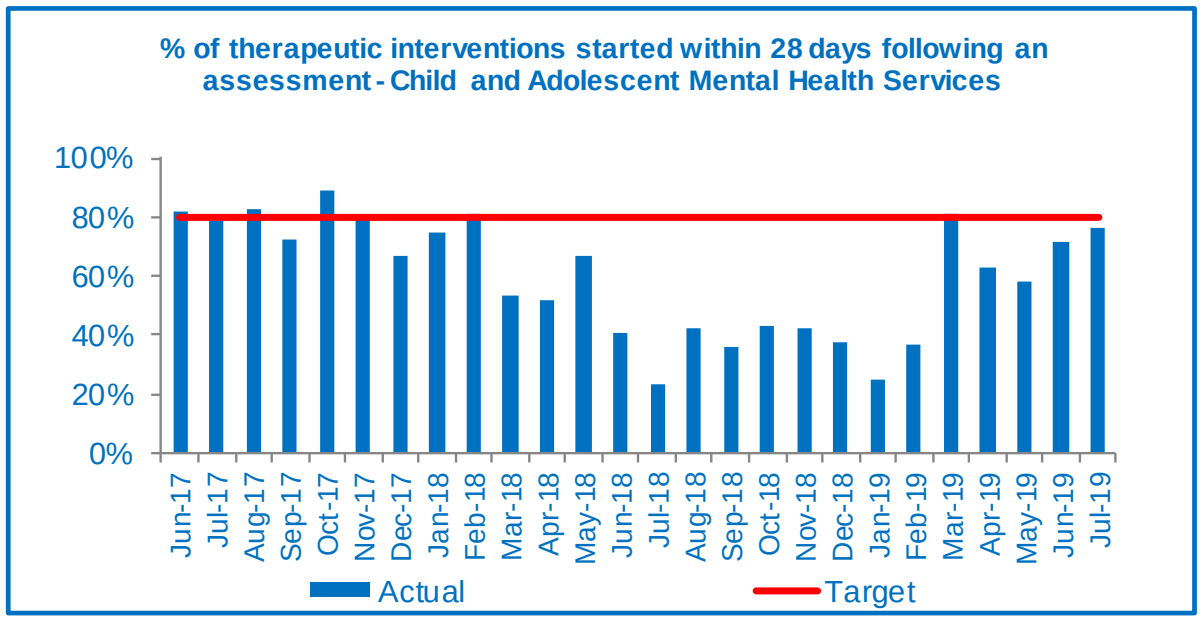
Actions	Outcomes	Timeline
1. Patients 'treated in turn' has been widely adopted which has had a negative impact on performance but, is clinically the right action for patients.	Proactive management of caseload to ensure patients are seen as quickly as possible. Improved quality and safety.	Backlog and waiting list trajectory to clear March 2020
2. Timely weekly reporting direct to area teams and a weekly 'deep dive' analysis to focus on potential breaches. We have also standardised intervention outcomes & reporting. Thus, ensuring Can Not Attend (CAN) & Do not attend (DNA) are accurately and timely recorded.	Correct & validated information ensuring Teams are timely informed and engaged and also can implement any remedial actions quickly.	Current and ongoing action
3.Mental Health Measure (MHM) Lead(s) are supporting areas to increase focus and traction on specific issues and action plans. We have closer monitoring & scrutiny of referral activity which also informs the weekly targeted intervention meetings.	Correct & validated information. Teams timely informed and engaged.	The solution to target achievement is a complete service transformation which is currently been worked through via the strategy implementation.
4. We have undertaken piloting Threshold Assessment Grids (TAG), are holding weekend & additional clinics and have strongly focused on recruitment and workforce issues such as: • 'Support Time and Recovery' workers are now working through the interventions backlog • Secured additional funding for extra posts • Clinical & Social care staff deployed to focus on areas performing below target	Skilled workforce deployed to improve activity and compliance and provide a community asset based approach which supports earlier intervention and GP based consultations.	Compliance with part 1a and 1b profiled for April 2020
5. Increased Senior Manager focus to lead a Focus Group to address performance and continually develop and implement the agreed Divisional and local action plans and to provide leadership to improve targets.	Developed and implemented action plans to improve performance against 80% target.	The solution to target achievement is a complete service transformation for this identified group which is being worked through via strategy implementation.

Chapter 4 – Mental Health

CAMHS Graphs

LM060b	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	Jul-19	81.20%	Status ↑	Wales Benchmark	N/A	Executive Lead	Chris Stockport	Plan Ref	AP027
LM061b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	Target >= 80%	Plan AP	Jul-19	76.00%	Status ↑	Wales Benchmark	N/A	Executive Lead	Chris Stockport	Plan Ref	AP027





Why we are where we are: Performance on both measures has improved and it is pleasing to confirm that the assessed patients were seen within 28 days of referral, and for the third month on the run children and young people commencing treatment within 28 days of assessment improved and is now approaching the national target. Work has also been completed on the overall CAMHs waiting return. Funding has been received from Welsh Government to further improve access times for CAMHs

Actions	Outcomes	Timeline
1.Recruitment of staff across teams following successful bid for Mental Health Service Improvement funding	Development of Early Intervention teams and enhancement of core service to deliver Part 1 targets	Staff in post February 2020
2.Recruitment of CAMHs Practitioners in GP Clusters following successful bid for Mental Health Service Improvement funding	CAMHs Practitioner based in each GP Cluster to provide support and advice to manage demand appropriately	Staff in post in February 2020
3.Refresh and submission of CAMHs Crisis Service Bid to Welsh Government	Additional funding for crisis services will allow for increased access to crisis services out of hours and reduce requirement for admissions to Paediatric Wards	Staff in post in March 2020 dependent on successful outcome
4.Action plan to be developed for CAMHs services following receipt of final report from Delivery Unit	Clarity of Primary/Secondary Care thresholds/improved record keeping/improved communication with GPs	Full action plan to be completed by March 2020
5.Weekly meetings held across the teams to assess demand and review capacity available in form of core staff availability, additional hours, bank and agency staff.	Understanding of current demands levels and capacity available to meet, identifying any gaps/anticipated breaches	Ongoing

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 Committee

24.9.19

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

To improve health and provide excellent care

Report Title:	Concerns, Litigation, Incidents, Coroner and Healthcare Inspectorate Wales (CLICH) report Quality Assurance April-June 2019
Report Authors:	Dr Kath Clarke, Interim Assistant Director Service User Experience Mr Mathew Ross, External Reporting Support Manager Mrs Alison White, Senior Project Support Officer, Transforming Care Team
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The CLICH report is designed to provide a high-level summary for the Quality, Safety and Experience Committee in relation to the numbers and high-level themes and trends from complaints, incidents and inspections. It also provides a summary of the numbers of legal claims received and closed along with feedback received as part of the coronial process. The report represents a range of issues under the executive responsibility of the Executive Director of Nursing and Midwifery.
Approval / Scrutiny Route Prior to Presentation:	Associate Director of Quality Assurance
Governance issues / risks:	Implementation of the Once for Wales Concerns Management System: development of phased roll out and trial of functionalities. Above system does not support the new public voice and the gathering of service user experience. This will put out to tender shortly and the national programme team will work with Health Boards to help plan for the costs associated with this new functionality when it becomes available.
Financial Implications:	There are financial implications attached to the Putting Things Right (PTR) and Litigation elements and these are managed and monitored by established processes.
Recommendation:	The Committee is asked to note the content 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		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 An EqIA is not required for this report: this report is applicable to all staff			

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

CLICH REPORT

(CONCERNS, LITIGATION, INCIDENTS, CORONER, HIW)

QUALITY ASSURANCE

April - June

2019

Authors: *Kath Clarke, Interim Assistant Director Service User Experience.*

Mathew Ross, External Reporting Support Manager.

Alison White, Senior Project Officer, TC Team.

Responsible Director: Deborah Carter, Acting Executive Director of Nursing & Midwifery

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INTRODUCTION

The CLICH (Complaints, Litigation, Incidents, Coroner's, HIW) report is designed to provide a high-level summary for the Quality, Safety and Experience Committee in relation to the numbers and high-level themes and trends from complaints, incidents and inspections. It also provides a summary of the numbers of legal claims received and closed along with feedback received as part of the coronial process. The report represents a range of issues under the executive responsibility of the Executive Director of Nursing and Midwifery.

COMPLAINTS

On The Spot (OTS) Complaints

In total, 882 "On the Spot" complaints were opened in quarter 1(2019/20), an increase of 4% (32) on the previous quarter. Of these 588 were resolved by the next working day, and 244 within five working days, the remaining cases exceeded the five day target. Where the target was exceeded it was with the complainant's agreement.

OTs complaints are complaints where there is no allegation of harm and should be answered by the next working day.

OTS opened per Quarter by Region	18/19 Q4	19/20 Q1
BCUHB Central	308	368
BCUHB East	272	248
BCUHB West	270	266

As the above table displays, there was an increase of 19% (60) for the number of OTS complaints opened by Central region whilst East and West region saw a decrease in the overall numbers received.

Central Region OTSComplaints	18/19 Q4	19/20 Q1
Surgery (Secondary)	106	143

Reviewing the OTS concerns received by Central region and comparing the number of complaints received by service it was identified that surgery (Central Secondary Care) saw an increase of 35% (37) from Q4 to Q1.

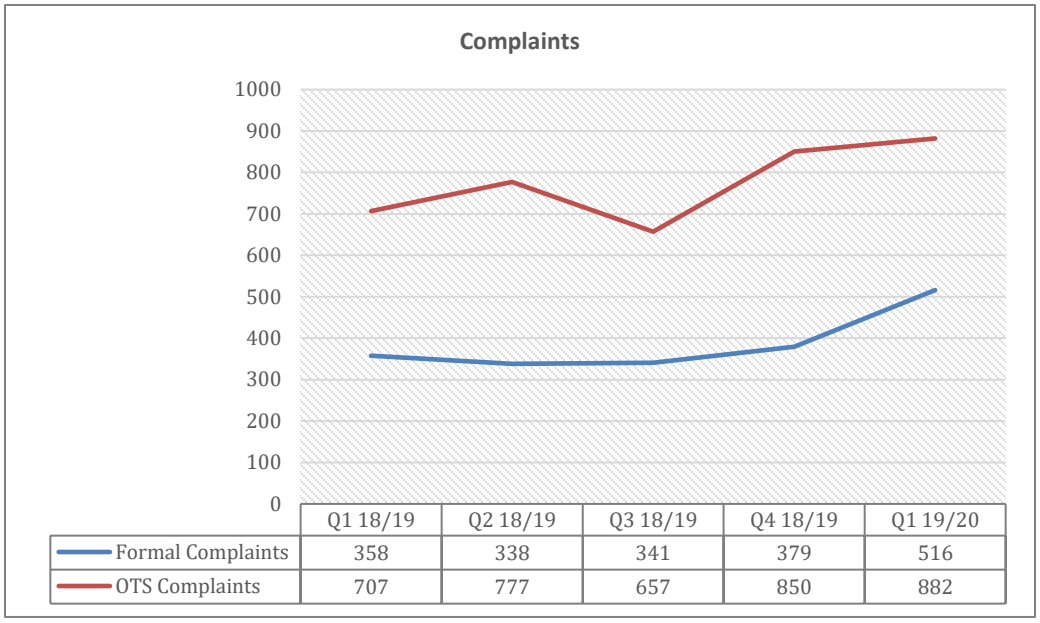
Surgery OTS (Central Region)	18/19 Q4	19/20 Q1
Access, Appointment, Admission, Transfer, Discharge	63	96

The most noticeable increase for surgical OTS complaints received by Central Secondary Care related to Access, Appointment, Admission, Transfer, Discharge, with an increase of 52% (33), of which the largest increase between Q4 and Q1 related to unacceptable waiting times. The below specialties saw the largest increase between quarters.

COMPLAINTS

Surgical OTS Concerns by Speciality (Central Region)	18/19 Q4	19/20 Q1
Ophthalmology (Secondary)	9	20
Urology (Secondary)	10	18
General Surgery (Secondary)	3	10
Breast Surgery (Secondary)	1	8

The table below shows the total number of complaints (formal and OTS) received over a 5 quarter period.



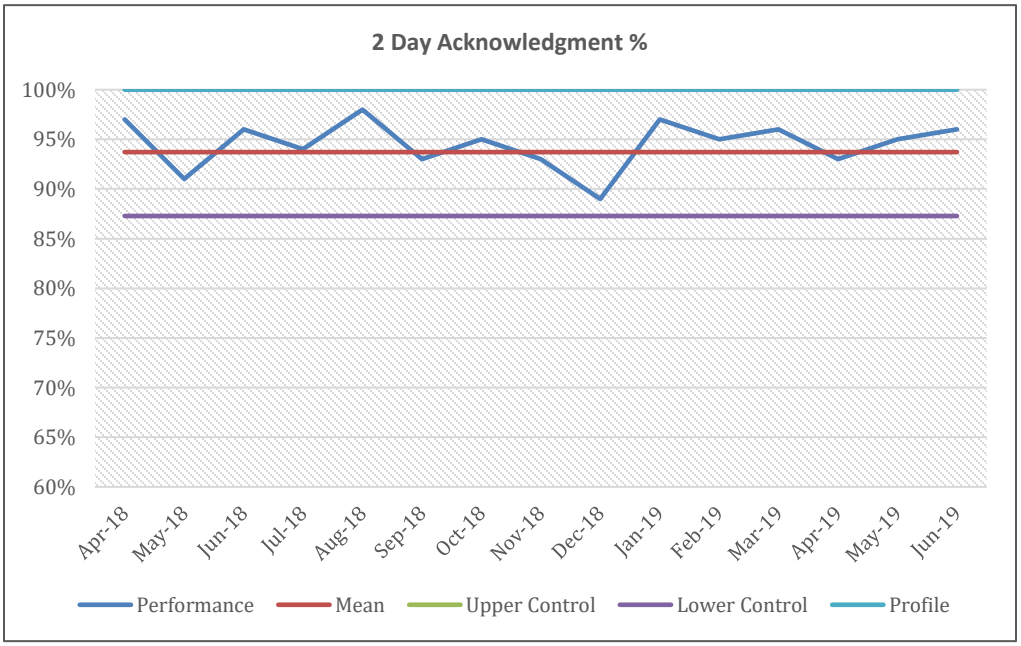
Formal complaints

Between April and June 2019 (quarter 1 2019/20) , the Health Board has received 516 formal complaints this is an increase of 36% (137) on the previous quarter. The number of complaints reported each week for quarter 1 across BCUHB ranged from 20 to 58 with, on average, 39 complaints being received each week. This is almost an average additional 10 complaints per week based on the last quarter with the increase in complaints being evenly distributed across all services/divisions. The largest increase in complaints being received was Secondary Care Central with an

COMPLAINTS

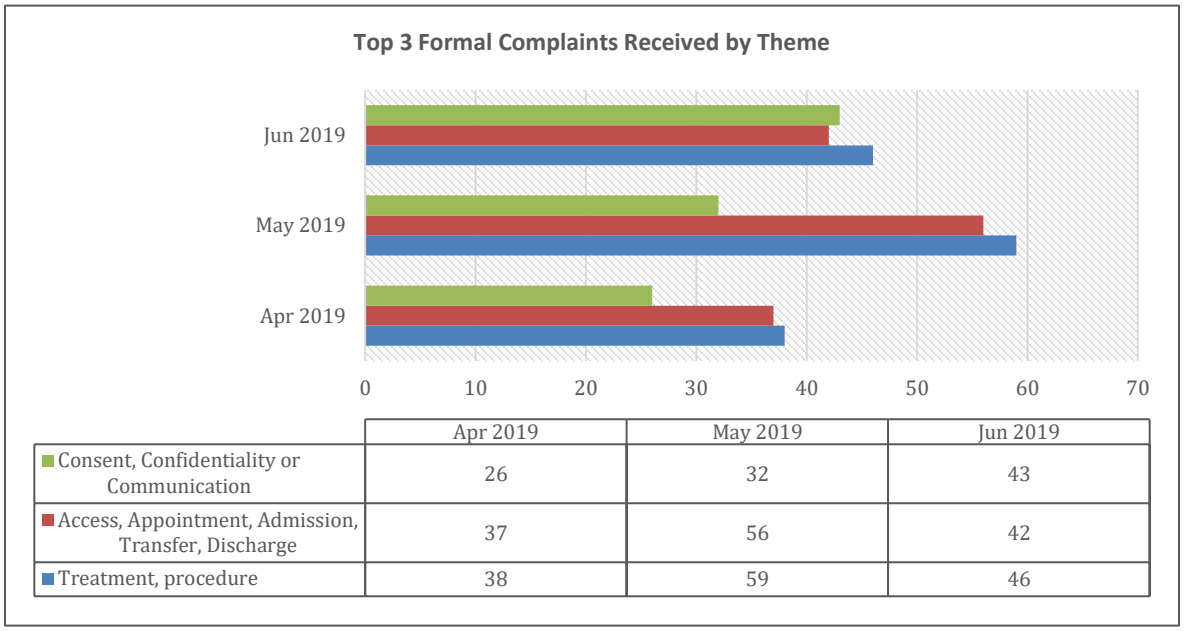
increased number of complaints in relation to the Emergency Department and perceived staffing issues within ophthalmology and outpatient departments. The Services review all complaints at local regular scrutiny meetings as well as any complaint overdue by two months being reviewed as part of the weekly corporate scrutiny meeting.

Of the 516 formal complaints opened, 95% received an acknowledgment letter within two working days and is acceptable compliance. Complaints are receipted from when they arrive into BCUHB not from when the corporate concerns team receive them. It is, therefore, important that if complaints are sent to persons or addresses outside of the BCUHB complaints address that they are sent to the corporate concerns team as soon as possible for registering and to enable an acknowledgement letter to be sent within the required two days of the complaint being received by the Health Board.



COMPLAINTS

Of the 516 formal complaints received, the below themes are consistently the highest received on a monthly basis and equate to 70% of those received in this period.



	Apr 2019	May 2019	Jun 2019
Consent, Confidentiality or Communication	26	32	43
Access, Appointment, Admission, Transfer, Discharge	37	56	42
Treatment, procedure	38	59	46

The sub-subject “Communication with the patient (other than consent issues)” makes up 64% of the total number of formal concerns raised relating to “Consent, Confidentiality or Communication”.

Consent, Confidentiality or Communication by Sub Subject	Total
Communication with the patient (other than consent issues)	65
Communication with family	14
Communication between staff, teams or departments	13
Total	92

The sub-subject “Unacceptable waiting time” makes up 44% of the total number of formal complaints relating to the category “Access, Appointment, Admission, Transfer, and Discharge”. The Health Board is aware of the challenges currently within waiting list management and are actively working to improve the situation

COMPLAINTS

Access, Appointment, Admission, Transfer, Discharge by Sub Subject	Total
Unacceptable Waiting Time	59
Date for admission cannot be given to the patient	19
Delay in admission	12
Total	90

The below sub-subjects make up 77% of the total number of formal concerns raised regarding Treatment, Procedure.

Treatment, Procedure by Sub Subject	Total
Co-ordination of medical treatment	30
Wrong diagnosis	25
Poor aftercare	24
Treatment didn't have expected outcome	18
Lack of continuity	13
Total	110

The remaining formal concerns received (30% of total) relate to the below themes.

Themes – April to Jun 2019	Total
Clinical assessment (investigations, images and lab tests)	30
Abusive, violent, disruptive or self-harming behaviour	26
Infrastructure or resources (staffing, facilities, environment)	24
Medication	23
Implementation of care or ongoing monitoring/review	15
Patient Information (records, documents, test results, scans)	9
Continuing Healthcare Decisions	4
Medical device/equipment	3
Infection Control	2
Privacy and Dignity	1
Security, including patients property	1

A further exploration of the category “Abusive, violent, disruptive or self-harming behaviour” relate to the below sub-subjects.

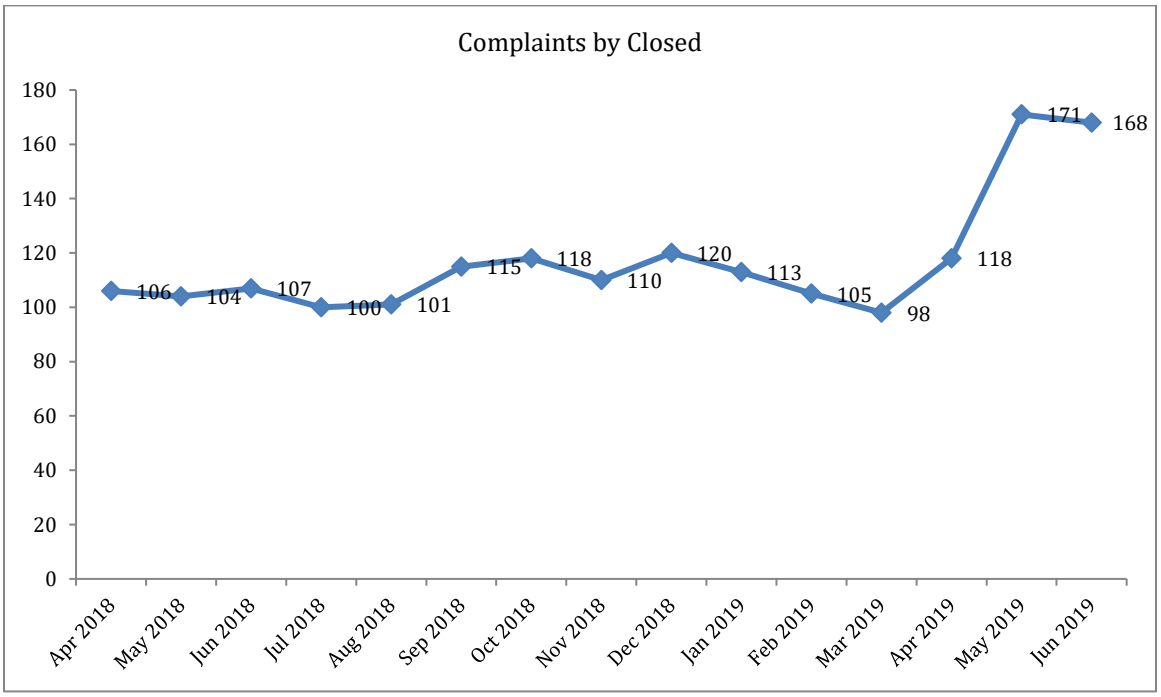
Abusive, violent, disruptive or self-harming behaviour by Sub Subject	Total
Staff attitude	10
Insensitive to patient needs	8

COMPLAINTS

Inappropriate comments	3
Total	21

Information on all complaints are provided to each division who are responsible for the consideration of learning and improvement. Each division provide a monthly report to the Quality and Safety Group where further themes, trends and hot spots can be identified and shared.

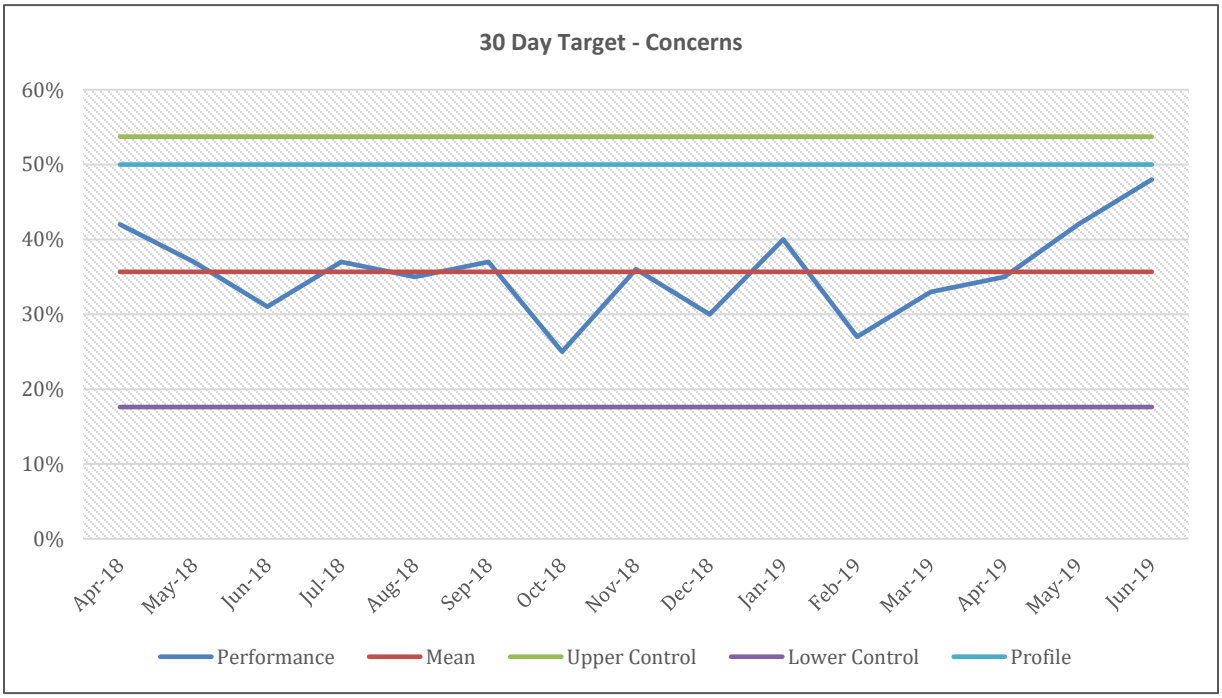
Closed Complaints



Of the formal complaints closed in the quarter, 42% received a response within the 30 working day timeframe. As of 22/07/2019 there is only 1 complaint over six months. This overdue complaint is beyond the control of the Health Board awaiting permission from an external agency (police) to release the response. All complaints open beyond 2 months are reviewed as part of the weekly Incident view meetings. Previous months' performances can be seen below.

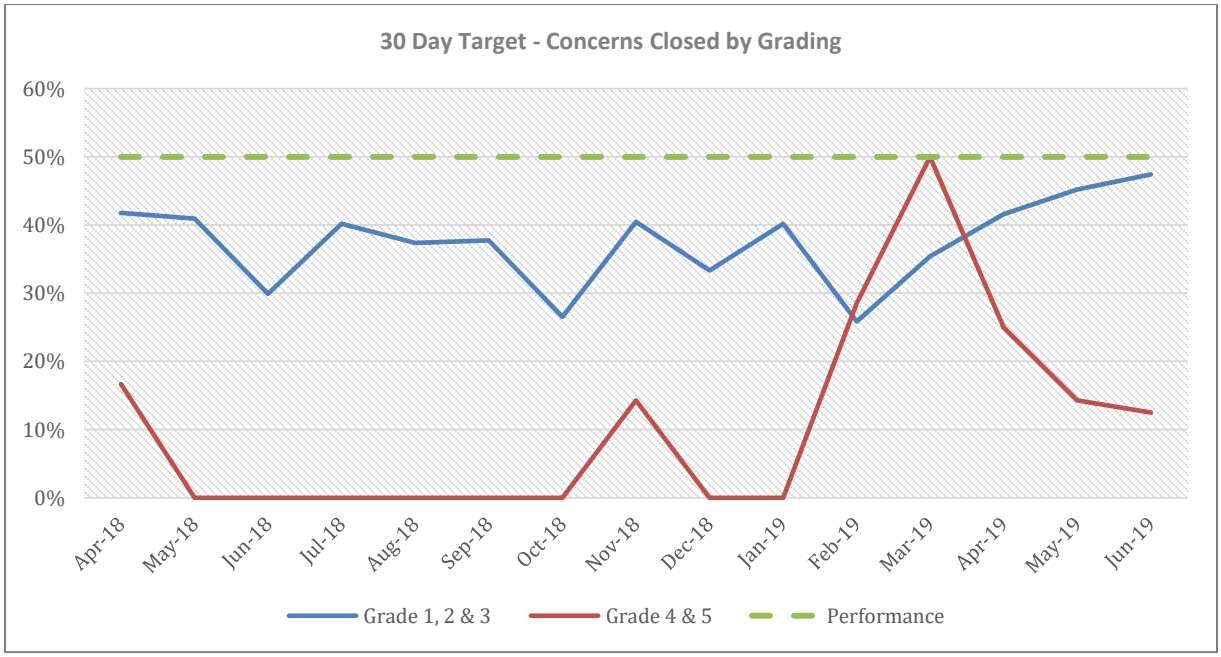
COMPLAINTS

The two graphs below show the percentage of complaints that are closed within the 30 working day target. The graph below illustrates the closing of all grade complaints within the 30 working day target which is continuing to show improvement month on month.



COMPLAINTS

The graph below illustrates the closing of complaints within the 30-day target by grade. The Health Board would expect all grade 1, 2 and 3 complaints to be closed within the 30-day target whereas the grade 4 and 5 complaints, which are more complex, require a serious incident review and therefore may take up to six months to finalise.



COMPLAINTS

Lessons Learned

Each complaint provides an opportunity for learning and each division takes this learning though their governance and quality and safety arrangements to share and disseminate. In addition, learning is also shared by each division with the Quality and Safety Group who consider learning on a BCUHB wide basis.

Sharing learning across Wales has become priority for Welsh Risk Pool and since reimbursement for complaints redress now sits under Welsh Risk Pool rather than Welsh Government a process of peer reviewing the learning from complaints that require redress has been developed. This peer review group sits approximately every six weeks

The overall objective of the Peer Review Group is to ensure that learning is shared across NHS Wales with the aim of reducing similar patient safety incidents. Following the detailed appraisal of the learning outlined within the Learning from Events Reports (LfER) the members of the Peer Review Group will reach a recommendation decision for financial reimbursement of the redress costs or to defer payments pending further information.

The learning identified from BCUHB's redress complaints (below) has been taken from the LfERs recently discussed at the Peer Review Meeting:

Three complaints that requested reimbursement of redress to a value of £75,254.11 related to delays within the Urology Service. The issues identified were:

- Delay in referral by GP for a patient with haematuria
- Delays in in referral to tertiary centres following multi-disciplinary team decision.

Learning identified and actions taken:

- GP practice has reviewed guidelines and devised a new protocol for referral of patients presenting with haematuria
- In order to address and reduce delays in Urology, patients are referred to external providers (e.g. Arrowe Park/Royal Liverpool) via an agreed North Wales pathway. This is overseen by a pathway coordinator based at Ysbyty Glan Clwyd, thus ensuring that a central log is kept of all patients for North wales. Patients are tracked by name and NHS number and their information is shared with providers via the NHS secure portal network, which allows for confidential, auditable and instant information sharing. Details of referral are also logged with the Health Board's internal Contracting and Commissioning Team.

- Regular discussions take place between the coordinator and the hospital undertaking the procedure.
- Escalation of any delays to the pathway is made directly to the receiving hospital and locally, via the operational management team and clinical team. Issues that do not require immediate escalation are raised with the contracting team

One complaint that requested reimbursement of redress to a value of £1,731 related to missed diagnosis of ligament damage to foot which resulted in a delay of surgery.

Learning identified and actions taken:

- Reporting of x rays are monitored against the Welsh Radiology Reporting Times and are included within the Emergency Department's key performance indicators.
- The Emergency Department now have a one day timescale for reporting
- The Emergency Department is working with the Reporting Radiography Team to introduce hot reporting for the Emergency Department and minor injuries where the examinations fall within their reporting scope of practice.

PSOW

Public Service Ombudsman for Wales (PSOW)

Complainants, if not satisfied by the Health Board's response to their complaint, can ask the Public Service Ombudsman Wales (PSOW) to undertake a further independent investigation.

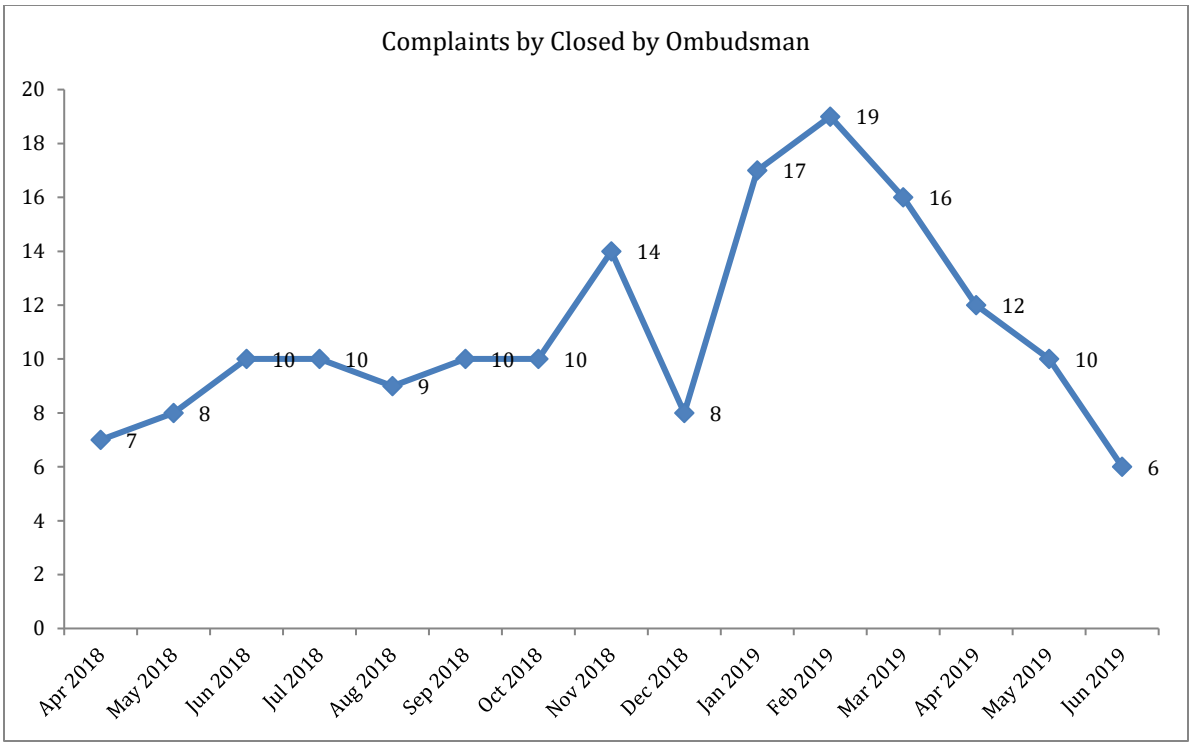
In total, the Ombudsman has contacted the Health Board on 25 occasions between April and June 2019 to request further information in order to inform the PSOW's decision whether to investigate the Health Board's handling of a complaint. Of the 25 contacts from PSOW: eight were enquiries only, nine became full PSOW investigations, five were proposals by PSOW to the health Board in order to satisfy the complainants and PSOW chose not to investigate three.

The main themes for contacting PSOW relates to:

- delay in Health Board response;
- delay in diagnosis;
- delay in treatment and mis-diagnosis.

PSOW closed 28 cases in quarter 1. Of the 28 cases closed, eight were partially upheld with the Health Board required to pay £1,250.00 in compensation.

PSOW



Further details of the cases reviewed by the Ombudsman will be available online in the Public Service Ombudsman for Wales Annual Report at: https://www.ombudsman.wales/annual-report-accounts/

PSOW Learning

What happened?

Ms. A complained about the care and treatment she received during a Gynaecology appointment at a Community Hospital. She said a Consultant took a biopsy without discussing the procedure with her or seeking her consent.

What the Ombudsman's investigation found

The Ombudsman found the indication for the biopsy, or an explanation of its side effects, was lacking in the records, and there was sparse evidence to indicate informed consent was specifically obtained for the biopsy. The Ombudsman found there was a failure in communication and record keeping and upheld the complaint.

What we can learn from this incident?

To ensure wider learning, all medical staff within Women's Services were issued with a copy of the General Medical Council and Royal College of Obstetrics and Gynecologists consent guidance.

- GMC Consent Patients and Doctors making decisions together
- RCOG – CG6 Obtaining Valid Consent.

To ensure that the clinician involved in this incident has personal learning, he has met with the Clinical Director to discuss events and the ombudsman findings have been shared with him. The clinician has reflected and now incorporates the learning into practice. The clinician will also reflect upon the incident and learning in his annual appraisal.

What happened?

Mr. A complained about:

1. The care and treatment he received from the Health Board in relation to a Brachiocephalic Arteriovenous Fistula Formation procedure (the connection of a vein and an artery, causing more blood to flow through the vein) ("the procedure") on his left arm, to aid kidney dialysis.
2. Mr. A also raised his concerns about the consent process for the procedure and the reasonableness of the Health Board's complaint response.

What the Ombudsman's investigation found

The complaint was not upheld:

1. The Ombudsman concluded that the Health Board had acted reasonably in carrying out the procedure and obtaining the correct consent.
2. Whilst the Health Board's complaint response did not include information about some relevant tests, overall, it was reasonable and the omission did not have a significant impact.

What we can learn from this incident?

Whilst not upholding this complaint the Ombudsman asked the Health Board to carefully consider the relevance of including all aspects of a person's medical history in future complaint response correspondence.

PSOW

Annual Position report from PSOW

The Health Board recently received an Annual Position report from PSOW. The detail of which can be seen below:

A. Complaints Received and Investigated with Health Board average adjusted for population

Section A compares the number of complaints against the Health Board which were received and investigated by the PSOW's office during 2018/19, with the Health Board average (adjusted for population distribution) during the same period.

Local Health Board	Complaints Received	Average	Complaints Investigated	Average
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Aneurin Bevan University Health Board	134	146	38	36
Betsi Cadwaladr University Health Board	194	173	44	42
Cardiff and Vale University Health Board	102	123	28	30
Cwm Taf University Health Board	75	74	22	18
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Section B provides a breakdown of the number of complaints about the Health Board which were received by the PSOW office during 2018/19 with the Health Board average for the same period. The figures are broken down into subject categories.

Betsi Cadwaladr University Health Board	Complaints Received	Average
Complaint Handling- Health	25	12
Health - Appointments/admissions/discharge and transfer procedures	7	4
Health - Clinical treatment in hospital	113	70
Health - Clinical treatment outside hospital	23	8
Health - Confidentiality	1	1
Health - Continuing care	4	4
Health - Medical records/standards or record-keeping	2	1
Health - Non-medical services - food. cleanliness etc	2	0
Health - Other	11	5
Health - Patient list issues	3	3
NHS Independent Provider - Care Homes	2	0
Various Other - Poor/No communication or failure to provide information	1	0

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population

Section C compares the complaint outcomes for the Health Board during 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/voluntary settlement	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part	Public Interest Report	Grand Total
Betsi Cadwaladr UHB	32	26	46	38	4	16	48	0	210
Health Board average (adjusted)	28	21	45	34	2	14	34	2	

D. Number of cases with PSOW intervention

Section D provides the numbers and percentages of cases received by the PSOW in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% interventions
Abertawe Bro Morgannwg University Health Board	54	139	39%
Aneurin Bevan University Health Board	49	128	38%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board	17	33	52%

LITIGATION (CLAIMS)

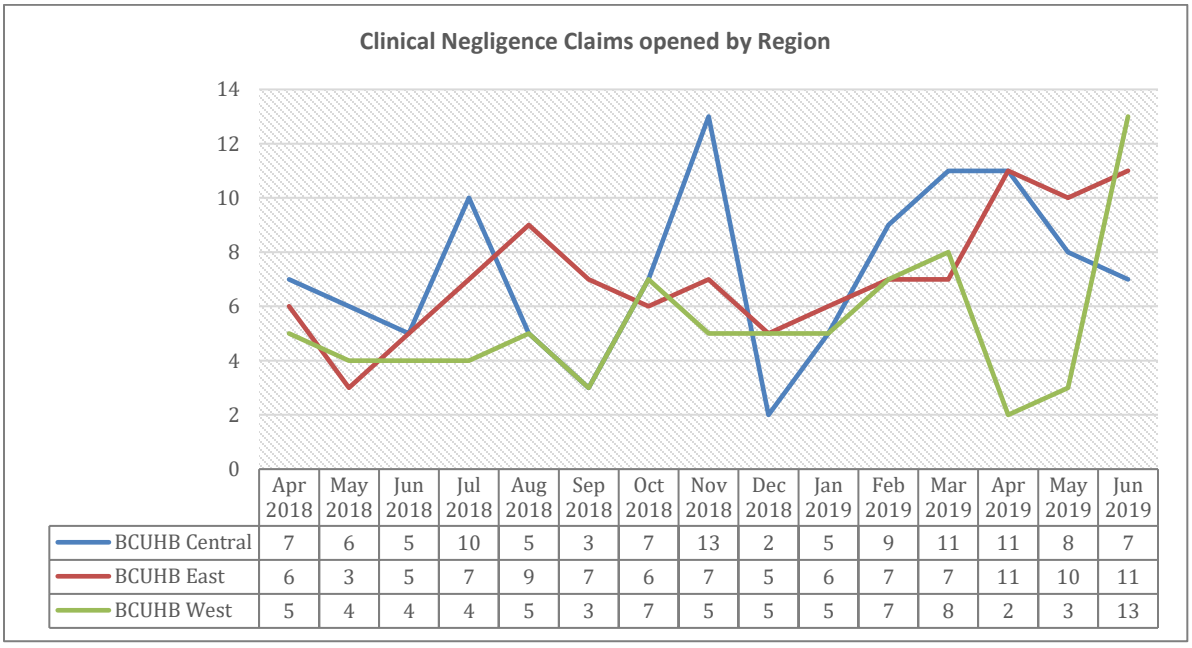
Claims Management

The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board, either:

- clinical/medical negligence claims
- personal injury claims

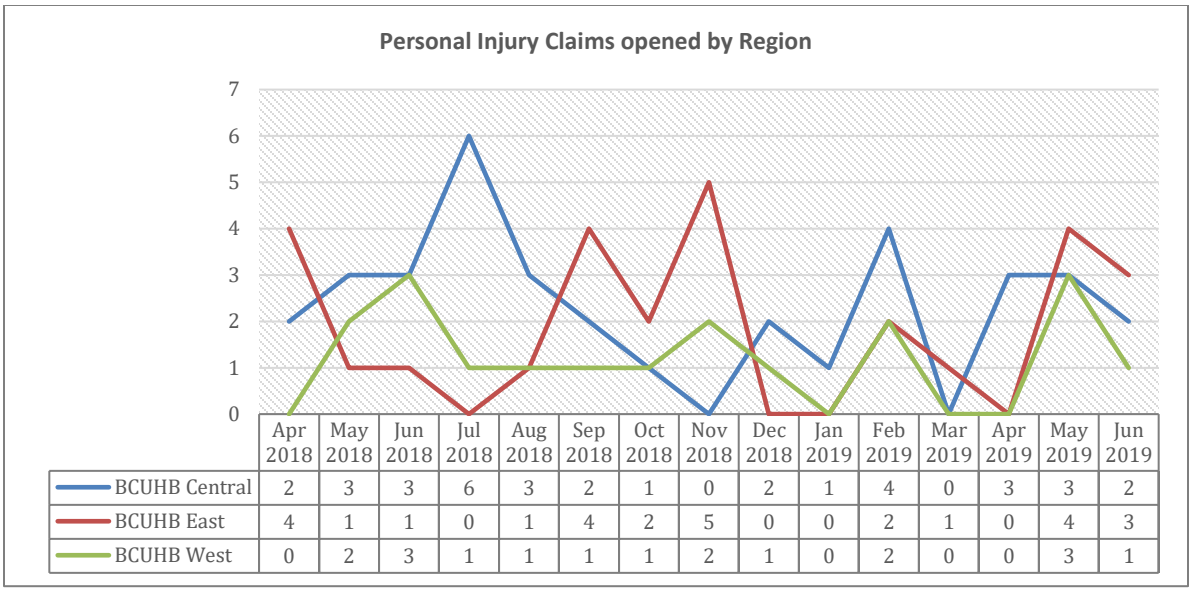
Clinical Negligence and Personal Injury claims are managed by the Health Board on the basis of legal advice provided by NHS Wales Shared Services Partnership Legal and Risk Services. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

Between April and June 95 new claims have been opened, 19 as Personal Injury claims the remainder as Clinical Negligence claims.



	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
BCUHB Central	7	6	5	10	5	3	7	13	2	5	9	11	11	8	7
BCUHB East	6	3	5	7	9	7	6	7	5	6	7	7	11	10	11
BCUHB West	5	4	4	4	5	3	7	5	5	5	7	8	2	3	13

LITIGATION (CLAIMS)



	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
BCUHB Central	2	3	3	6	3	2	1	0	2	1	4	0	3	3	2
BCUHB East	4	1	1	0	1	4	2	5	0	0	2	1	0	4	3
BCUHB West	0	2	3	1	1	1	1	2	1	0	2	0	0	3	1

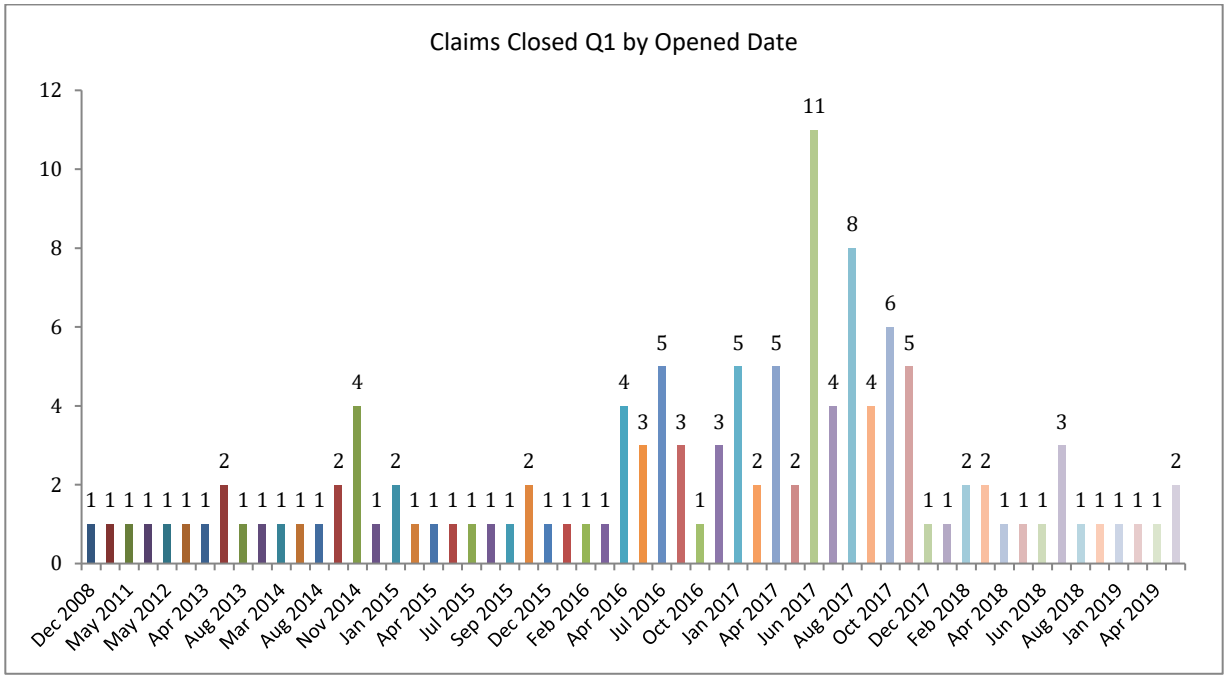
Claims opened by Speciality – Q1	Central	East	West	Total
No value	8	18	0	26
Surgery (Secondary)	10	6	8	24
Women's and Maternal Care (Secondary)	3	5	5	13
Specialist Medicine (secondary)	8	1	4	13
Division of Mental Health and Learning Disabilities	0	3	2	5
Estates and Facilities	1	3	1	5
Radiology (Secondary)	2	0	1	3
Anaesthetics, Critical Care and Pain Management	1	1	0	2
Primary Care (Area)	1	0	1	2
Cancer Services (Secondary)	0	1	0	1
North Wales Community Dental Service (Area)	0	1	0	1
Total	34	39	22	95

The “no value” category identifies that the information has not been inputted into the claims module within the Datix system. This is now being managed as a key performance indicator for the Claims Teams with performance being monitored weekly at local level.

LITIGATION (CLAIMS)

For the same period 125 claims were closed, seven of which were Personal Injury claims, the rest Clinical Negligence. The expected cost to the organisation is £17,861,260.00. There were no high-value claims paid out in quarter 1.

The graph below shows the number of claims closed in Q1 against the date the claim was actually opened.



Learning from claims: change in process

To ensure that learning and improvement is commenced and implemented at the earliest possible stage the Welsh Risk Pool (WRP) has amended its reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case. These changes will become effective from 1st October 2019. In addition, the submissions to WRP are retrospective in relation to existing triggered cases.

Previously an 'Appendix S' form was submitted to WRP for all claims where financial compensation exceeded £25,000. The trigger to submit this application was related to the date of the last payment on a claim and the Health Board had four months to submit the report from this date.

LITIGATION (CLAIMS)

The new WRP procedures replace the Appendix S form with a Learning from Events Report (LfER) and a Case Management Report (CMR). These are to be used by the Health Board to report the issues that have been identified from a clinical claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event.

The trigger for a LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. For all cases that have triggered prior to the commencement of the new procedures, the submission of a LfER will be required sixty working days from the 1st October 2019, in effect 24th December 2019.

A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that Hospital Management Teams have been advised of the claims.

The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

There is a backlog generated by the introduction of these new processes and all clinical departments will need to be aware of the situation and what is required of them. In practical terms, actions plans and improvement information will be requested by the Claims Team from clinical departments. The Claims Teams will need to draft the LfER'S including the summary of the case, investigation findings and identify the issues in the case before sending to clinical departments for assistance with the learning information.

All Health Boards in Wales contribute to a liability fund and have a risk share agreement. The WPR 'pot' for 2019-2020 is £119 million. WRP have indicated that all Health Boards may have to add to the funds at the end of the financial year. This amount will be determined by how well each Health Board is at learning, therefore, there is a financial incentive to do well. A fully completed LfER submitted on time is one of the measures to be used in determining how well a Health Board is performing.

LITIGATION (CLAIMS)

Lessons Learned from litigation

Case 1

The learning identified from one of BCUHB's claims (below) has been taken from the LfERs submitted to Welsh Risk Pool in quarter 1 2019/20. This claim requested reimbursement of redress to a value of £252,970.81 related to loss of sight through delayed appointments. The index incident occurred in 2011

Learning identified and actions taken:

- The Eye Care measure, an all Wales initiative, has been introduced
    - All patients (new and follow up) are allocated a health risk factor as follows:
        - R1 Risk of irreversible harm or significant patient adverse outcome if target date is missed.
        - R2 Risk of reversible harm or adverse outcome if target date is missed
        - R3 No risk of significant harm or adverse outcome
- In order to accommodate the new national outcomes, BCUHB are required to produce a waiting list view of all patients (new and follow up) in ophthalmic services with their clinical prioritisation . They will be required to book patients from this list in line with their target review date and health risk factor
- The outcome measures have been devised to account for both new and follow up patients, based on clinical need and risk of harm. The measures establish a system for the introduction of a new Patient Target Date for both new and follow up appointments and monthly reporting of the % patients waiting over their agreed target date.
- Within all categories, patients will have a clinically evidenced patient Target Date, which will include their holistic need.
- This new national approach will support the operational difficulties of identifying the patients most at risk of harm and allow us to prioritise accordingly.

LITIGATION (CLAIMS)

Case 2

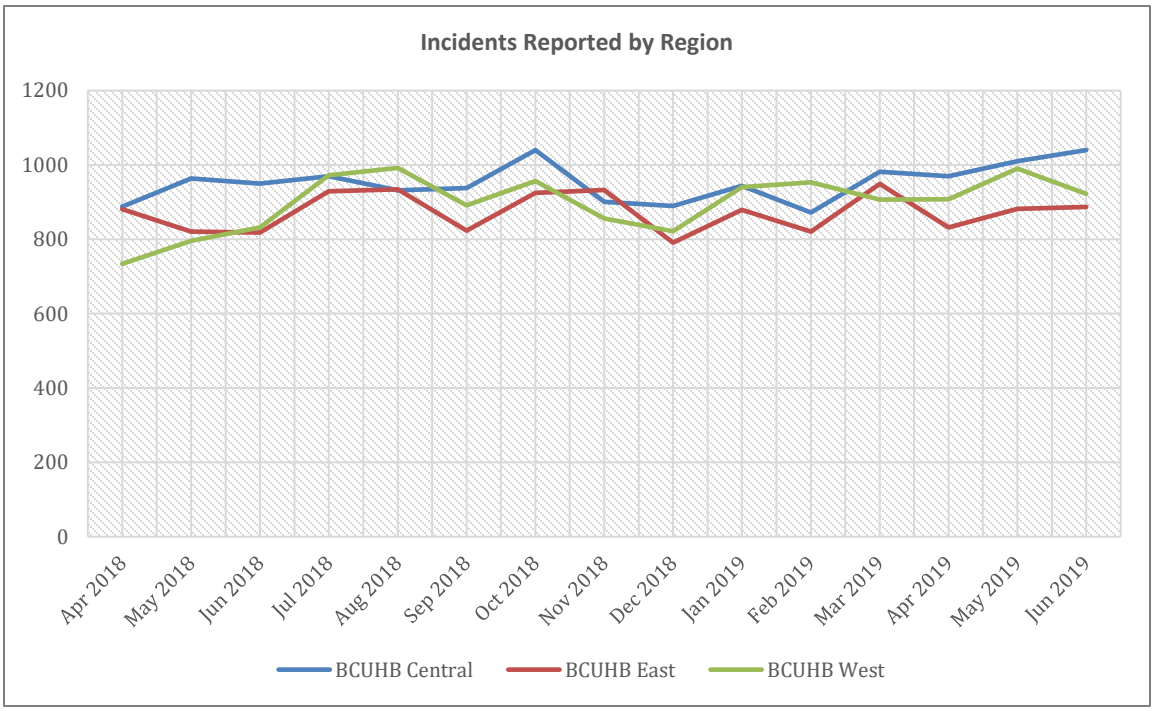
The learning identified from one of BCUHB's claims (below) has been taken from the LfERs submitted to Welsh Risk Pool in quarter 1 2019/20. This claim requested reimbursement of redress to a value of £204,231.88 related to failure to note injury during a hysterectomy procedure and to repair it. The index incident occurred in 2014

Learning identified and actions taken:

- The investigation identified that this was an operator error but learning was shared across the Division through the clinical governance meeting.

- The operator met with the Clinical Director and the case was discussed in detail. In addition, the operator will also be required to reflect upon this as part of ongoing revalidation.

INCIDENTS



Between April and June, 8,426 incidents have been reported onto the Datix system, 60% of which related to the below themes.

Top 10 Incident by Theme – Q1	Total
Pressure sore / decubitus ulcer	1505
Slips, trips, falls and collisions	1190
Abuse etc of Staff by patients	515
Implementation of care or ongoing monitoring - other	409
Accident caused by some other means	296
Infrastructure or resources - other	293
Security - other	248
Administration or supply of a medicine from a clinical area	243
Appointment, Admission, Transfer, Discharge - other	179
Self-harm during 24-hour care	164
Total	5042

INCIDENTS

The Health Board has ongoing work collaborates aimed at improving pressure area care and reducing patient falls. This work is reported elsewhere and is, therefore, not repeated within this report.

For the purpose of the report areas of significance have been identified and are discussed below:

The vast majority of incidents reported regarding “Abuse etc of staff by patients” relates to incidents reported by the Division of Mental Health and Learning Disabilities

Abuse etc of Staff by patients by Region	BCUHB Central	BCUHB East	BCUHB West	Total
Division of Mental Health and Learning Disabilities	61	55	177	293
Specialist Medicine (secondary)	14	30	50	94
Primary and Community Services (Area)	17	21	31	69
Total	92	106	258	456

Administration or supply of a medicine from a clinical area identifies two wards within Llandudno hospital has reported the highest number of incidents. There is ongoing improvement work within the sphere of medicines management which has included the development of a checklist to improve compliance with the administration of medicines and the reporting of omissions.

Administration or supply of a medicine from a clinical area – Top 10	BCUHB Central	BCUHB East	BCUHB West	Total
Morfa, LLGH (Area)	31	0	0	31
Llewelyn, LLGH (Area)	24	0	0	24
Emergency Department (secondary care)	6	8	1	15
Erddig Ward, WM (secondary care)	0	8	0	8
Foelas, Villa 15, BYN	0	0	5	5
Wards, Ysbyty Alltwen (Area)	0	0	5	5
Ward 5, YGC (secondary care)	5	0	0	5
Conwy, YG (secondary care)	0	0	5	5
Tegid, YG (secondary care)	0	0	4	4
Neonatal Unit, YGC (area)	4	0	0	4
Total	70	16	20	106

INCIDENTS

In addition, there is work ongoing with the medicines management collaborative across the sites led by the Associate Nurse Director of Quality

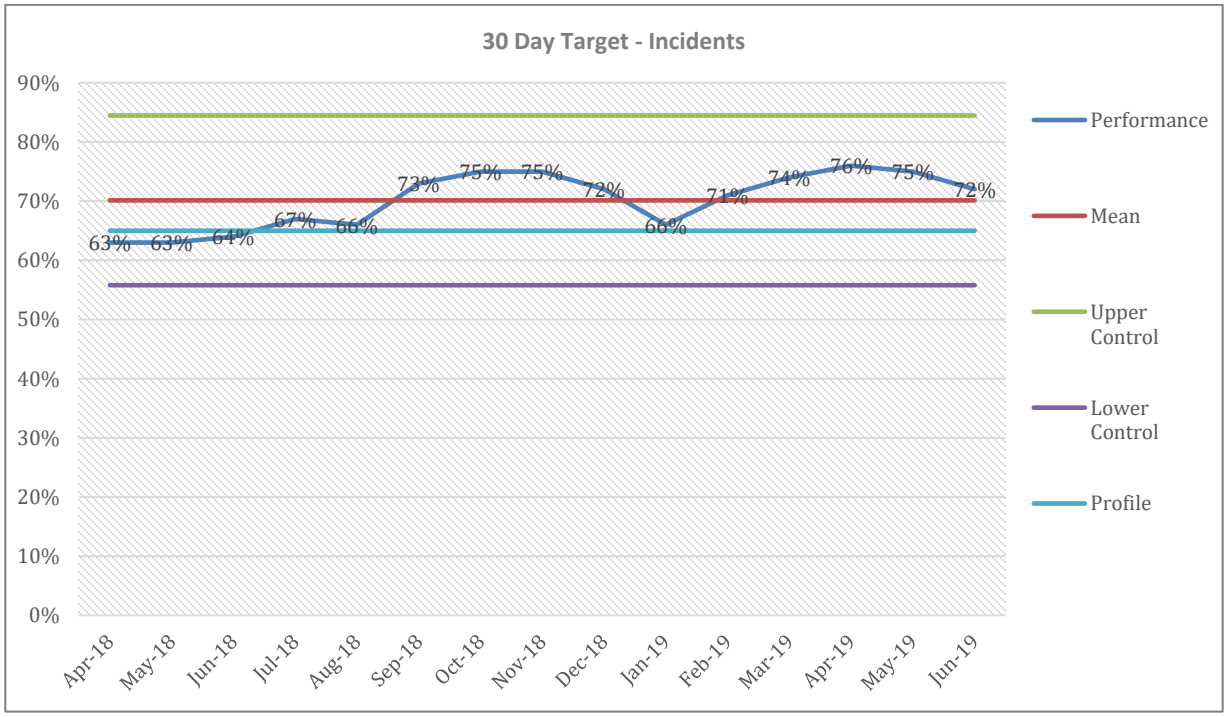
Appointment, Admission, Transfer, Discharge – other – Top 10	BCUHB Central	BCUHB East	Total
Emergency Department (secondary care)	12	5	17
Lloyds Pharmacy, Prestatyn	7	0	7
Rowlands, Coleshill Street, Holywell	0	7	7
Lloyds Pharmacy, Belfield Market, West Kinmel Street, Rhyl	6	0	6
Rowlands, Brynteg	0	6	6
Rowlands, Chester Road, Garden Village, Wrexham	0	5	5
Main Theatre Recovery (secondary care)	5	0	5
Rowlands, Summerhill	0	5	5
Morrisons, Colwyn Bay	4	0	4
Bersham Ward, WM (secondary care)	0	4	4
Total	34	32	66

The remaining incidents reported in Q1(2019/20) are broken down as below:

	Total
Labour or delivery - other	144
Lack of/delayed availability of facilities/equipment/supplies	144
Treatment, procedure - other	131
Abuse etc of patient by patient	130
Other medication error	127
Adverse events that affect staffing levels	124
Environmental matters	124
Needlestick injury or other incident connected with Sharps	120
Patient's case notes or records	114
Medical device/equipment	108
Diagnosis - other	100
Medication error during the prescription process	100

INCIDENTS

Of the 8,426 incident reported between April and June 2019, 74% have been fully investigated and closed within timeframe. Previous months' performance can be seen below



The learning identified from one of BCUHB's incidents was a joint investigation between BCUH and Public Health Wales (PHW). This incident resulted in a patient developing encephalitis on discharge from Ysbyty Glan Clwyd following a result from a lumbar puncture being missed. This incident was considered under Putting Things Right regulation but the family/patient were advised to proceed with litigation based on the value of the claim would exceed £25,000

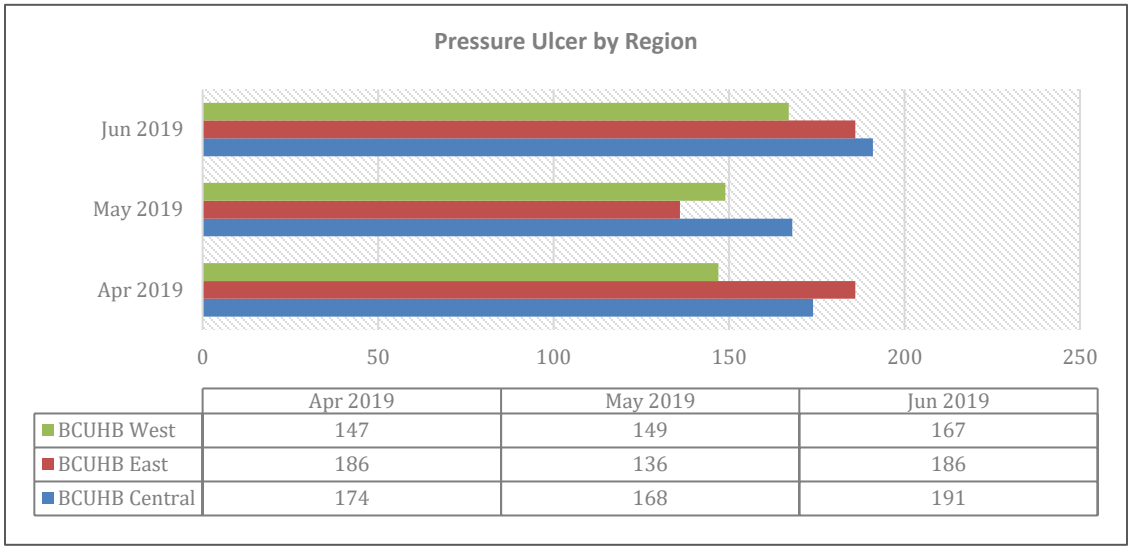
Learning identified and actions taken:

- Results from tests, when they become available, are linked back to the day the test was taken – not to the day received. Clinical staff made aware of this anomaly and reminded to review all results from day of admission through to present date.
- Email read receipts were accepted by PHW to assure that clinicians had read the email emphasizing a serious test result rather than a positive email response. Today, positive email responses only are accepted.

PRESSURE ULCERS

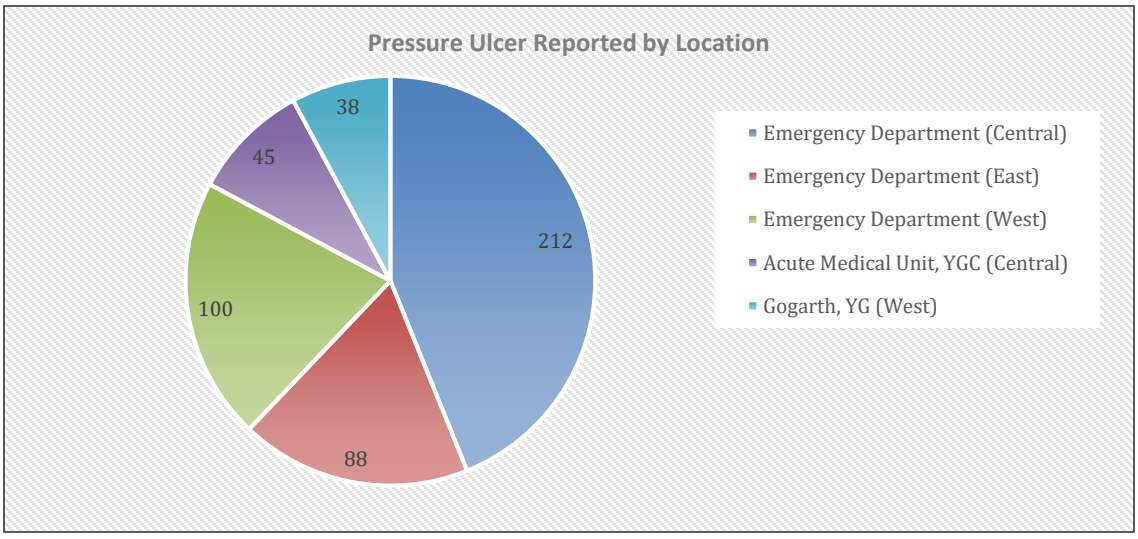
1,477 pressure ulcer incidents were reported in the quarter, this is a decrease of 2% on the previous quarter.

Central region have reported the highest number of Pressure Ulcers overall.



	Apr 2019	May 2019	Jun 2019
BCUHB West	147	149	167
BCUHB East	186	136	186
BCUHB Central	174	168	191

However, the department that has reported the most Pressure Ulcer incidents between April and June is Emergency Department Central.



PRESSURE ULCERS

Of the 1,477 incidents reported relating to Pressure Ulcers, 629 were noted present upon admission, 261 were not. The remaining have yet to be categorised.

Mobility Issues and Medical Condition remain the most common contributory factors regarding Pressure Ulcer incidents.

Actions

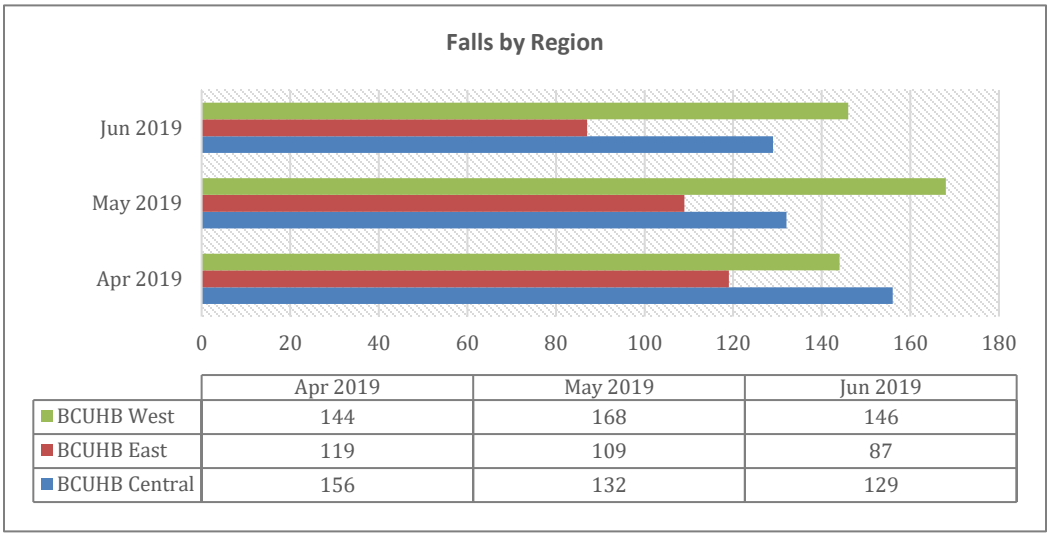
Staff involved in the care of patients at risk of developing Pressure Ulcers are aware of the importance of clear, accurate documentation. Staff awareness raised about providing air mattress for patients that have been Maelor risk assessed.

The importance of communication between day staff and night staff with regard to presence of pressure sore. Along with the importance of completing a Datix incident report on the discovery of pressure sore as soon as it is practically possible.

Regular encouragement to patients to mobilise/reposition regularly to minimise pressure.

SLIPS, TRIPS, FALLS & COLLISIONS

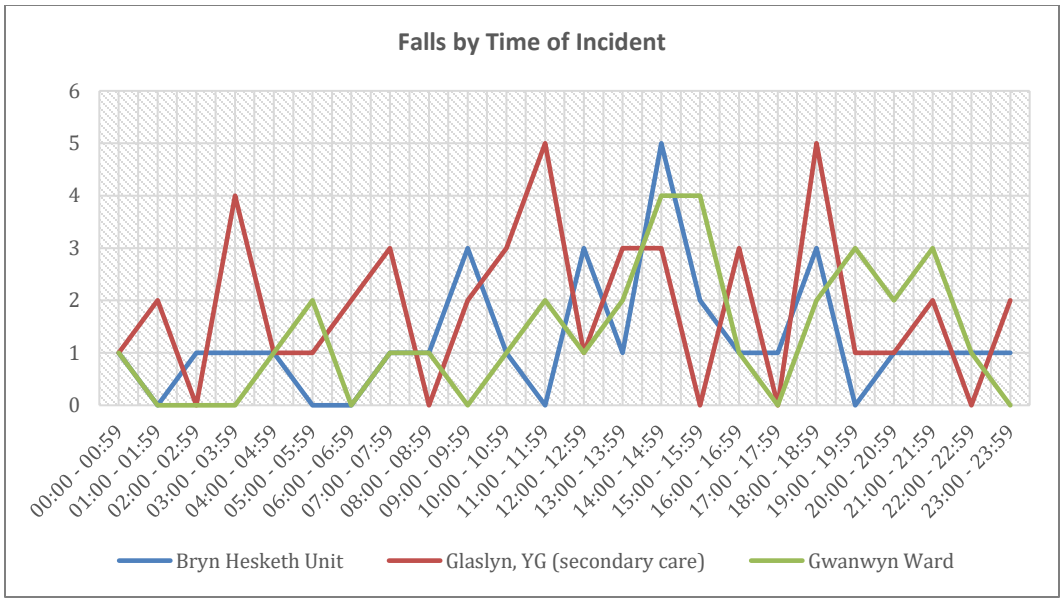
In total, 1,190 fall incidents were reported for the quarter, a slight decrease on previous. West region have reported the highest number of falls overall for the period.



	Apr 2019	May 2019	Jun 2019
BCUHB West	144	168	146
BCUHB East	119	109	87
BCUHB Central	156	132	129

The wards that have reported the highest number of falls between April & June are Glaslyn Ysbyty Gwynedd, Gwanwyn Ward & Bryn Hesketh Unit. The times in which the incidents occurred can be seen below

SLIPS, TRIPS, FALLS & COLLISIONS



Mobility issues, medical condition and dementia are the most common contributory factors relating to falls.

Actions

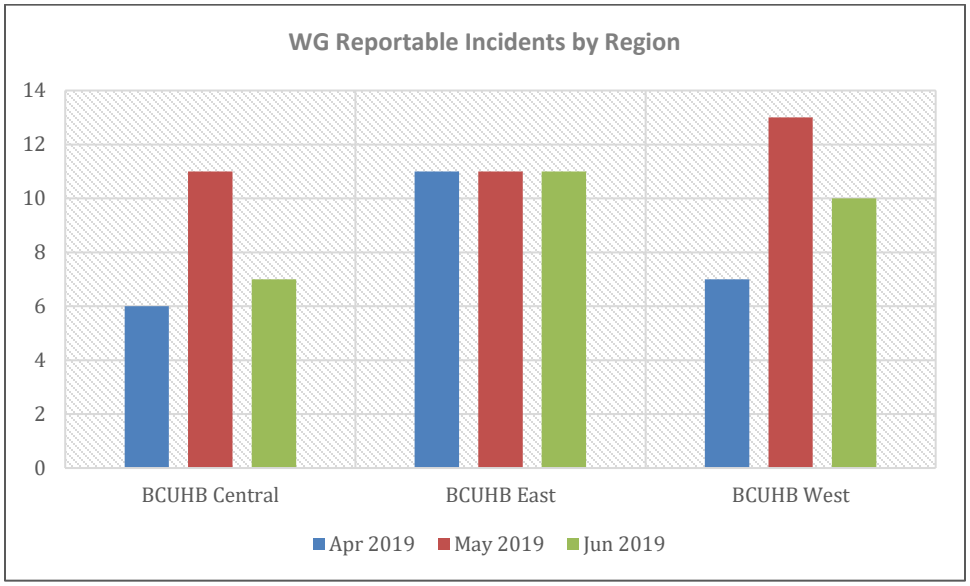
Patients with mobility issues are encouraged to use call bell and ask for assistance when required. Staff must ensure that mobility aid is kept close to patient at all times.

Continue to complete and educate regarding the importance of risk assessments and audit to ensure quality care obtained.

Lying and standing BP to be carried out on all patients at risk of falls.

WELSH GOVERNMENT

Between April and June, 87 incidents have been reported to Welsh Government, with East region reporting the highest overall.

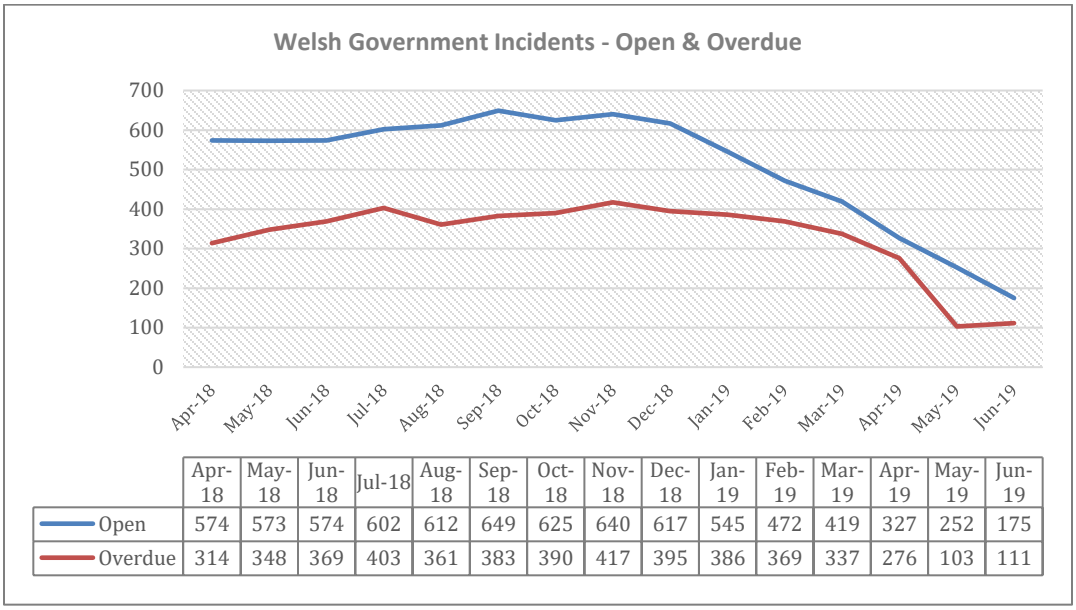


The most reported incidents to Welsh Government are “Patient Falls” and “Unexpected Death whilst under the direct care of a health prof” this latter category in the main relates to patients who are receiving care from mental health practitioners and will include natural cause death or death which is not related to the care provided by the mental health team. The above incidents make up to 68% of incidents reported to Welsh Government for the period.

Incident Type – April – June 2019	Total
Unexpected Death whilst under the direct care of a health prof.	30
Patient fall resulting in harm/death to patient	29
Other type of incident	6
Suicide(or attempted) or homicide committed by an NHS MH patient	6
HCAI outbreaks resulting in the death or harm to patients	4
Sensitive Issue	4
Grade 3 or above healthcare associated pressure ulcer develops	3
Mental Health - Attempted suicides as inpatients	3
Any serious act of Violence or Aggression	1
Serious Medication-related error	1

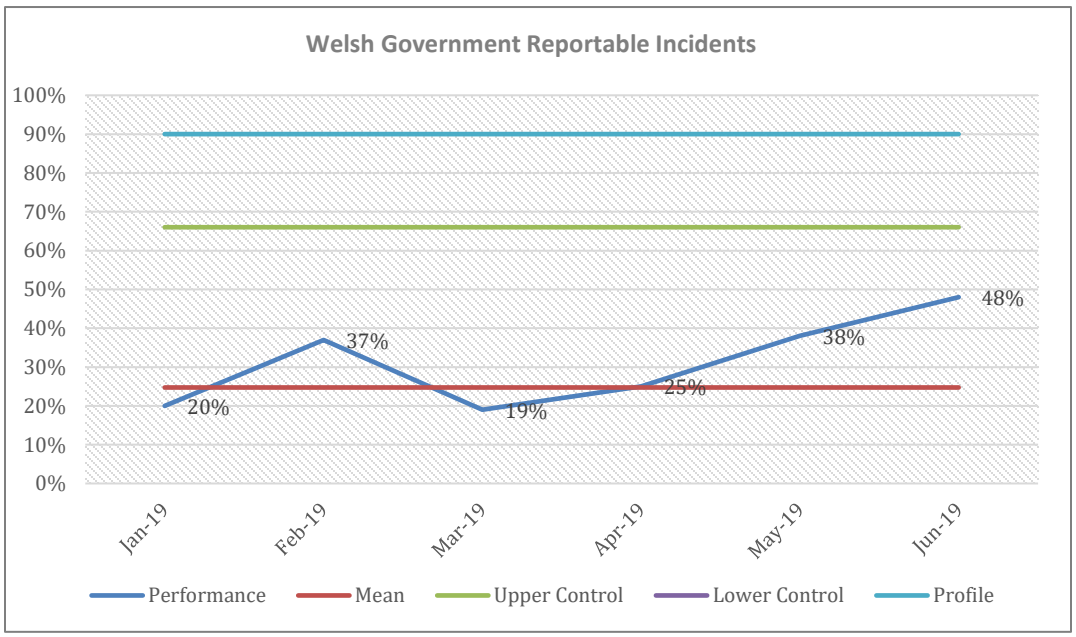
WELSH GOVERNMENT

In recent months, the Health Board has seen a substantial decrease in the number of Welsh Government incidents open and the number of incidents overdue.



	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	May-19	Jun-19
Open	574	573	574	602	612	649	625	640	617	545	472	419	327	252	175
Overdue	314	348	369	403	361	383	390	417	395	386	369	337	276	103	111

Overall, 37% of Welsh Government incidents have been closed within timeframe, since March 19 the Health Board has seen a steady increase in the percentage month on month.



NEVER EVENTS

Never Events defines a Serious Incident that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Each Never Event is fully investigated to include full and meaningful engagement with patients, families and carers at the beginning of and throughout the investigation. All investigations identify the learning from the Never Event and is crucial to prevent future harm.

There have been no Never Events within the Health Board during the time period covered by this report; the last Never Event having occurred in December 2018. Investigations for all previous Never Events have been completed and lessons learnt identified.

Any new Never Events that might occur in the future will be included within this report moving forward. For completeness the actions taken from recently closed never event incidents are detailed below.

NEVER EVENTS

Never Events Closed

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
INC150862	Negligible	BCUHB West	Ysbyty Gwynedd - Acute	Gogarth, YG (secondary care)	Nurse administered intravenous hydrocortisone orally and then proceeded to administer oral Ranitidine intravenously. Nurse ceased administration when patient complained of "stinging". She stopped administering the drug and then realised her error. Nurse has not used the oral syringe for oral administration which would have prevented this error. The syringes were exactly the same, unlabeled and in same tray.	Wrong route administration of medication	19/03/2019	Patient Safety Alert circulated BCU wide reiterating importance of using syringes for oral and IV medication Incident highlighted at morning Safety Huddle – all ward managers made aware of incident Importance of second checker feedback to ward via Safety Brief for 2 weeks Nurse to undergo reassessment of IV and oral administration of drugs. Reflection to be completed by Nurse Involved. Also completed redone ANTT training and worked through drug competency booklet All wards checked to ensure stock of all syringes are available. Spot to check to be completed on ward in 1month
INC174655	Major	BCUHB West	Ysbyty Gwynedd - Acute	Coronary Care Unit (secondary care)	Patient transferred to CCU from ITU with aortic aneurysm for control of blood pressure. Awaiting transfer to Liverpool. Patient requiring	Retained foreign object post-operation	19/03/2019	Support offered to the doctor to help reflection and learning Clinical Alert to be issued BCU wide to raise awareness of risk of retained guidewire

NEVER EVENTS

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
					insertion of midline as venflon had tissue. Senior nurse attempted to insert line without success and requested help of doctor. Doctor inserts midline into right mid forearm under ultrasound guidance. The line is not used for any treatment, however when nurse attempts to flush line as part of maintenance bundle, line appears blocked. Nurse removes line to discover the guide wire in situ.			Second person to be present during insertion to acknowledge guidewire removal and sign "sticker" to be placed in medical records LocSSIPs to be introduced for insertion of midlines
INC134811	Moderate	BCUHB Central	Ysbyty Glan Clwyd Hospital - Acute	Theatre F, YGC (secondary care)	PICC line insertion for Total Parenteral Nutrition (TPN) by doctor in anaesthetic room of theatre complex. Aseptic technique used. Two guide-wires in PICC line pack One removed at end of procedure, the other had been mistakenly advanced	Retained foreign object post-operation	12/06/2019	Development of LocSSIP for insertion of PICC lines Secondary Care Medical Director to review current access to insertion of PICC lines: Audit of the amount of requests and support calls received regarding vascular access. Standardisation of equipment Doctor involved contributed to investigation through personal reflection and learning.

NEVER EVENTS

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
					into the patient with the PICC. Error identified by treating doctor approximately four later on reflection of procedure (whilst at home).			
INC138308	Negligible	BCUHB East	Wrexham Maelor Hospital - Acute	Radiology (secondary care)	Patient was consented for a steroid joint injection of her left talo-navic joint. WHO check list was performed and previous images checked. The left sub-talar joint was injected instead of the left talo-navic. Patient was sent home with a pain diary. Ten working days later it was noted the report did not match the x-ray image.	Wrong site surgery	10/07/2019	Images and report to be reviewed in a timely way – completed time now formally allocated for images to be reviewed post procedure. Circulate top tips for completing a request card with the new request cards – completed. Investigate if a more detailed list can be generated from Radis – completed – this is not possible due to these codes not being available. Verbalise the joint name in full and do not abbreviate – completed. Audit correct completion of request cards – part of annual audit programme Radiology to consider when it is appropriate to use abbreviations – following consideration it was decided a risk assessment on the impact of delays for urgent requests if card is received with abbreviations is being undertaken prior to a final decision – Risk assessment indicated if all abbreviations were stopped

NEVER EVENTS

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
								then there could be a negative impact on patient care. During the procedure there are 3 people in the room each with a specific role. Nurse caring for patient, Radiographer performing the injection and the radiographer operating the X-ray equipment. The neither the nurse or the radiographer operating the X-ray equipment would be expected to be able to identify the individual joint being injected on the image on the screen however an action to explore 'Joint Injection Education' material for staff these staff is being pursued – currently being worked through as part of the training package for new interventional equipment that has recently been installed. Review modified WHO radiology checklist which was used in the procedure, to look for any modifications that may be required – The checklist was completed appropriately at the time of the procedure. Subsequent review of its use in practise did not identify any amendments that would have helped reduce the likely hood of this event occurring.
INC167650	Moderate	BCUHB Central	Ysbyty Glan Clwyd	Ward 7, YGC	Following a fall at home, the patient was admitted to the	Wrong route administration of medication	12/06/2019	To review and strengthen current training in relation to FICB to include

NEVER EVENTS

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
			Hospital - Acute	(secondary care)	ward with a fractured neck of femur to the left side. The ward doctor was requested to provide an iliac nerve block for pain relief. The doctor performed the block to the right leg not the left leg which was fractured. The doctor realised his error and informed the Orthopaedic ANP, who contacted the patient's consultant.			checking the correct limb and completion of documentation. Clinical Alert 'Stop before you Block' to be redistributed to all Clinical staff To review and develop the current induction process for new doctors to include mentorship and close monitoring procedures. Roles of Educational Supervisors in Orthopaedics to be defined and to include responsibility for individual's support plan and risk assessment. Clinicians to be reminded of their responsibility to ensure patient files are updated accurately and in a timely manner ANP to liaise with educational lead in ED to ensure consistency of training within the department. Stop before you block checks to be added to WHO Surgical Safety Checklist

CORONER INQUESTS

For the period, the Health Board has not received a Regulation 28 report from Her Majesty's Coroner.

WALES CONCERNS MANAGEMENT SYSTEM - UPDATE

The Once for Wales Concerns Management System is a single concern management electronic system to aid learning across Wales in complaints, claims, incidents and risk. The tender process for the Once for Wales Concerns Management System has concluded and RLDatix have been awarded the tender for the main system. The new system has a wide range of functionalities to meet the needs of NHS Wales' organisations which includes incidents, complaints, redress, claims and risk management. The overall vision for the project is to deliver a structured all-Wales platform to strengthen organisational learning through focusing on a learning and investigation process. In addition the learning from deaths (mortality review) process is included and specification of how the system is to link to the new function of Medical Examiner.

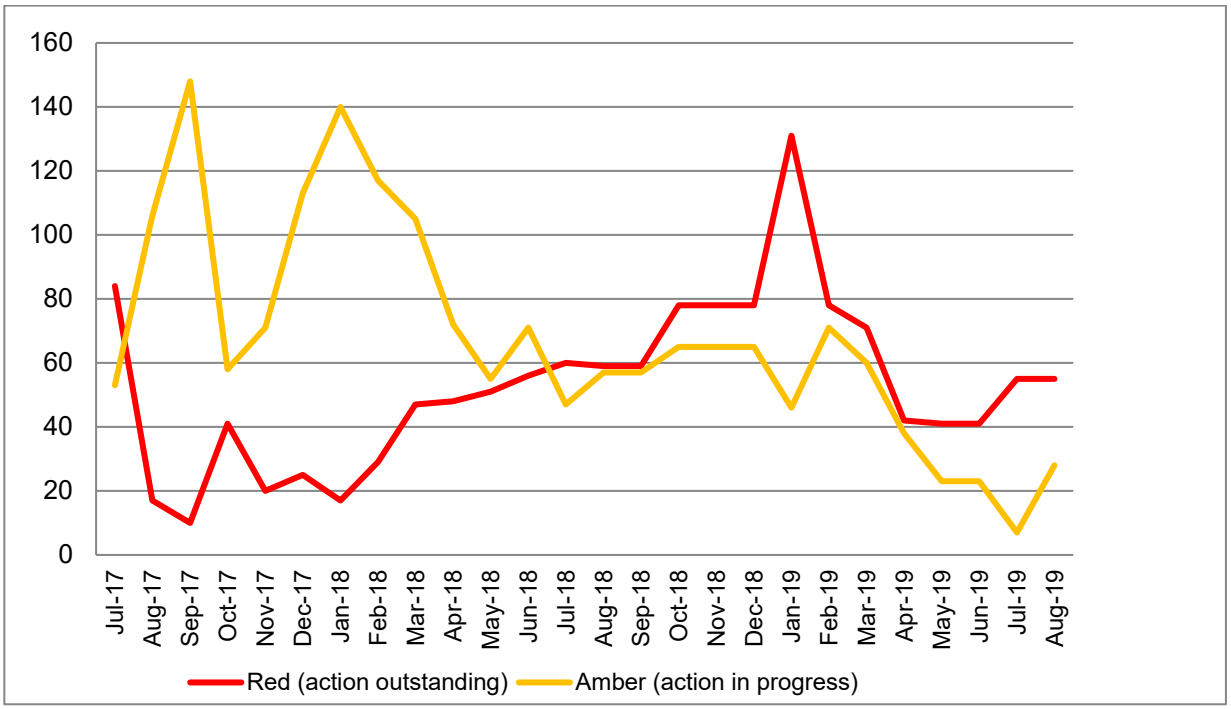
Systems to support the new public voice body and the gathering of service user experience was not awarded. The service user feedback system will be put back out to tender in the near future. The national programme team will work with the Health Board to help plan for the costs associated with this new functionality when it becomes available.

The implementation plan for RLDatix will be phased, with early adoption and trial roll out of the various functionalities undertaken by Hywel Dda and Swansea Bay Health Boards. The intention is to introduce new functionalities and complaints functionality by April 2020, with a phased introduction of the remaining functionalities during the 2020-21 financial year.

Healthcare Inspectorate Wales

HIW inspections, actions and outstanding matters are tracked / recorded via an excel tracker tool. This Tracker Tool records all inspections and subsequent actions, plus preparatory references where inspection reports and Thematic Reviews are expected.

Below is a summary of current BCUHB **internal actions** against HIW recommendations to 31st August 2019 (where stated "action outstanding", this refers to the date of completion for actions communicated to HIW when the initial action plan was returned following receipt of the inspection report):



Providing Assurance:

Each Area Lead is required to submit an update on a monthly basis against their open actions. These updates are co-ordinated by the Office of the Executive Director of Nursing and provided for discussion at QSG on a monthly basis.

The Corporate Quality Improvement Team have tested the assurance methodology as outlined in the HIW Management Plan whereby meeting local leads individually and / or secondary care governance leads led to closure of actions, sharing of good practice and provided assurance against open actions.

In addition, the Corporate Quality Improvement Team tested the Site Walk around methodology (also detailed within the HIW Management Plan) with local leads which again at the time provided momentum and closure of open actions and sharing of good practice.

These approaches provided opportunity for rigorous and meaningful action planning. It is envisaged with the complete recruitment of the Business Support Manager (working closely with Director of Quality Assurance), this tested process will be fully implemented and embedded to offer support and assist in sharing of lessons learned.

	Site	Service/Ward/Location	Lead	Healthcare Standards identified for improvement
AMBER **28** actions in progress from date confirmed in HIW action plan	Glan Clwyd- Central	Secondary Care- Emergency Department	Director of Nursing	• Effective Care (Documentation). • Safe Care (HAPU & Falls Assessment, IP Policy / procedures, Medicines Management & Fluid intake / output charts). • Staff & Resources (Mandatory Training).
	Wrexham Maelor- East	Mental Health & Learning Disabilities- Heddfan	Director of Mental Health & Learning Disabilities	• Effective Care (Records Management). • Safe Care (Provision and maintenance of CMHT facilities, Records Management & alignment of processes within CMHTs). • Implementation of WCCIS).
	Ysbyty Alltwen- West	Secondary Care- Morfa Ward (Care of the Elderly)	Locality Matron	• Health Promotion and Improvement (providing designated lounge/dining space, during any future refurbishment of the ward) • People's Rights(Review process and address issues around recording of mental capacity assessments) • Medicines Management (Record patients' weight on medication administration charts) • Workforce (Reflect on the less favorable staff responses to some of

				the questions in the HIW questionnaire)
	Glan Clwyd- Central	Secondary Care- Trauma & Orthopaedics (Theatres and Abergele Hospital)	Secondary Care Medical Director	• Managing Risk and Promoting Health & Safety Safe and Clinically Effective Care • Record Keeping
	Ysbyty Gwynedd- West	Secondary Care- Emergency Department	Director of Nursing	• Patient Information • Communicating Effectively • Timely Access • People's Rights • Information Governance and Communications Technology • Workforce • Health Promotion, Protection and Improvement • Managing Risk and Promoting Health & Safety • Record Keeping
	Wrexham Maelor- East	Secondary Care- Emergency Department	Secondary Care Medical Director	• Managing Risk and Promoting Health & Safety • Safe and Clinically effective care • Record Keeping • Timely access • Preventing pressure and tissue damage

	Site	Service/Ward/Location	Lead	Healthcare Standards identified for improvement
RED **52** Actions outstanding from date confirmed in HIW action plan	Wrexham Maelor- East	Secondary Care- Emergency Department	Site Director of Nursing	• Effective Care (Communication methods: in waiting area &referral to OOH).
	Wrexham Maelor- East	Mental Health & Learning Disabilities- Heddfan, Ty Llewelyn, CMHT's, Cynydd (Ablett)	Director of Mental Health & Learning Disabilities	• Safe Care Medicines Management, Replacement of damaged furniture, S136 Suite arrangements, Extractor Fans in kitchens, Refurbishment work, Hand wash basin in clinic room (re IP), Management of Patient Monies& Garden works / lighting). • Effective Care (Records Management & alignment of processes within CMHTs). • Timely Care (Discharge planning & privacy measures for patient toilets). • Dignified Care (Storage of / access to patient toiletries, Nursing station, Vision Panels, & Advocacy Services). • Application of the Mental Health Act (Policies & Procedures).

				Access to LAs joint electronic case system and access to relevant CMHT records.
	Health Board Wide	Ophthalmology	General Manager, Surgery	• Staying Healthy (Health promotion). • Effective Care (Electronic records). Workforce (Workforce plans).
	Care Homes	Care Home Review	Commissioning Manager CHC	• Effective Care (Partnership care and support – CRTs, co-production of a learning & development programme re meeting needs of older people). • Individual Care (Accessing Therapist Support, Information pack re service availability & Continence support& reporting of concerns whilst their residents are in hospital). • Dignified Care (Dementia Care). • Scope of joint quality monitoring tool. • Workforce (Staff training, clarity re roles and responsibilities of Community Nurses& staff responses to HIW questionnaire). • Timely Care (patient discharge & Safer Discharge Group role review and refresh).

HEALTH INSPECTORATE WALES

BCUHB Wide actions:

The following 2 HIW actions have been identified by the Quality Safety Group (QSG) for implementation pan BCUHB and require review:

Originally highlighted in	Date of HIW inspection	HIW action	BCUHB Lead
Pen y Maes Health Centre (BCUHB Managed Practice)	April 2017	The Health Board should review arrangements in respect of managed practices and consider whether there needs to be a separation of its role as commissioner and provider of primary care services, whilst at the same time ensuring that equitable resources are secured for both functions.	Assistant Director Primary Care Contracting
Ward 1 & 2b, YGC	July 2017	The Health Board must take measures to ensure that patients' capacity to make decisions is recorded consistently.	TBC

Future / expected HIW activity:

- HIW have started undertaking **inspections of Surgical Departments** throughout Wales, taking into account NatSSIPs which were introduced in Wales in September 2017. As part of this programme of work, all Health Boards across Wales were required to undertake a self-assessment to assess progress towards meeting NatSSIPs – the BCUHB self-assessment was submitted to HIW in June 2018. No further communications have been received from HIW, however it should be noted that inspections will be unannounced.

- On 2nd, 3rd and 4th July 2019, the HIW carried out an unannounced inspection of **Trauma & Orthopaedics at Glan Clwyd Hospital**. Following the inspection, the HIW issued an immediate assurance letter. An action plan was completed and submitted to the HIW. On 27th July 2019, the HIW confirmed that the actions provided them with sufficient assurance.
- A National Thematic review of **Maternity Services** has commenced. The review will involve unannounced inspections of maternity services across BCUHB. A

report will be published following each inspection. Following which the National review will conclude with the publication of a National Maternity Services Report in the summer 2020.

Maternity Services completed a self-assessment of Maternity Services in June 2019 and has recently provided further information to the HIW end of August 2019. This will assist the HIW with an understanding of the service and they will write to the Health Board should they require any further information.

- Following the joint thematic review of Adult Mental Health in the community 2017/18: (https://hiw.org.uk/sites/default/files/2019-06/190207joint-thematic-review-community-mental-health-en.pdf), the HIW have been undertaking inspections of **Community Mental Health Team's (CMHT's)**. On 28th August 2019, the HIW informed the Health Board that they plan to inspect: **Ty Derbyn at Wrexham Maelor Hospital on 15th and 16th October 2019**.

  HIW have requested information from the Health Board in advance of the inspection with a deadline of 24th September 2019. This matter is with the service at present.

Healthcare Inspectorate Wales Annual Report: April 2018- March 2019

The Annual Report for 2018-19 acknowledges how Health Boards in Wales are balancing ongoing financial pressures and increasing health care needs from an ageing population with complex conditions.

Over the past year, the HIW have carried out 179 inspections, including follow up inspections of Primary, Community and Secondary care services. The report details the findings of those inspections in terms of good areas of practice and improvements which need to be made in line with Care Standards.

For BCUHB, the HIW carried the following inspections in 2018-19;

- Two hospital inspections, one of which was a follow-up. *No immediate assurance issues*
- Four mental health unit inspections. *No immediate assurance issues*
- One IR(ME)R inspection. *No immediate assurance issues*

- Five GP Practice inspections and 1 follow-up inspection. *No immediate assurance issues*
- Twenty-one dental practice inspections. *One immediate assurance issues*
- One CMHT inspection. *No immediate assurance issues*

For follow-up inspections, most improvements have been implemented and sustained. There are however, some issues which remain apparent and significant challenges for the BCUHB in maintaining patient flow through the Emergency Department at Glan Clwyd, and tackling prolonged waiting times.

HIW noted that for Mental Health services, there were no immediate assurance issues and it is clear that much effort is being made to improve services. The HIW do however, remain concerned about the overall capacity of BCUHB's mental health inpatient services and the length of time some patients may be waiting for access to psychological services.

HIW reported that for BCUHB, GP inspections were positive overall. However patients consistently reported concerns to the HIW regarding the ability to make appointments at their GP Practice.

Next Steps

Corporate Nursing leads will continue to work with and support local leads with the HIW inspection process, along with the implementation and monitoring of improvements from inspections. The role of the Central Corporate Lead (Business Support Manager) will play a pro-active role.

We aim to strengthen the relationship between with Health Board and HIW, ensuring collaborative working and learning.

Additional Information:

The Corporate Nursing team would like to take this opportunity to emphasise compliments received from the HIW in relation to Health Board staff. The HIW have complimented and thanked staff for their professionalism and support with recent inspections they have undertaken so far in 2019.

Quality Safety & Experience Committee **24.9.19**	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 Gap Analysis Report
Report Author:	Peter Bohan Associate Director of Health, Safety and Equality
Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development
Public or In Committee	Public
Purpose of Report:	This report provides an overview of a gap analysis of 31 key pieces of legislation reviewed by the Health and Safety Team, Occupational Health, Manual Handling Manager in partnership with the Trade Union Representatives. It highlights gaps in compliance and proposed solutions to the issues identified.
Approval / Scrutiny Route Prior to Presentation:	Strategic Occupational Health and Safety Group.
Governance issues / risks:	A full review of legislative compliance has now been undertaken to identify if the current safety management systems within the Board are appropriate. The evidence suggests considerable work is required to ensure that assurance to the Board can be evidenced in all service areas. The report highlights areas of concern and good practice and makes recommendations on its findings.
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, sickness absence and claims against the Board.
Recommendation:	The Committee is asked to: 1. Note the position outlined in Gap Analysis Report. 2. Support the proposed improvement plan and findings of the gap analysis of legislative compliance and subsequent proposed project plan and time line.

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 Update paper – Gap analysis review with project timeline.			

1. Executive Summary

This report provides an overview of the gap analysis undertaken over a 6 week period from 17th June - 31st July 2019 by the Health & Safety (H&S) Team, Occupational Health (OH), Violence & Aggression (V&A) Case Manager and Manual Handling Manager. The analysis of 31 pieces of Occupational Health and Safety (OHS) legislation, included site visits of 117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP Berwyn. The OHS team had significant support from our trade union partners who visited a significant number of gap analysis reviews with the Team. The process has been further evaluated by Internal Audit who will provide a report on its findings to ensure that the systematic and fair evaluation had taken place. There was significant support from a number of key staff in the majority of service areas with good practice being evidenced in Wards and Departments that had taken on the advice of the OHS Team or had developed their own safety systems.

The audits identified that 15 pieces of legislation are deemed to be non-compliant 13 partially compliant and 3 fully compliant (Appendix 1). The overall impression of safety management systems was that OH&S performance had become fragmented, with central control taking responsibility from sites with limited overall evidence of training, good quality risk assessments and safety management systems being implemented. Clear lines of responsibility and accountability are not being evidenced in a number of service areas. There is serious concern over the management of key areas of the business including H&S training and level of competence, asbestos management, legionella, contractor management and control, stress management, permits to work systems, work at height, manual handling and control of substances hazardous to health.

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

2. Introduction

This report is produced to inform the Betsi Cadwaladr University Health Board of the current position on Occupational Health and Safety compliance and best practice guidance documentation provided by the Health and Safety Executive (HSE). The improvement plan (Appendix 2 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 31 pieces of legislation and over 179 questions (Appendix 3) has been completed over a 6 week period from the 17th June- 31st July 2019. The evaluation has been undertaken in a total of 117 premises, 47 premises including GP practices for H&S, 31 Manual Handling audits, 24 occupational health reviews and 15 Violence and aggression visits to premises for compliance. The focus was to provide a snapshot of compliance based on evidence identified on site during the period of evaluation of key legislation included asbestos, legionella, Control of Substance Hazardous to Health (COSHH), stress, sharps, work at height, RIDDOR and workplace regulations. The self-evaluation scores of 93% for last year and 88% for Q1 are considerably more optimistic than the findings indicated within this report. A project plan based on the findings (Appendix 4) and 3 year strategy are provided as a baseline for work on improvements required.

3. Background

The purpose of the gap analysis is to provide a baseline for the Board of current levels of compliance, it should not be seen as critical or overly onerous. The organisation has seen a number of significant changes over many years and this has resulted in a lack of oversight at senior level of the safety management system. The review will assist in building a foundation of systems and processes that will support the organisational improvement plan. All organisations have statutory duties to ensure suitable arrangements are put in place to manage occupational health, safety and wellbeing effectively which should form an integral part of workplace behaviours and attitudes. It should be noted that the Health and Safety Executive (HSE) are currently undertaking a series of in depth inspections in South Wales Boards which includes between 5-9 inspectors looking at key areas of legislative compliance, the initial focus is asbestos, musculoskeletal disorders and violence and aggression, once they have looked at these areas they will then focus on contractor management and control, COSHH and a range of other subjects throughout acute and community services. It is likely they will be inspecting BCUHB as part of this program. This report will support the Board and acknowledge the good work that has been undertaken and identifies additional work and evaluation 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:

- Contractor management and control.
- Asbestos action plan to address shortfalls in system.
- Work at height permit to work system for a variety of services.
- Legionella management and controls systems.
- COSHH risk assessment including latex management and control.
- Training for all levels of staff required on H&S Management.
- Union representatives and H&S Leads provision.
- Stress management systems.
- Manual handling musculoskeletal disorders.
- Fire safety and evacuation.
- Vibration monitoring and control.
- Noise assessment and control.
- Clear lines of responsibility in relation to building management and control.
- Vehicle Driver safety.
- Lone Working.

5. Methodology

A systematic approach was taken to ensure consistency of audits throughout BCUH. Initially a H&S team away day identified a lack of assurance in legislative compliance throughout the Board. It was agreed a total of 50 audits would be undertaken across all areas of BCUH. Each member of the team was tasked with developing a set of questions that tested compliance with the legislation. The format and scoring was based on the current methodology used for reviews by the H&S Team and the self-assessment audit tool currently in use. The range of premises visited included the following:-

GP's	**2**

Healthy Prestatyn	H&S
Hillcrest Surgery, Wrexham	H&S
Mental Health	**22**
Heddfan, Wrexham Maelor Hospital (WMH)	H&S, OH, MH
Ablett Unit, Ysbyty Glan Clwyd (YGC)	H&S
Dinas Ward	H&S
Ablett Unit	OH
Ty Llewellyn Bryn y Neuadd (ByN)	H&S V&A
Clywedog Heddfan	OH
Cefni	H&S MH
Cemlyn Ward Cefni	OH
Physiotherapy Cefni	OH
Cynan Ward, Ysbyty Gwynedd (YG)	V&A
Cynnydd Ward, YGC	V&A
Home Treatment Team, Hergest	V&A
Community Mental Health Team Rhyl	V&A
Substance Misuse Service, Anglesey	V&A
Coed Celyn	H&S
Substance Misuse Service Central	H&S
Kestrel Ward, NWAS, Abergele Hospital (ABH)	H&S
Bryn Hesketh Unit, Colwyn Bay	H&S, MH
Community Hospitals	**18**
Deeside Community Hospital (CH)	H&S, MH V&A
Mold CH	H&S
Colwyn Bay CH	H&S
Abergele GH	H&S V&A
Denbigh CH	H&S
Llandudno GH	H&S
Ruthun CH	H&S
Royal Alexandra GH	H&S
Ysbyty Dollgellau	H&S
Ysbyty Alltwen	H&S
Holywell CH	V&A
Wards A & B, Holywell Hospital	OH
Clwyd Ward, Mold Hospital	OH
Ceiriog Ward, Chirk Hosptial	OH
Eryri	H&S
Padarn Ward, Eryri	MH
Llewellyn Care of the Elderly (COTE) Llandudno Central	OH
Community Services (Area)	**6**
Posture & Mobility	H&S
Informatics East	H&S
HMP Berwyn	H&S V&A
Postural Mobility Services West	H&S
Talarfon West	H&S
Secondary Care	**45**

Radiology East	H&S
Pathology East	H&S
Radiology West	H&S
Pathology West	H&S
Audiology West	H&S
HSDU East	H&S
Mortuary Central	H&S
SuRNICC Central	H&S
Glaslyn Ward, YGC	MH
Ward 7 SC YGC	OH MH
Ward 11, YGC	MH
Ward 3 SC YGC	OH
AMU / RAU SC YGC	OH
Theatres SC YGC	OH
A&E East	MH, V&A
A&E West	MH, V&A
A&E Central	MH
Maternity Services West	H&S
Bonney Ward, WMH	OH
Theatres, WMH	OH
Children's Ward, WMH	OH
Pantomime Ward, WMH	OH MH
Children's Unit, YGC	OH
CCU, YGC	OH
Tryfan Ward YG	V&A
Ward 9, YGC	V&A
Evington Ward, WMH	V&A
Dyfrdwy Ward, WMH	V&A
Ward 2 – COTE, SC Central	OH
Conwy Ward YG	OH MH
Theatres YG	OH
Moelwyn YG	OH MH
Labour Suite YG	OH
Pharmacy Central	OH
Errdig Ward, WMH	MH
Ward 19, YGC	MH
Morris Ward, WMH	MH
District Nursing	**7**
Rhyl District Nurses (DNs)	MH V&A
Flint DNs	MH
Denbigh DNs	MH
Caernarfon DNs	MH
Children's Community Health Visiting, School Nursing, West	H&S
Community Nursing Team, Wrexham	V&A
Estates & Facilities	**16**
Capital Planning East	H&S
Catering Services Central	H&S, MH

Estates Central	H&S
Domestic Services West	H&S, MH
Domestic Services East	H&S MH
Domestic Services Central	H&S
Catering Services West	H&S
Estates West (H&S)	H&S
Portering Services West	H&S MH
Portering, YGC	MH
Portering, WMH	MH
Catering Services East	MH
Dental	**1**
Ty Nerys, YGC Central	H&S
Total	**117**
*OH= Occupational Health H&S =Health & Safety V&A = Violence & Aggression MH = Manual Handling	

Internal audit reviewed the questioning process and system of evaluation. They will provide feedback on their findings defining if the audits were consistent and provide assurance that appropriate governance reporting lines were in place for OHS.

6. 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. The gap analysis did not ask any specific questions on HASWA but the overall findings would deem the organisation non-compliant with this legislation. The regulation made under the Act form part of the gap analysis findings are described below.

7. Gap Analysis Findings

The scoring system for the gap analysis is based on the self-assessment review and best practice guidance from the Health and Safety Executive. The marker next to the legislation indicates the following:-

Non-compliant <65  Partially Compliant <8  Compliant 85 

1. Control of Asbestos Regulations 2006

The overall view of asbestos was that the system was fragmented and inconsistently managed. There is a policy on the intranet which was due to be reviewed in January 2019. It notes that the policy acts as an overarching document which supports local asbestos management procedures. Where asbestos has been removed, no record is kept on site to inform contractors, management or H&S Leads. An asbestos management plan is available on the intranet, but this hasn't been signed off or approval evidenced. The plan is an overarching plan and mentions that "local asbestos action plans including localised asbestos registers will be held at each BCU site and reviewed every 6 months". There is limited evidence of this process taking place. The surveys are material scored and priority scored in line with HSE asbestos essentials guides. However, the audit was unable to verify whether 6 monthly or annual reviews and inspections are carried out and priority scores reviewed to enable and inform a plan for managing the asbestos controlled materials locations on site.

The external contract for asbestos management was previously provided by Environmental Essentials. This contract has now been terminated and a number of providers are undertaking surveys on behalf of Estates and Facilities. The Information required for asbestos registers is often not stored at the location, this is particularly relevant in community services. The information is generally stored centrally; actions identified as significant on surveys could not be seen as completed and assumption made that work would have been completed from previous surveys. When work is carried out on asbestos there is limited evidence of the central plans being updated.

A number of internal staff were unaware of the asbestos register in the area they worked in. The re-survey documents in many cases appear to be a copy of the previous year's survey with the asbestos pictures showing the same area and condition of the asbestos. Staff training was in place however locations and condition of asbestos requires clearer dissemination to staff involved in maintenance work. There was limited evidence that contractors are inducted and provided with information regarding the exposure to asbestos. The Estates and capital planning team will commission targeted surveys where work is undertaken rather than rely on management surveys previously undertaken. The asbestos register for the YGC was not up to date; this was surprising with the recent completion of the asbestos removal work.
The asbestos registers seen on the community sites were for the most part out of date. However, there was evidence for some of them that they had been done by Estates and the site boxes just not updated. Across all departments it was evidenced that there is no signage on ACMs. It was noted that this was a BCUHB decision that could affect safety, it would be recommended to have signage in plant rooms that would not be in the public view. A permit to work system in specific areas in relation to asbestos related work is required; one has been drafted but not approved. There was air monitoring taking place when it may not have been required, as a competent surveyor would provide assurance that the asbestos was being managed effectively. A systematic review of surveys standards and the quality of the surveyor who has undertaken the work requires reviewing. Actions completed require centrally logging and records kept on site.

2. COSHH – Management of Water Systems

The Policy on the intranet is currently out of date requires reviewing. The legionella management is externally monitored by Clearwater in the majority of premises. This provides the organisation with a system for Red, Amber, and Green (RAG) rating the premises based on

risk. The organisation cannot give full assurance that this element is effectively managing the control measures for the water system include flow and temperature. Currently if there is an unused outlet on a ward or department, the ward or department informs facilities who then flush the outlet. There were several examples where this system had failed leaving outlets unflushed creating in effect a dead leg in the system. A positive assurance of flushing is required to evidence that every water outlet is flushed in accordance with the Policy. The lack of management oversite leaves many infrequently used water outlets that require removing in both the Acute sites and in the Community. However, to achieve this Estates are relying on information and a risk assessment coming from the site occupiers who may not be able to identify or agree remedial work. The water safety group should provide assurance to the Board that the system is changed to deliver safe water procedures in all service areas. Testing has recently taken place on sites due to parameters of cold-water temperatures not being met, the sampling confirmed growth. However, none of the area teams is aware of the outcome. There are generally no locally kept records that evidence the flushing regime or results of sampling schematic diagrams where not evidenced however, it is believed the engineering recommendations from the Clearwater risk assessments are taking place. It is recognised by Estates Department that they may not be compliant with L8 best practice guidance document. There appears to be no annual review of Legionella risk assessments to confirm that actions have been completed or to confirm that there has been no material change to the system. There are medium risks pertaining to management of legionella that remain outstanding. There limited evidence of formal arrangements between estates and local sites where local responsibilities have been allocated and identified. A full review of the policy communication on findings of inspections, schematics and risk assessment is required to provide assurance of a safe water management system in place across all service areas.

3. Corporate Manslaughter and Homicide Act

There is limited evidence of a clear understanding of the significant risks associated with this piece of legislation. A number of staff had training, which they had been made aware of through the BCUHB's Managing Safely Course. A Board away day on the 1st August provided an overview of the legislation to Board members. A systematic process of training of senior leaders is required to ensure that the organisation is clear on roles and responsibilities including consequences of actions.

4. Control of Substance Hazardous to Health (COSHH) Regulations 2002

The COSHH legislation requires a systematic review of substances hazardous to health this can range from dusts and a range of products and substances. Some of the items used have exposure limits which require controls as defined in EH40 (Workplace Exposure Limits 2018) and monitoring of such controls. The process involved gathering data sheets and undertaking a risk assessment although risk assessments are evidenced files can be found but are often very outdated and never reviewed with some working to safety data sheets which are several years old.

There was very limited understanding of a Whole time Equivalent Exposure Limits (WEL) or short term exposure (STL) limits when dealing with carcinogens. There was an assumption that exposure limits would not be met without any testing to verify this. The risk ranking for such substances was low risk when clearly the substance was very high risk. There was insufficient knowledge of risks in many areas. Engineering controls used in very few areas but those that had these could evidence testing/maintenance. A concern during the COSHH questioning was the volume of Latex products still used throughout the Board. They were being procured in many service areas with no risk assessments in place, which poses a potential risks to patients

and staff who may have a latex allergy. A review undertaken by the Head of OH identified that 45% of surgical gloves where latex. A meeting has been held with procurement who have been advised to stop purchasing latex products unless there is a specific risk assessment in place. A systematic review of the COSHH system and policy is required to ensure a consistent approach across all service areas.

5. Working at Height Regulations 2005

There are a number of training and equipment reviews in place by Estates on tower scaffold that are owned by the Department. A program to identify fragile surfaces had not been completed which poses a risk to staff working in that area. Staff in Estates do have some training but the risk assessments are generic and not specific to the work area. There is a tendency to rely on generic risk assessments when a more specific assessment such as changing bed curtains etc. is required although examples have been developed and readily available. There is no specific permit to work system for working near fragile surfaces or within 2 metres of edges, however many of the roof areas do have permanent edge protection. There is a lack of consistent approach to inspection of ladders and kick stools within departments and wards. There have been Corporate Health and Safety reviews undertaken but actions not completed. A permit to work system and clear policy on working at height is required with specific guidance risk assessment and training for all staff involved in high risk activities.

6. Pressure Systems Safety Regulations 2000

The pressure systems within Estates are managed by an external contractor Evans Maintenance and Zurich and this appeared to be well managed. However in a number of services there was limited understanding of responsibilities for pressure systems and maintenance procedures. A systematic review of outliers is required to be built into the central contract to ensure adequate controls are in place. The lack of systems in smaller sites resulted in the poor scoring on this issue.

7. Safety Representatives and Safety Committees Regulations 1977/Health and Safety (Consultation with Employees) Regulations 1996

The H&S Team received considerable support from our Trade Union Partners who attended many of the gap analysis meetings and their contribution was significant to this report. A concern on one visit was that a representative who had raised H&S concerns was told that he should get on with the job and stop causing problems, the task was to use an angle grinder on a road surface without any test on underground services which was potentially very hazardous. A number of managers see safety representatives as a problem instead of an asset to their department. It was difficult to find representatives on all sites with Managers displaying a variety of levels of awareness of the roles of safety representatives. There was currently limited effective method of communication or consultation evidenced. An education program for representatives and managers is required to ensure knowledge of law and practical application of representative's roles is clarified. There should be clarity on numbers of safety representatives within service areas and their remit.

8. Personal Protective Equipment (PPE) at Work Regulations 1992

There was limited evidence of risk assessment in place. Often PPE is used as a protection measure due to COSHH risk assessments not being robust enough, with PPE used instead of more effective engineered controls. PPE is generally based on existing Standard Operating Procedures (SOPs) and clinical practice, so there is a tendency not to do risk assessments. PPE was mostly disposable in clinical areas and training was generally considered good for clinical teams. Further work on PPE is required to ensure that there is an understanding of

when it should be used and consideration as a last resort being key to control hazards in the first place.

9. Ionising Radiation Regulations 2017

The Radiation Department has robust policies, committees, engineering controls, exposure monitoring systems and standard operating procedures in place to give assurance that they are compliant with relevant legislation. However the information was not available for local rules and risk assessments that were site specific in the community. HMP Wrexham appeared to have robust systems in place. A review of the community sites will be undertaken as a priority from September to ensure that the shortfall identified is effective in the community as other locations.

10. Construction (Design and Maintenance) Regulations 2015

The paper work appears to be in place but there have been a number of incidents of poor contractor behaviour, management and safety issues. There is standardised documentation in use in Estates and Capital Planning. Generally speaking, roles and functions are well managed, but weaknesses are in site induction and site monitoring of contractors. Further work on the effectiveness of CDM and gathering safety files after completion of work and updating plans requires further evaluation. Examples include staff at a community hospital not aware how to shut off piped oxygen in the event of a fire. The role of the client will also require further review under the legislation to ensure the client (BCUHB) is aware of its role and responsibilities.

11. Confined Space Regulations 1997

There are some within BCUHB who have identified confined spaces but not all with the majority of the work contracted out to specialists who carry out such work. There was some confusion within Estates over definition of a confined space (being worked on), and a tendency to categorise rather than assess spaces individually based on the activity that may create the hazard. Due to lack of definition, there may be some environments which have not been classified correctly. Risk assessments had not been completed and Estates staff don't work in confined spaces however, as these have not been fully identified this would be difficult to evidence. Estates advised they were writing a confined spaces policy and were in the process of identifying all of the confined spaces in Central, this work has not been completed.

12. Gas Safety (Installation and Use) Regulations 1999

The knowledge of gas safety was limited to Estates and Capital Planning; the contractor was Evans Maintenance and assurance gained by the Contractors Guidelines documentation which may need further verification from Procurement. There was reliance on contractors being tendered for in April and that was the review date for the annual check. There will be further evaluation required as this was not clearly identified in all service areas.

13. Health and Safety (Safety Signs and Signals) regulations 1996

There is basic signage in place and appropriately displayed, with specific hazard warning/mandatory signage for specific hazards and zones, however not generally linked to specific risk assessments. Signage in many areas was poor and Estates confirmed they had no budget allocated for replacement of damaged signage. Some workshops had specific PPE signage but others had general 'PPE must be worn'. A workshop that was no longer used still had signage in place. Areas were identified during the gap analysis, including main hospital corridors, where fire signage was not in place (YGC). This has been escalated to the fire officer as this should have been identified as part of the refurbishment work undertaken and fire risk assessment process.

14. Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2005

The majority of areas where not clear on all aspects of the requirements of RIDDOR, with a number of incidents reported as RIDDOR on Datix that were not appropriate. There is a requirement to have additional awareness training in place. Knowledge of reporting timescales, specified injury types and Dangerous Occurrence knowledge is low, there was knowledge that this was a regulation but not of the requirements. All incidents will now be viewed by the H&S Team as a pilot as there is a concern dangerous occurrences may be missed within the current system. A tracking system of RIDDORS by the H&S Team will be implemented to ensure that RCA's are undertaken by service leads and actions completed. This will be reported to the Strategic OHS Group. The timely reporting of information is required to ensure that we are compliant with the regulations therefore service leads will need to provide basic information to the H&S Team to ensure incidents are reported as soon as reasonably practicable to the HSE. Further work is also required on the quality of RCA's undertaken which are often very poor quality.

15. Fire (Regulatory Reform) Order 2005

The evidence suggests different levels of compliance in a variety of areas with many having fire risk assessments in place others in high-risk areas with no fire risk assessments in place. There are examples of risk assessments that are out of date and no evidence of the implementation of the significant findings. There was limited compliance with the annual evacuation drill and record keeping of such drills at locality. Of concern was the departments who did not have access or knowledge of the fire risk assessment. It was unclear if departments/sites could evidence that they were updating the action plans on the FRAs after remedial work or change in activity. Most areas scored well with knowing who the designated staff were and how to manage emergency procedures although a number of departments or sites had not had fire evacuation drill. The fire risk assessment and evacuation plans require reviewing and those services that are not compliant require supporting in the development of safety systems in place to further improve on some of the positive work undertaken.

16. Health and Safety (First Aid) Regulations 1981

There is limited understanding and risk assessment for first aid as there is an assumption that medical staff will provide first aid. Assessments in place in some areas, not so in others. There was a lack of first aid signage. In one area 10 out of the 15 departments had not completed a first aid risk assessment with approximately half without adequate signage. Clinical teams were able to confirm that clinical staff would provide first aid however Estates both on the acute and community sites had no first aiders in their teams. A review of areas and individuals at risk particularly none clinical areas is required to ensure adequate control measures are in place in an emergency incidents.

17. Non-Notifiable Control of Contractors

The system for managing contractors is not robust or clearly evidenced. The management of contractor's policy describes the role of the Fire Officer is to provide induction to all contractors visiting the site the evidence was that this hadn't taken place at the premises for 5 years. There was evidence of contractors starting work with no consultation with site occupiers. There is considerable reliance on the contractor to manage their own health and safety, with limited evidence of site induction. There was no system in community hospitals to sign contractors in and issue them with an identification badge. Estates confirmed that for small tasks they were unlikely to read through risk assessments and method statements which are likely to be generic rather than site or task specific in nature. The small companies are at greater risk of accidents

than larger organisations according to HSE statistics. A contractor was seen working nearby on a roof with no edge protection. The risks of not providing site induction and control are significant to the Board a system of control and management is required to reduce such risks.

18. The Control of Vibration at Work Regulations 2005

There is limited evidence of management of vibration in the identification of equipment, staff time using equipment and health surveillance for staff at risk. Where applicable this set of questions was not well answered. Identification of vibrating equipment in general hadn't been completed and an assessment of the risks hadn't been undertaken. Staff at risk had not been identified or referred to Occupational Health. This is an area of significant risk and work with these departments should be prioritised using external contractors to evaluate current levels of exposure and controls implemented.

19. HTM 07-01 – Safe Management of Healthcare Waste 2006 and Hazardous Waste (England and Wales) Regulations 2005

The system for safe management of waste is audited by the Environmental Officer and information and arrangements are put in place. It is recognised that some departments do not have copies of Environmental Audits which would be helpful. The Environmental Officer confirmed that BCUHB work to ISO14001 and are externally audited against this criteria. Waste stores were found unlocked and therefore supervision and monitoring of these areas is required for security and potential fire risks. A number of concerns have been identified with the waste store in YGC including traffic management and the key left in the compactor. Work is being carried out to rectify a number of these issues and vigilance and security of compounds requires additional work that has also been highlighted by the security gap analysis.

20. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Although the evidence from the H&S gap analysis identified that sharps was generally being managed across BCUHB, the OH review indicated a lack of control in certain areas. Areas such as theatres, Emergency Departments (EDs) etc. disposal of sharps is still a concern with a number of staff receiving sharps injuries. This is one of the highest reported incident types and therefore requires further investigation to identify root causes and additional control measures. Risk assessments are in place for non-safety sharps, and most departments will default to safety sharps wherever possible. Sharps boxes are generally used correctly although not always dated correctly or the temporary closure is not utilised. The clinical staff have a good understanding of policy and training was identified as general Infection Prevention and Control (IP&C) training.

21. Prevention of Slips, Trips and Falls (STF)

There was evidence of hazard checklist being completed by a number of services. Clinical are working hard on blackspots/reasons for patient falls but hazard spotting walk rounds are not seen in all areas. A few departments had full score for completing a STF risk assessment or for completing any hazard identification checks. The new STF checklist might help with this and the corporate H&S reviews should start flagging the requirement to do these. There was very little evidence of staff making an external check outside of their immediate departments although estates did confirm they did an annual external inspection on sites. A review of surfaces and regime for dealing with internal and external hazards is required as this is also one of the highest reported incidents within the accident data collated from Datix.

22. Health and Safety (Display Screen Equipment - DSE) Regulations 1992

There was limited evidence of DSE assessments being systematically implemented with some clinical staff not identifying that they are DSE users. There was limited registers of identified DSE users and assessments were dependent on awareness of the managers within the service areas. Where the manager was aware of the legislation the controls are good, where they are not, it is poor.

23. The Control of Noise at Work Regulations 2005

There was some risk assessments in place but limited assessment of exposure levels of staff. PPE was available in some plant rooms but they hadn't been used for some considerable time. There was no evidence of zoning areas or specific noise assessments in place. Staff in the H&S Department did not have calibrated equipment to undertake noise assessments. Areas such as the laundry did not identify as having noise levels above 85dBA but this may be as a result of poor equipment. This will require additional evaluation by an external consultant who can also provide evidence of vibration levels.

24. The Electricity at Work Regulations 1989

The current system for undertaking portable appliance testing relies on external contractors testing everything that is available. There is no written advice to the site occupier to identify equipment to be tested, therefore some may be missed it is also costly as a risk based approach would see items such as computers requiring testing every 5 years as opposed to annually. High voltage work is generally outsourced to a contractor. There was evidence of a good system for isolation but permit to works where seen in a small number of premises. Staff were reported to be trained as this is relevant to their role but this requires evidencing. There is currently no Policy in place that describes Electrical Safety.

25. The Provision and Use of Work Equipment Regulations (PUWER) 1998

There appears to be reasonable management of medical devices and maintenance by EBME. Although not many services have an equipment inventory and maintenance records. Managers generally referred back to 'Estates or EBME' rather than management control of their own equipment. Estates had certification for main items of workshop equipment. Local inventories and management would be recommended in each department or area. Within estates, there is no inventory of power tools or other equipment and no records of vibration rates, exposure rates for noise and vibration. There is currently no Policy specifically for the PUWER equipment across all service areas.

26. The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998 (not including patient hoists and slings)

Lifting equipment is generally managed by EBME in the East and appears well maintained. It was identified in a plant room that a gantry hoist was being maintained when it had not been used for several years. The patient and staff lifts with evidence available in most cases of lifts being checked by an external contractor (Zurich). LOLER checks of (hoists) are carried out differently in each area with no pan BCU policy followed with EBME complete work in East, Central outsource it, and West carry out the examination in house with a 'colleague' certificating the work. The inconsistent approach may lead to items being missed or not complying with the thorough examination required by the law. The Policy will require it to describe the process in place and that it is centrally managed and consistent.

27. Management of Health and Safety at Work Regulations 1999. To cover RA's on activities including Young Workers

The legislation requires risk assessments to be undertaken where there is a significant hazard. Often these were not suitable and sufficient in areas such as estates, had generic risk assessments that had not been updated for a number of years. Wards would rely on the Environmental Risk Assessment to cover all of their requirements without understanding that this may not cover all aspects of the risks faced. There was a good understanding of the requirement to do risk assessments for new/expectant mothers although this prompted a check of facilities for these staff and none have been identified. A requirement to undertake a specific risk assessment for young persons under 18 or child 16 and under was not evidenced in departments visited as very few departments had young workers.

28. Workplace (Health, Safety and Welfare) Regulations 1992 including Workplace Transport

Space and accommodation is an issue in many service areas with over-occupancy in a number of office spaces. The driving at work policy is not in place and systems to monitor transport of equipment and materials requires risk assessing at local level. Workplace vehicular movement, deliveries and pedestrian walkways are not assessed, monitored or controlled this poses a significant risk to pedestrians, visitors and patients. Welfare provision was very mixed across sites. Some having access to showers, lockers etc. and others having very little staff facilities. Lone working is a significant risk with only some departments identifying good procedures with limited evidence of risk assessment. Recommendations for vehicle safety requires a systematic review particularly driving at work, lone working and vehicle delivery areas.

29. Occupational Health - Health Surveillance

The majority of staff were unaware of this policy and had not received any information regarding health surveillance however recently a health surveillance program had started between the H&S Team and OH. A review of latex, night workers, immunisation, noise vibration etc. is required to support staff who may be exposed to substances, equipment or work environments that may cause ill health from the workplace.

30. HSE Stress Management Standards

There are a number of services who manage stress very well along with other aspects of H&S these wards and departments have fewer sickness days with staff. Management are often unable to manage their own stress and are dealing with staff who have stress. There is often a reactive approach to managing stress looking at individual stress assessments when staff have gone off and little evidence of group stress risk assessments. Although managers knew the type of issues that may cause stress in staff they had little understanding of how to pro-actively manage this. A pro-active training program is required to enable managers and staff to recognise the key elements of stress including demands, control, relationships, culture, change and environment. The Policy and process will require simplifying to enable managers to pro-actively manage this most significant area of ill health within the Board.

31. Manual Handling at Work Regulations 1992

The manual handling specific audit undertaken identified that very few staff are aware of the Manual Handling Policy with most not knowing what the process was to undertake a risk assessment using Task, Individual, Load and Environment process although this is used as part of the training. The majority of staff are aware of the Procedure for the Larger Patient, only 44% (red) have actually completed a referral that is recommended and often not been in contact with manual handling regarding them. There is some bariatric equipment available in a number of work areas, but if the patient was an inpatient chairs, commodes, and beds would require hiring.

Staff have difficulties tracking available equipment for patients. Community services have limited storage although Deeside Hospital have a bed but this needs an engineer to be called out (for a fee) to take the bed from its stored state to the ward needed and assemble it then take down once the patient has left. There are currently 196 manual handling champions who can support manual handling in wards and Departments this is a tremendous asset and has the ability to reduce musculoskeletal disorders in the workplace. With interest from staff to become champions this requires tapping into, managers have also expressed concern that staff are reluctant to become a Champion without financial gain or increased banding. Despite 90% (green) stating they access training through ESR to book classroom or e-learning, Champions or Workbooks, only 27% (red) were up to date in the Manual Handling and only 68% (amber) record anything local for other staff to be aware on compliance for the ward.
A number of staff identify unsafe practice in patient handling or load handling. 84% (amber) have completed a Datix following a Musculoskeletal Disorder (MSD) in the workplace there are high numbers of MSD with retired staff who return to work with increased risks in areas with higher manual handling activity such as domestics, porters, mental health from frequent unpredictable fallers, Orthopaedic and Care of the Elderly, which result in their back and shoulders injury due to frequent turning of patients. The risk assessments used are generally non-clinical and patient handling risk assessments. Only 50% completed these correctly, despite in-depth training. Finding information on the intranet was difficult and completing inanimate load risk assessment form was poor. The majority of people believed if they identified an issue it went back to the manual handing team with any outstanding issues, rather than be locally managed.

The majority of equipment was in good working order, however there is no visible inventory for staff to highlight what equipment is available. The Safe Working Load (SWL) is required to be checked prior to use but many staff were unaware who was responsible to check the equipment, saying it was up to their Housekeeper, who would undertake checks. Not all sites use EBME and some externally pay companies to LOLER check and service their equipment. There are only 38% of premises audited which have a current sling register. The majority of areas now use disposable slings, but many are unaware of the guidance regarding disposable slings. It is the Housekeepers responsibility to order and monitor slings, but they have not been trained in LOLER as they currently have Level 1 Manual Handling Training only. Many staff now use disposable slide sheets (single patient use). Of those using the disposable slide sheets, not all staff knew they were to add the Patient ID and date given onto the slide sheet. The majority of staff use manual turning of patients giving the reason for the need to check pressure areas, which is not best practice.

8. Summary

The overall findings of the report identify that there is a willingness to be open about the current state of OHS compliance in many service areas. There is also an acceptance that ‘this is how it is’ and that we are not telling the organisation anything new. Funding of services was often raised as a concern which makes compliance difficult to achieve. There are areas of excellent practice in place, however the overriding safety culture requires significant improvement. A lack of structure in terms of responsibility for sites in the community make safety seem like someone else’s problem and therefore no one takes ownership of OHS.

The evidence gathered identifies a lack of central control of systems and processes this includes Policy with many staff referring to different versions of policies or guidance. There are many policies that are in draft or process of development but require a systematic review to identify and manage safety critical areas such as electrical safety work or work at height as

examples. The organisation has a limited handle on all its aspects of OHS Policy which has developed independently of each other with some adopting good practices and others not.

The HSE and UK law places specific duties 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.

Although there are methods of communication with safety leads and manual handling champions in place the level of knowledge and training of representative including Trade Union Partners requires reviewing to ensure a consistent approach is taken to safety issues identified. A shortfall in the evaluation identified that training was provided by the H&S Team but this was poorly attended. A more structured approach with accredited safety training should be considered to improve overall performance and build a more effective OHS culture. There are areas of serious concern in relation to asbestos, work at height, contractor control, legionella, vibration, noise, manual handling, stress and COSHH to name but a few.

The risk management structure requires improving as many local risks are not escalated in a timely manner leaving the Board open to surprises that they may not be aware of. Risks can never be eliminated, but minimising high risks has to be priority. The findings of this report are in stark contrast to the self-assessment undertaken in Q1 report which indicated that departments were 88% compliant with H&S compliance.

Self-Assessment April 1st – June 30th 2019

Corporate H&S Self-Assessment Feedback Data		2019
1	Health and Safety Procedure	91%
2	Information, Instruction and Training	74%
3	Risk Assessment	89%
4	Fire and Emergency procedure	92%
5	First Aid	89%
6	The Workplace	90%
7	Work Equipment	90%
8	Hazardous Substances, biological agents	88%
9	Sharps	94%
10	Violence and Aggression	81%
11	Display Screen Equipment (DSE)	85%
12	Work at Height	90%
Total Self-Assessment Compliance		88

The level of compliance that many in the organisation feel they are achieving is not consistent with the findings of the gap analysis. Further work on the level of scrutiny that will be undertaken if the HSE were likely to visit the organisation.

9. Recommendations.

The recommendations within this report will require implementing within a short space of time; this will take time and resources. It may also mean that previously agreed Board objectives will require changing to deal with the risks identified.

9.1 Asbestos

Review the Asbestos management Policy and ensure it is fit for purpose. Ensure asbestos registers are in date and the Policy is clearly implemented in all service areas. Implement an appropriate signage system on ACM's not in public areas; where identified in public areas indicate work should not be carried out unless discussed with Estates. A permit to work system specific areas in relation to asbestos related work is required. A systematic review of surveys which includes the standard of surveyor who has undertaken the work. This may involve a sample re-survey of premises to ensure they are accurate. The actions identified need positive assurance they are completed, logged and records kept on site. Schematic diagrams require updating and readily available to our own staff and all contractors. Safety files completed after CDM work require updating when asbestos is removed. A review of all resurveyed premises is required as many repeat the previous year's pictures and actions. Community services require clear understanding of roles in managing asbestos and information provided to contractors.

9.2 Legionella

Ensure all annual reviews confirm that actions have been completed and that any material change in the system has the schematic drawings updated if not already in place. There are medium risks pertaining to management of legionella that remain outstanding, ensure they are reviewed and work completed as planned to minimise the risk of amber risks escalating to red risks. Local outlets and flushing regimes require clear ownership, a systems that gives positive assurance of outlets being flushed is required. This may involve investment in a central data base that can give assurance on the flow and control of legionella. Develop formal arrangements between estates and local sites to ensure local responsibilities have been allocated and identified. A full review of the policy communication on findings of inspections, schematics and risk assessment is required to inform the Water Safety Group and Board that a safe water management system is in place across all service areas.

9.3 Corporate Manslaughter

A review of all training needs for OHS across the organisation is required as staff in senior positions where not aware of their responsibilities in many cases. A program based on senior leaders receiving the IOSH Directing safely course, senior leads being accredited with the IOSH managing safely course will provide assurance of quality assured training and development of the OHS Lead role within the organisation to develop a pro-active safety culture.

9.4 The Control of Substances Hazardous to Health

A review of the COSHH Policy along with safety critical substances that have whole time equivalent exposure limits (WEL) or short term exposure (STL) limits should be reviewed and eliminated if possible to avoid any risks of staff being exposed to carcinogens. The risk assessments for substances that remain high risk require engineering controls and health surveillance implemented. Latex products should be removed from the procurement list and as an exception be purchased only when a specific risk assessment is provided. A systematic

review of the COSHH system and policy is required to ensure a consistent approach across all service areas.

9.5 Working at Height Regulations 2005
The identification of fragile surfaces is required with a minimum of 2 metres exclusion zone implemented and specific risk assessment for work at height avoiding reliance on generic guidance currently in place. Ensure a consistent approach to the inspection of ladders and kick stools is adopted with clear guidance to undertake visual inspections. A permit to work system and clear policy on work at height is required as a matter of urgency.

9.6 Pressure Systems Safety Regulations
In a number of services there was limited understanding of responsibilities for pressure systems and maintenance procedures. A systematic review of outliers is required to be built into the central contract to ensure adequate controls are in place. The lack of systems in smaller sites resulted in the poor scoring on this issue.

9.7 Safety Representatives and Safety Committees Regulations 1977/Health and Safety (Consultation with Employees) Regulations 1996
An education program for representatives to ensure levels of competence are increased is required and Trade Union Partners clearly identify who representative are in the workplace. The numbers require increasing to support the culture change required in several service areas. Managers require further education on the law and the practical application of representative's role in the workplace. There should be clarity on numbers of safety representatives within service areas and their remit.

9.8 Personal Protective Equipment at Work Regulations 1992
Specific guidance on PPE and how to undertake specific risk assessments in non-clinical areas to minimise the risks to staff and avoid incorrect PPE being provided without considering elimination of the hazard in the first place a guidance document is required to give staff the knowledge required to undertake such assessments.

9.9 Ionising Radiation Regulations 2017
Ensure the planned review of the community sites is undertaken and local arrangements implemented. This will ensure that this element of legislation is fully compliant in all service areas.

10.0 Construction Design and Maintenance (CDM) Regulations 2015
An effective system of gathering safety files after completion of work is required and updating central plans is required. The role of the client will also require further review under the legislation to ensure the client (BCUHB) is aware of their roles and responsibilities. Ensure the CDM Policy is reviewed to reflect the findings.

10.1 Confined Space Regulations 1997
The definition and clarity on confined spaces access and control requires implementing with the current Policy development work currently undertaken. A permit to work system is required and site specific risk assessments required to ensure contractors can be monitored against such documents when entering confined spaces.

10.2 Gas Safety (Installation and Use) Regulations 1999

A Gas Safety Policy or guidance document is required to describe the system in place to manage gas safety and ensure annual checks of equipment can be evidenced in all service areas.

10.3 Health and Safety (Safety Signs and Signals) regulations 1996
Remove inappropriate signs from workshops and ensure zoned areas in plant rooms have adequate identification and signage in place. A guidance document would be recommended of types and signage required in all service areas to ensure consistency of the BCUHB approach.

10.4 Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2005
All service areas required to provide adequate information to the OHS Team to ensure BCUHB are compliant with the regulations. The OHS Team will review all incidents to ensure that RIDDORs are initially identified and information will be provided to the Strategic OHS Group on progress with the requirements. Further work is also required on the quality of RCA's and RIDDOR training should form part of the IOSH managing safely course proposed for OHS Leads.

10.5 Fire (Regulatory Reform) Order 2005
Fire risk assessments require updating in a number of service areas. A program of work that provides evidence of the number of fire drills undertaken and those services that have not carried out a drill will be required to report to the Strategic OHS meeting. The fire risk assessment and evacuation plans require reviewing in those services that are not compliant.

10.6 Health and Safety (First Aid) Regulations 1981
A clear policy or guidance based on risk assessment is required to identify first aiders on both the acute and community sites is required. A review of areas and individuals at risk particularly none clinical areas is required to ensure adequate control measures are in place in an emergency, this is particularly relevant in remote locations.

10.7 Non-Notifiable Control of Contractors
There is a requirement to sign all contractors in and issue them with a local induction and identification badge. Estates should ensure that a minimum assessment of contractors is undertaken for example using the contractor health and safety scheme (CHAS). This would act as the first stage of the tender process and provide assurance of basic safety requirements being in place. All tasks require a review of the risk assessments and method statements and a system that signs off that the contractor is working to those standards required is achieved. The current Contractor Management Policy requires reviewing to be realistic about what can be achieved and all estates staff understanding the content and how it should be implemented.

10.8 The Control of Vibration at Work Regulations 2005
A review of all equipment, staff time using vibrating equipment, exposure levels, and risk assessment with adequate health surveillance is required to identify those staff at significant risk of harm. A suitable policy and guidance document is required. An external contractors should be employed to identify and evaluate current levels of exposure and controls being implemented. This could be undertaken alongside a noise assessment process to ensure exposure levels are within safe parameters.

10.9 HTM 07-01 – Safe Management of Healthcare Waste 2006 and Hazardous Waste (England and Wales) Regulations 2005

Waste stores require securing in all service areas and monitoring of these areas is required for security and potential fire risks. Vigilance and security of compounds requires additional work that has also been highlighted by the security gap analysis.

11.00 Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
A continual review of sharps safety is required in high risk areas such as theatres and Emergency Departments (EDs) etc. Disposal of sharps is still a concern with a number of staff receiving sharps injuries. Regular audits and feedback to the Strategic OHS group is required to continually review processes and systems currently in place.

11.1 Prevention of Slips, Trips and Falls
The new STF checklist requires rolling out to all service areas. With clear evidence of surface reviews of public areas reporting on priority assessments of areas likely to be high risk particularly to vulnerable patients and staff. A review of policy and guidance for surfaces is required and clear regime for dealing with internal and external hazards identified.

11.2 Health and Safety (Display Screen Equipment) Regulations 1992
A review of policy and guidance with self-help guides being implemented in service areas is required to reduce the risk associated with work related upper limb disorders.

11.3 The Control of Noise at Work Regulations 2005
Noise control will require appropriate policy or guidance along with an additional evaluation by an external consultant who can also provide evidence of vibration levels.

11.4 The Electricity at Work Regulations 1989
The current system for undertaking portable appliance testing relies on external contractors testing everything that is available annually. Advice to site occupier to identify equipment to be tested is required and a risk based approach that reduces cost and manages risk more effectively. The permit to work system is required for specific activities. An Electrical Safety Policy is required to describe the safe systems of work being implemented.

11.5 The Provision and Use of Work Equipment Regulations (PUWER) 1998
There is a requirement to identify all items of workshop equipment that requires maintaining. Local inventories and management would be recommended in each department or area. Estates should develop an inventory of power tools or other equipment to ensure vibration rates, exposure rates for noise are evidenced. A policy specifically for the PUWER equipment across all service areas is required.

11.6 The Lifting Operations and Lifting Equipment Regulations 1998 (not including patient hoists and slings)
There is a requirement to ensure all lifting equipment, hoists, slings etc. are consistently managed across all service areas to ensure they comply with the thorough examination required by the law. The policy for LOLER will require development to describe the process in place that is centrally managed and consistent.

11.7 Management of Health and Safety at Work Regulations 1999. To cover RA's on activities including Young Workers
Risk assessments require to be site specific and deal directly with the hazards in the workplace. A range of risk assessments should be developed to assist staff develop skills in this area.

Training should be specific to the risks posed in the service area. A policy or guide is required to help staff understand how the risk assessments can be used as working document that assists in the implementation of safe systems of work and not be seen as a paper exercise.

11.8 Workplace (Health, Safety and Welfare) Regulations 1992 including Workplace Transport

Workplace vehicular movement, deliveries and pedestrian walkways are a particular concern. A clear driving at work policy is required. Delivery areas require suitable risk assessments that are monitored and controlled. Workplace welfare policy is required and a lone worker policy that sits under the Security Policy is required with specific risk assessments in place for those deemed to be lone workers.

11.9 Occupational Health - Health Surveillance

The Health Surveillance Policy requires developing and further information for staff regarding health surveillance. The recently work undertaken by the H&S Team and OH requires evidencing and further review of latex, night workers, immunisation, noise, vibration etc. is required to support staff who may be exposed to substances, equipment or work environments that may cause ill health from the workplace.

12.0 HSE Stress Management Standards

A pro-active training program is required to enable managers and staff to recognise the key elements of stress including demands, control, relationships, culture, change and environment. The policy and process will require simplifying to enable managers to pro-actively manage this most significant area of ill health within the Board.

12.1 Manual Handling at Work Regulations 1992

The current patient handling training 2 hour refresher course requires amending to ensure key elements of practical bedside training can be completed by manual handling champions in their own workplace or via the Manual Handling Team during work based competencies. This would reduce the need for staff requiring additional training in the classroom, improve the standard of compliance and deliver realistic patient handling at the bedside. A work based competency will be required before attendance, followed by suitable practical training. It is recommended that the cost of hiring bariatric equipment and identification of areas who hire most equipment is evaluated. When replacing older beds it is recommended that extendable width beds are purchased to assist in managing the increasing risk posed by bariatric patients.

The manual handling champion’s course requires reviewing to ensure it. Each manual handling champion should be is allocated 10 staff members per workplace to train, this will improve locally managed manual handling risks specific to the workplace. Additional support will be required to observe group sessions run by champions and annual update of training to aid the reduction of MSD’s. The champions should collate an inventory of equipment used in their work areas. They would be expected to self-report on work activities including training and evidence of competence, LOLER requirements and ensure 6 monthly sling registers are kept up to date for washable slings. Identification of cost for disposable slings used against cost to purchase and launder washable slings should be assessed including environmental impact of disposable slings.

The manual handling Team will provide additional slide sheet workshops for staff and champions to minimise the risks associated with rolling patients, this practice has been identified to increase MSD’s. Champions and the manual handling team should identify areas

where there are frequent requirements to move patients in beds and improve slide sheet usage. The manual handling team, should work closely with HR and the occupational health team to target areas of unsafe practice reported through Datix or identified as reporting high levels of sickness absence. This will initially target the top 3 areas of sickness from workforce reports utilizing the Manual Handling Advisor to improve current practices and highlight where improvements can be made. This may include the identification of specialist equipment and fast track for OH physiotherapy support. It is recommended that one central department provides all LOLER checks with washable slings tagged to ensure they are adequately inspected. A review of policy and guidance should be undertaken to ensure staff can easily undertake TILE risk assessments in both clinical and non-clinical areas of BCUHB.

12.2 General Recommendations

The Health and Safety Policy and structure of policies and guidance and control requires centrally managing. It is estimated that 13,000 documents are in the system. BCUHB has a responsibility to ensure that its governance arrangements include a robust process for the management of policies, procedure, guidelines and other written control documentation (WCD). The BCUHB Policy on Policies (PoP) will be launched in September 2019. Running parallel to this is the review and development of the new BCUHB Policies, procedures, guidance and other written control documentation internet page. The project aims to develop a central and authoritative location for the storage of all pan BCUHB WCDs. This will act as a point of assurance enabling the Health Board to review its internal control framework and provide further confidence in its operational working. The Occupational Health Policies could be used as a pilot in the development of the central control process required.

The intranet site for Occupational Health and Safety requires easy helpful guidance and policies available that are agreed and controlled centrally as described above. Staff require simple self-help guides and information developing on what is required in a safety file and what an audit will be looking for.

The current capacity to deliver OHS is limited to 1 Safety Advisor per area and their role is to support and guide the organisation through development of training, accident investigation, policy development and guidance to leaders on how to comply with the law. The range and scope of work is significant and the capacity has been exacerbated by the Head of H&S currently focusing specifically on security issues which has reduced his capacity to oversee all elements of H&S. The level of support that is required outstrips current workload in the service and a replacement for the post of Head of H&S should be considered as soon as possible. There are currently Risk Management/H&S Leads in Service areas who a number have a range of safety skills that do not report centrally to the Occupational H&S Team adding to the fragmented approach to Occupational Health and Safety Management. It is recommended that a review of their roles and responsibilities is undertaken to evaluate how the whole OHS service can be delivered effectively.

The current system for H&S Leads relies on volunteers to undertake the OHS Lead role for the service areas. It is recommended that a Service Manager with appropriate skills and training are designated to take responsibility as Leads. They will require appropriate authority to implement safe systems of work and hold individuals to account for safety performance. The Leads should be provided with tasks that can be centrally monitored and reported to the Strategic OHS Group. This may include numbers of reviews undertaken, training events, risk assessments and

incident reviews. They should as a minimum receive IOSH 4 day managing safely course or similar accredited course that focuses on projects in their service area.

There is a requirement to clearly map out who is responsible for site management in Community Services. Those people identified should be given the basic skills required to manage key elements of the safety management system and Estates.
The occupational health service will require staff to be suitably trained with the correct equipment available to provide adequate health surveillance support to BCUHB. The health surveillance program will require additional work to ensure it is effectively implemented in all service areas.

Appendix 1: Scoring of Compliance Levels

Non-compliant <65 🔴 Partially Compliant <85 🟡 Compliant >85 🟢

Legislation	Pan BCU	%	Range	Actions
Control of Asbestos Regulations 2006	🔴	44	14-63	Non compliant
COSHH Management of Water Systems	🔴	66	50-86	Non compliant
Corporate Manslaughter & Corporate Homicide Act 2007	🔴	51	n/a	Non compliant
Control of Substance Hazardous to Health Regulations 2002	🟡	77	50-99	Partial compliant
Working at Height Regulations 2005	🔴	52	33-78	Non compliant
Pressure System Safety Regulations 200	🔴	51	21-73	Non compliant
Safety Reps & Safety Committee Regulations 1977/H&S (Consultation with Employees) 1996	🟡	66	53-80	Partial Compliant
Personal Protective Equipment at Work Regulations 1992	🟡	77	40-100	Partial Compliant
Ionizing Radiation Regulations 2017	🔴	55	50-69	Non-compliant
Construction (design & Maintenance) Regulations 2015	🟢	94	83-100	Compliant
Confined Space Regulations 1997	🟡	68	29-100	Partial Compliant
Gas Safety (Installation & Use) Regulations 1998	🟡	78	63-92	Partial Compliant
H&S (Safety Signs & Signals) Regulations 1996	🟡	82	62-100	Partial Compliant
Reporting of Injuries, Diseases & Dangerous	🔴	62	60-67	Non-Compliant

Legislation	Pan BCU	%	Range	Actions
Occurrences Regulations 2005				
Fire (Regulatory Reform) Order 2005		70	53-95	Partial Compliant
H&S (First Aid) Regulations 1981		66	44-85	Partial Compliant
Non-notifiable Control of Contractors		49	43-52	Non-Compliant
The Control of Vibration at Work Regulations 2005		26	9-46	Non-Compliant
HTM 07-01 - Safe Management of Healthcare Waste 2006/Hazardous Waste (England & Wales) Regulations 2005		75	34-93	Partial Compliant
H&S (Sharp Instruments in Healthcare) Regulations 2013		87	72-100	Compliant
Prevention of Slips, Trips & Falls		85	70-100	Compliant
H&S (Display Screen Equipment) Regulations 1992		76	58-93	Partial Compliant
The Control of Noise at Work Regulations 2005		53	19-92	Non-Compliant
The Electricity at Work Regulations 1989		64	19-100	Non-Compliant
The Provision & Use of work Equipment Regulations 1998		75	57-90	Partial Compliant
The Lifting Operations & Lifting Equipment Regulations 1989 (not patient slings/hoists)		79	68-92	Partial Compliant
Management of H&S at Work Regulations 1999 (to cover RAs on		82	69-93	Partial Compliant

Legislation	Pan BCU	%	Range	Actions
activities e.g. Young People)				
Workplace (Health, Safety & Welfare) Regulations 1992 (including Workplace Transport)		49	17-79	Non-Compliant
Occupational Health – Health Surveillance		46	29-75	Non-Compliant
HSE Stress Management Standards		62	11-81	Non-Compliant
Manual Handling Operations Regulations 1992		33	0-95	Non-Compliant

The highest scoring area is CDM = 97%

The lowest scoring area is Control of Vibration = 28%

Area	Number of Visits to Date	Score
East	15 (1 GP)	75%
Central	16 (1 GP)	68%
West	16	64%
Total	**47**	

<u>Manual Handling</u>

Number of visits = 31 Overall score = 33%

Appendix 2: 3 Year OHS Strategy

Occupational Health, Safety & Wellbeing Strategy 2019-2022

We recognise as a Board that good Occupational Health and Safety is good for business. A workplace that promotes employee wellbeing and the development of a strong safety culture is vital in achieving our vision of providing the best care we can for the people of North Wales. We are passionate about improving peoples working lives providing a safe and healthy environment free from ill health, accidents, violence and equality for all our staff. We want a workplace that helps employees to achieve a healthy work life balance. This three year strategy incorporates elements of wellbeing strategy. The strategy provides a clear guide to how we can achieve our safety objectives and build a positive safety culture. We want all our employees to feel supported empowered, resilient and safe. The plan will enable the organisation to continue to develop and build on its people who are the organisations greatest asset.

OHS 3 year Strategic Plan 2019-2022
The OHS 3 year strategy provides BCUHB with a clear program of improvement to achieve our safety objectives, based on the gap analysis of the organisation.

The OHS Vision
The Vision for OHS is to reduce as much as possible workplace injuries, ill health and unsafe work practices, promoting OHS and wellbeing in all service areas the vision below requires long term commitment and leadership determination not to be average.
'To be a world class Occupational Health, Safety, Wellbeing and Equality Service; that provides comprehensive, appropriate and competent advice to Betsi Cadwaladr University Health Board with systems and processes that develop a learning culture. To continually improve the OHS wellbeing and equality for staff, patients, visitors, volunteers and contractors'.
The objectives to achieving the vision include:-

- Creating a positive OHS culture.
- Maintaining an effective safety management system.
- Developing strategies that improve work life balance where people thrive in work.
- Reducing unacceptable risky behaviours that are detrimental to health.

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 Boards 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 2: 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	Develop risk register for project with actions to mitigate risk. Ensure risk	Datix system reports and staff clinic on quarterly basis. Hotspots identified and strategies to	Annual calendar training plan established. Ensure the training is accredited by	The audit system will undertake 50 audits in both clinical and non-clinical areas to see if the baseline audit has	Establish key performance indicators to include number of training events, incidents

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.	evaluation and management is easily understood and effectively implemented across service areas.	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.	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.	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.	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 and owners for such risks.	Ensure the Committee structure escalates risk appropriately in a timely manner.	Review RIDDOR and accident investigation process to ensure lesson are learned across the organization. Identify, produce and disseminate appropriate Fact/Guidance/Information Sheets across the organisation in the classification and reporting of RIDDOR	The specific training requirements will be identified within service areas as a result of the 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.	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 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	The audit system will be cross referenced with self-assessment	Data from sickness absence and incidents will be evaluated with	Additional local training will be undertaken on gaps identified. It will be	The audit will be undertaken on a rolling program with quarterly and annual reports on	The Quarterly reports will be used as part of the evaluation of the

including self-referral and internal audit process that tests the audit system.	data to ensure the compliance system is working effectively.	hotspot areas. It would be anticipated that those areas who are well engaged through OHS will have lower rates of sickness and incidents.	clear from the self-assessment and more formal OHS led audits what level of training will be required.	progress samples of areas will be undertaken to provide a clear picture of compliance in all service areas.	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 policies and procedures to be in date and gone through the Governance structure.	Quality controlled OH Department will ensure that the systems in place are accurate, timely and have the most influence on staff Occupational Health and Wellbeing.	A review of hotspots from pro-active health surveillance will support the development of positive OH management in all service areas. Stress and MSK are the biggest areas of sickness absence.	A review of service and organisational needs to be undertaken to determine if specialist training is required including audiometry, lung function tests, vibration monitoring evaluation forming part of TNA.	SEQOSH requires a self-audit system to be implemented once accreditation is obtained this requires constant monitoring of 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.	Annual self-assessment. Full accreditation expected within 12 months of development of 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 the controls at local level require further evaluation. The gap analysis of 20 premises will form part of the review of implementation.	Musculoskeletal disorders account for 10.5% of all sickness absence. There will be a review of recorded incidents as there are large numbers not recorded in the Datix system. A targeted approach of hotspot areas is required once clear data is evidenced.	On-site training and further development of the champion's network to be established to ensure that staff have access to competent advice in the workplace. Additional work on specialist bariatric equipment and training will be required in year 1.	There will be a six monthly audit system established with quarterly reports to the Strategic Occupational Health and Safety Group to ensure progress is further developed.	The evidence of a successful manual handling program will be a reduction in ill health conditions of staff and a better experience for 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	Consider if lessons are learned regarding asbestos and evaluate number of training session's reviews and control measures being implemented.

		support for staff as necessary.	emergency procedure.	sample a number of premises annually.	Highlight most high risk premises first.
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 and Occupational Health.	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 and other patients who may be placed at risk.	Evaluate the effectiveness of systems and processes put in place including training to reduce V&A incidents across all service areas.

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 be required on more complex schemes.	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 the risks of serious accidents.	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.
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 45001 and certification of the service. Ensure TOR and membership of the OHS Group is	Update risk register and risk assessment process. Ensure evidence of risk actions are being mitigated. Review if new technology can be used to reduce risk in the workplace using best practice.	The data base systems support staff evidencing the effectiveness of interventions. MSD's are reduced to lowest possible level. Stress sickness absence reduced. Research is undertaken to further drive down MSD's	Evidence numbers who have completed the e-learning and training. Include contractors training to the appropriate level. Continue to ensure all staff work to organizational standards.	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 champions to reduce the risks within all service areas.	Evaluate all aspects of work activity outcomes and feedback to Committee. The feedback from audits will help improve learning. Risks are being effectively mitigated. All staff are clear on roles

continually adding value. All documentation is up to date and in line with law and readily available on the intranet site.	Ensure principles are embedded with evidence available.	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.			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	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.

		detrimental effect on worker wellbeing.			
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.

Appendix 3: Questionnaire used in Gap Analysis

Area inspected:	Date:
Reviewed by:	Ref:
Department Manager:	Department Type:
Number of Staff:	Division:
Overall department score:	(*record score and colour code the box in line with RAG rating)*

Guide to scoring		
0 = No evidence / not compliant	1 = Partial compliance, either incomplete or out of date	2 = Fully compliant

		0	1	2	N/A
	Control of Asbestos Regulations 2006				
1	Is there an Asbestos Register on site, which clearly indicates the location(s) and type(s) of any Asbestos present?				
2	Where there is potential exposure to asbestos, is exposure calculated using an established methodology which takes in to account frequency of exposure, duration of exposure, and particle/fibre count?				
3	Are inspections/surveys undertaken to ensure that condition of affected areas is known, and are records kept up to date?				
4	Are Method Statements in place and scrutinised before work, and Permits to Work controlled?				
5	Do all relevant employees and contractors have appropriate competence/training to undertake work in areas known or suspected to contain Asbestos?				
6	Where Asbestos is present, are there visible warning signs?				

		0	1	2	N/A
	COSHH – Management of Water Systems				
7	Do you know how to access BCUHB's Policy ES02 – The Policy for the Management of Water Systems and are you aware of its contents?				
8	Are you aware of your responsibilities within this Policy?				
9	Who is the responsible person within BCUHB for the Management of Water Systems?				

		0	1	2	N/A
10	Is there a testing regime in place for legionella/pseudomonas?				
11	Do you have knowledge of all the water outlets and dead legs in your area of responsibility and what flushing and checking arrangements are in place?				
12	Are there any cooling towers, and are they licensed?				

		0	1	2	N/A
	Corporate Manslaughter and Corporate Homicide Act 2007				
13	Are you aware of your responsibilities under the Corporate Manslaughter and Corporate Homicide Act 2007?				
14	Is there training in place for Senior Management (8C & above) which relates to their responsibilities under the Corporate Manslaughter and Corporate Homicide Act 2007?				

		0	1	2	N/A
	Control of Substance Hazardous to Health Regulations 2002				
15	Do you know how to access BCUHB's Policy HS13 – The Control of Substances Hazardous to Health and are you aware of its contents?				
16	Can you produce a CoSHH Risk Assessment and explain its contents and purpose?				
17	What arrangement have you in place to ensure that you are complying with the Workplace Exposure Limits of any relevant hazardous substances?				
18	Are engineering controls managed appropriately?				
19	Do you use latex products in your service/department and how do you manage the associated risks?				
20	What Personal Protective Equipment training/instruction do you provide to staff?				

		0	1	2	N/A
	Working at Height Regulations 2005				
21	Are you aware of the definition of 'working at height' as detailed in the Working at Height Regulations 2005?				

		0	1	2	N/A
22	Is there training in place to work at height within your service/department?				
23	Have you relevant working at height risk assessments in place for the working at height activities within your service/department? Do you have permits to work for working at height activities deemed high risk or involving fragile surfaces?				
24	Do you have the appropriate working at height equipment for the working at height activities carried out by your service/department?				
25	Do you have documented inspections of your working at height equipment?				

		0	1	2	N/A
	Pressure Systems Safety Regulations 2000				
26	What pressure limits are governed by the Pressure Systems Safety Regulations 2000?				
27	Do you have a register of all pressure systems/equipment you have within your service/department that are governed by the Pressure Systems Safety Regulations?				
28	Do you have a written scheme of examination for all pressure systems/equipment that is carried out by a 'competent person'? How often are written schemes of examinations carried out?				
29	Do you have an insurance inspection document which has been undertaken on a pressure system?				
30	Do you have a permit to work system in place for all work on pressure systems?				

		0	1	2	N/A
	Safety Representatives and Safety Committees Regulations 1977/Health and Safety (Consultation with Employees) Regulations 1996				
31	Is there a policy in place for consultation with employees in line with the Safety Representatives and Safety Committees Regulations 1977/Health and Safety (Consultation with Employees) Regulations 1996?				

		0	1	2	N/A
32	What are the legal requirements of BCUHB managers in relation to employee consultation?				
33	What are the roles and functions of Trade Union Safety Representatives?				
34	What was the last thing that staff were consulted about with your service/department and how was this carried out?				
35	Do you have regular health and safety committees/team meetings with a standing health and safety agenda item?				

		0	1	2	N/A
	Personal Protective Equipment at Work Regulations 1992				
36	Are there risk assessments identifying the requirements for PPE within the department, relevant to the hazards?				
37	Have appropriate training needs been identified, and staff instructed in the use of PPE?				
38	Has PPE been issued?				
39	Is PPE maintained and replaced when necessary?				
40	Where respiratory protection is used, has it been fit tested?				
41	Where appropriate, is mandatory/warning signage in place?				
42	Is there Health Surveillance or exposure monitoring in places where there is a high level of residual risk or engineering controls are not verified?				

		0	1	2	N/A
	Ionising Radiation Regulations 2017				
43	Are staff aware of the BCUHB Radiation Protection Policy RP01?				
44	Are staff made aware of contact arrangements for the Radiation Protection Advisor and Radiation Protection Supervisor?				
45	Is there an identified risk of exposure to Ionising Radiation within this department, or via activities undertaken by staff working for this department?				

		0	1	2	N/A
46	Are risk assessments reviewed and up to date?				
47	Where appropriate, are notification, registration and consent managed as per Regulation 5, 6 and 7?				
48	Have appropriate training needs been identified, and staff instructed in managing controls (PPE, Protocols, exposure badges etc.)?				
49	Is there Health Surveillance or exposure monitoring in places where there is a high level of residual risk or engineering controls are not verified?				
50	Is there a system for determining which employees should be designated as “classified persons”?				
51	Where appropriate, is monitoring equipment maintained and calibrated?				
52	Are materials producing Ionising Radiation transported, stored and handled under adequate precautions, including security and prevention of accidental exposure				
53	Are there sufficient precautions in place to deal with accidental release, disposal, clean-up and over-exposure?				

		0	1	2	N/A
	Construction (Design and Maintenance) Regulations 2015				
54	Are Notifiable Projects identified (more than 30 working days, or more than 500 person days), and HSE notified of all Projects fitting criteria for notification?				
55	Are CDM roles (Client, Designer Principal Designer, Contractor, and Principal Contractor) documented for each Project, and assured by the Client?				
56	(Where there is more than one Contractor) is the Health and Safety File retained and available, and passed on as necessary?				

		0	1	2	N/A
57	Are there suitable arrangements for ensuring that: • Construction work can be carried out without (SFARP) risks to the health and safety of any person affected by the Project? • Welfare Facilities are provided? • Arrangements are maintained and reviewed throughout the Project				
58	Where existing buildings/grounds may be affected, is there engagement/planning around listed premises, conservation etc.?				

		0	1	2	N/A
	Confined Space Regulations 1997				
59	Is identification of Confined Spaces undertaken?				
60	Are suitable and sufficient risk assessments in place for each confined space?				
61	Is access to confined spaces appropriately restricted, sufficient to prevent accidental or unauthorised access?				
62	Are Employees (including Contractors) competent to work in confined spaces, and given adequate training?				
63	Are emergency arrangements in place before work starts?				

		0	1	2	N/A
	Gas Safety (Installation and Use) Regulations 1998				
64	Is all gas installation undertaken by competent persons?				
65	Are all installed gas systems identified and relevant information available?				
66	Are emergency arrangements in place before work starts?				
67	Are emergency control points adequately controlled and identified, along with appropriate signage?				
68	Are there arrangements in place for verification of systems before use, testing gas tightness and purging?				
69	Is there a system for inspection and maintenance of gas installations and installed appliances?				

		0	1	2	N/A
	Health and Safety (Safety Signs and Signals) regulations 1996				
70	Are there risk assessments in place which demonstrate where safety signs and signals should be used, including acoustic signals, illuminated signs and route marking?				
71	Where safety signs and warnings are in place, it be demonstrated that Principles of Prevention (hierarchy of control) have been followed?				
72	Are signs and signals suitably placed and in a format which is unambiguous?				
73	Are traffic routes, emergency egress routes, obstacles and dangerous locations appropriately indicated?				
74	Where hand signals and verbal signals are used, is there an established system for this, with all persons taking part trained?				

		0	1	2	N/A
	Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2005				
75	Are staff aware of what RIDDOR refers to or stands for?				
76	Are managers aware of the requirements to report under RIDDOR, and under what circumstances RIDDOR might apply?				
77	Are managers aware of the BCUHB arrangements for reporting under RIDDOR?				

		0	1	2	N/A
	Fire (Regulatory Reform) Order 2005				
78	Can managers identify where the Fire Safety Risk Assessment is held?				
79	Have the actions identified in the significant findings / action plan been actioned?				
80	Are there designated staff identified to manage, control and instigate emergency procedures?				
81	Does the department carry out an evacuation drill at least twice per annum and are drills recorded?				
82	Is the fire alarm regularly tested i.e. weekly?				

		0	1	2	N/A
83	If there is a requirement for zoning or horizontal evacuation, do all staff understand how this should be managed?				

		0	1	2	N/A
	Health and Safety (First Aid) Regulations 1981				
84	Has a First Aid risk assessment been carried out for your area of responsibility?				
85	Are First Aid boxes complete or suitable equipment available and in date?				
86	Is the first aid signage displayed and correct?				
87	Have adequate numbers of first aiders or appointed persons been identified?				

		0	1	2	N/A
	Non-Notifiable Control of Contractors				
88	Are you aware of the 'Contractors Safety Guidance Document' version 08?				
89	Are contractors vetted prior to being contracted to work? (Appendix 1 from the above guidance completed?)				
90	Do contractors attend or complete site awareness training prior to starting work on site?				
91	Are the contractors own risk assessments verified prior to commencement on site?				
92	Are method statements reviewed and recorded?				
93	Who issues and records 'Permits to Work' and who monitors these?				

		0	1	2	N/A
	The Control of Vibration at Work Regulations 2005				
94	Are you aware of the policy on the use and monitoring of vibrating tools? (HS10)				
95	Is there a designated inventory of all vibrating tools used within the function?				
96	Has each vibrating tool been assessed for its action level and action limit when purchased?				

		0	1	2	N/A
97	Have all staff who use vibrating tools received instruction, information and training?				
98	Are risk assessments in place for the use of vibrating tools?				
99	Is there a maintenance schedule in place for the monitoring and use of vibrating tools within your area of responsibility?				
100	Are staff who utilise vibrating tools provided with some form of health monitoring?				

		0	1	2	N/A
	HTM 07-01 – Safe Management of Healthcare Waste 2006 and Hazardous Waste (England and Wales) Regulations 2005				
101	Is there a policy/procedure in place for the control of waste?				
102	Who controls, records any waste consignment notes for your area of responsibility?				
103	What waste container would be used for the disposal of Cytotoxic & Cytostatic waste?				
104	Are clinical waste bins locked and secured?				
105	Has an annual environmental audit been completed?				
106	Are appropriate staff trained in handling of waste, and how?				

		0	1	2	N/A
	Health and Safety (Sharp Instruments in Healthcare) Regulations 2013				
107	Are general procedures in place for the use of Sharp Instruments which cover storage, safe use and safe disposal?				
108	Where non-safety Sharps are used, or there is a need to use a Sharp Instrument for other than its designed purpose, are there specific risk assessments in place which follow Principles of Prevention?				

		0	1	2	N/A
109	Are all staff appropriately trained in Sharps Safety, including actions to take in the event of an injury/exposure?				
110	Are all Sharps/Needle stick Injuries reported on Datix and reported to ED/Occupational Health and managed as per Occupational exposure procedure IPC07?				
111	Are Sharps Containers of the appropriate type(s) and size, correctly assembled, signed and dated, not overfilled and appropriately sited for use?				

		0	1	2	N/A
	Prevention of Slips, Trips and Falls				
112	Is there a general risk assessment which accounts for hazards associated with slips, trips and falls in the working environment?				
113	Is the environment regularly checked to ensure that controls are in place and slip, trip and fall hazards are dealt with (trailing cables, objects, flooring, clutter/inappropriate storage, access and egress routes etc.)?				
114	Are bed rail assessments completed for patients identified as at risk from falls, and reviewed on admission, transfer, change of mobility or when a fall happens?				
115	Are falls assessments completed for patients identified as at risk from falls and reviewed on admission, transfer, change of mobility or when a fall happens?				
116	Where patients are identified as at risk of falls, is there adequate staff provision to provide the required level of observation and manual handling?				
117	Are all employees involved in cleaning activities adequately trained in appropriate cleaning techniques (damp mopping, correct products etc.?				
118	Is flooring in good condition, and of an appropriate type for the environment?				
119	Are patients and staff advised to wear footwear appropriate to the environment?				

		0	1	2	N/A
	Health and Safety (Display Screen Equipment) Regulations 1992				

		0	1	2	N/A
120	Are you aware of the location of the procedure and guidance for DSE?				
121	What 'criteria' denotes a DSE user?				
122	Have DSE assessments been completed for identified users?				
123	Are your display screens appropriate for the DSE user?				
124	Are the wheels on all computer chairs appropriate for the flooring?				
125	Where is the information available to ensure staff are aware of how to claim for eye tests and corrective eyewear for DSE use?				
126	Are staff supplied with information on how to prevent and manage Musculoskeletal Disorders?				

		0	1	2	N/A
	The Control of Noise at Work Regulations 2005				
127	Are there any plant rooms in your area of responsibility?				
128	Are there risk assessments in place relating to the risks from noise?				
129	Is health surveillance carried out on identified staff who work in identified noise areas?				
130	How do you ensure that levels are not breached?				
131	Do you have hearing protection in place?				
132	Do you provide instruction and training for noise?				

		0	1	2	N/A
	The Electricity at Work Regulations 1989				
133	Is there a Policy in place and is it being implemented?				
134	Are staff trained in the use and maintenance of electrical systems?				
135	Are there relevant risk assessments in place?				
136	Is there a PTW system/ procedure in place for electrical isolations?				

		0	1	2	N/A
137	Is there a system in place to manage contractors undertaking electrical work?				
138	Is there a system in place to ensure that all Portable Appliance items are tested?				
139	Is there a system in place to remove faulty equipment from service?				
140	Where there are high voltage systems (transformers, substations, overhead cables etc.), are EMF Risk Assessments undertaken				

		0	1	2	N/A
	The Provision and Use of Work Equipment Regulations 1998				
141	Is there a Policy in place and is it being implemented?				
142	Are there risk assessments in place for the equipment used in the department, which gives detail of the use and maintenance requirements?				
143	Are staff trained in the use of equipment in the department and are there training records?				
144	Are there maintenance records for the equipment, and a Planned Preventative Maintenance schedule where required?				
145	Is equipment accompanied by suitable H&S measures, such as protective devices and controls? e.g. emergency stop devices				
146	Is there a system in place to remove faulty equipment from service e.g. hazard / safety checks?				
147	Is the environment suitable for the equipment being used?				

		0	1	2	N/A
	The Lifting Operations and Lifting Equipment Regulations 1998 (not including patient hoists and slings)				
148	Is there a Policy in place and is it being implemented?				
149	Has the department identified lifting operations undertaken which use lifting equipment?				
150	Are there appropriate risk assessments in place?				

		0	1	2	N/A
151	Is the equipment marked to indicate the safe working load?				
152	Has the lifting equipment had a Thorough Examination and are there records of these?				
153	Is there a system in place to remove faulty equipment from service				
154	Are staff competent to use the equipment and are there training records?				

		0	1	2	N/A
	Management of Health and Safety at Work Regulations 1999. To cover RA's on activities including Young Workers:				
155	Is there a Policy in place and is it being implemented?				
156	Does the department have relevant risk assessments for the work being undertaken?				
157	Have the risk assessments been reviewed appropriately?				
158	Is there a trained / competent risk assessor in the team?				
159	Is there a system in place to escalate risks that cannot be managed locally?				
160	Have specific staff groups including Young Workers (16-18) and expectant / new mothers had a risk assessment?				

		0	1	2	N/A
	Workplace (Health, Safety and Welfare) Regulations 1992 including Workplace Transport				
161	Is there a Policy in place and is it being implemented?				
162	Are welfare provisions adequate and if not has there been a risk assessment completed to escalate non-compliance?				
163	Is there a risk assessment for staff who drive for work?				
164	Is there a risk assessment for Lone Workers?				
165	Are there appropriate risk assessments in place for movement of vehicles in the workplace?				

		0	1	2	N/A
	Occupational Health - Health Surveillance				
166	Is there a Policy in place and is it being implemented?				
167	Is there a risk assessment in place detailing specific health surveillance required?				
168	Has the department identified specific staff groups who may require Health Surveillance?				
169	Is there evidence that staff have been referred to Occupational Health if required?				
170	If the risk assessment has identified that monitoring is required, either in the work environment or on the person, is this in place?				

		0	1	2	N/A
	HSE Stress Management Standards				
171	Do managers understand the HSEs Stress management Standards and how they should be applied?				
172	*Demands* – are demands on Employees known and managed – workload, work patterns and the work environment				
173	*Control* – are staff given a say in how they work?				
174	*Support* – is appropriate support in place for Employees to manage stress effectively?				
175	*Role* – do Employees understand their roles, what is expected of them and do management ensure that roles do not conflict?				
176	*Change* – where change is necessary, is it organised, communicated effectively, and are employees engaged with?				
177	*Relationships* – is positive and co-operative working encouraged, and unacceptable behaviour dealt with?				
178	Are cases of work-related stress reported on via Datix?				
179	Are suitable and sufficient stress risk assessments undertaken?				

Project: **Occupational Health and Safety Legislative Compliance Plan**
Date: 1st September 2019
Version: 1
Project Lead: Peter Bohan
Project team: Stephen Roscoe, Susan Morgan, Jill Hughes, Sara Jones, Sarah Wynne Jones, Sam Newitt, Clare Jones, Janet Jones, Wendy Calverly, Simon Talbott
The timeframes for completion is based on risk and complexity of work required. Work will begin imediately to mitigate the most serious risks.

Compliant	
Partial Compliant	
Non Compliant	

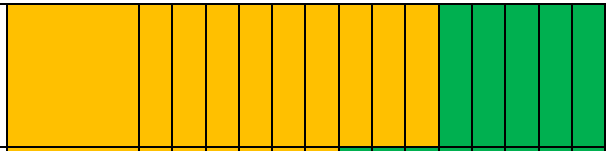
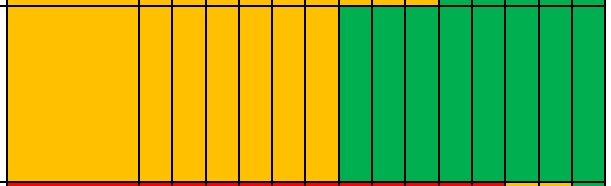
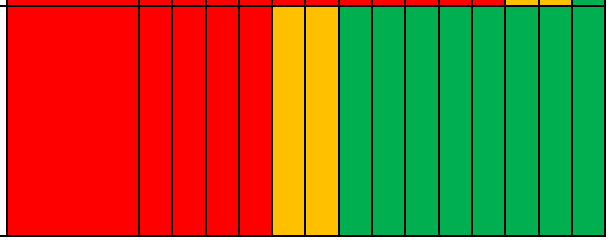
No:	Deliverables & Milestones	Owner	H&S Advisor/Support	Measures	Start (dd/mm/yy)	End (dd/mm/yy)	Revised date (dd/mm/yy)	01/09/2019	01/10/2019	01/11/2019	01/12/2019	01/01/2020	01/02/2020	01/03/2020	01/04/2020	01/05/2020	01/06/2020	01/07/2020	01/08/2020	01/09/2020	01/10/2020
	WORKSTREAM 1																				
1a	The Health and Safety at Work etc. Act 1974 and associated legislation.	CEO/Sue Green Peter Bohan Associate Director of Health, Safety and Equality. Stephen Roscoe Head of H&S	All	Review of legislative compliance through gap analysis of 31 pieces of legislation.	September 1st 2019	August 31st 2020															
1b	Control of Asbestos Regulations 2012. Review the Asbestos Management Policy and ensure it is fit for purpose. Ensure asbestos registers are in date and the Policy is clearly implemented in all service areas. Implement an appropriate signage system on ACM's not in public areas; where identified in public areas indicate work should not be carried out unless discussed with Estates. A permit to work system specific areas in relation to asbestos related work is required. A systematic review of surveys which includes the standard of surveyor who has undertaken the work and all actions identified documented and completed. Abestos central plans updated and evidenced. Clearly stipulated who does licensed non licenced work, provide information on asbestos to all contractors and BCUHB staff as reqiuired.	Rod Taylor	Susan Morgan	Policy and guidance fit for purpose evidence of local mangagement in all service areas. Review and audit against Policy undertaken. Asbestos Group reports into Strategic OHS Group of actions.	September 1st 2019	1st May 2020															
1c	COSHH- Management of Water Systems. Ensure all annual reviews confirm that actions have been completed and that any material change in the system has the schematic drawings updated if not already in place. There are medium risks pertaining to management of legionella that remain outstanding, ensure they are reviewed and work completed as planned to minimise the risk of amber risks which may escalate to red risks over time. Local outlets and flushing regimes require clear ownership, a systems that gives positive assurance of outlets being flushed is required. This may involve investment in a central data base that can give assurance on the flow and control of legionella at all sites. Review psuedomonis system in place and contol measures.	Rod Taylor-Debra Carter	Sam Newitt	BCUHB is assured that the organisation is compliant with L8 guidance and risk assessments are in place for amber risks identified ensuring all actions are completed. A central data base is required to provide assurance that all flushing is taking place.	September 1st 2019	1st June 2020															
1d	Working at Height Regulations 2005. The identification of fragile surfaces is required with a minimum of 2 metres exclusion zone implemented and specific risk assessment for work at height avoiding reliance on generic guidance currently in place. Ensure a consistent approach to the inspection of ladders and kick stools is adopted with clear guidance to undertake visual inspections are undertaken on a periodic basis. A permit to work system and clear policy on work at height is required as a matter of urgency.	Rod Taylor	Clare Jones	Work at height requires a suitable policy system of implementation of permit to work process. Positive assurance that all staff and contractors are working to the Policy is in place. A program of inspection of ladders and regime to monitor system is required.	September 1st 2019	1st February 2020															
1e	Non notifiable control of contractors. There is a requirement to sign all contractors in and issue them with a local induction and identification badges. Estates should ensure that a minimum assessment of contractors is undertaken for example using the contractor health and safety scheme (CHAS) not just reliant on a central list, which may not ask specific OHS questions. This would act as the first stage of the tender process and provide assurance of basic safety requirements being in place. All tasks carried out by contractors require a review of the risk assessments and method statements and a system that signs off that the contractor is working to those standards. The current Contractor Management Policy requires reviewing to be realistic about what can be achieved and all estates staff understanding the content and how it	Rod Taylor	Simon Talbot	Contractor management and control requires all contractors large and small to work to the Contractor Management Policy.The audit system will review if contractors have had local induction informed about emergency procedure and asbestos plans in the area they are working.	September 1st 2019	1st December 2019															

1g	Vibration at Work Regulations. A review of all equipment, staff time using vibrating equipment, exposure levels, risk assessment with adequate health surveillance is required to identify those staff at significant risk of harm. A suitable policy and guidance document is required. An external contractors should be employed to identify and evaluate current levels of exposure and controls being implemented. This could be undertaken alongside a noise assessment process to ensure exposure levels are within safe parameters.	Rod Taylor	Susan Morgan	The identification of staff who may be exposed to vibration equipment is required along with adequate assessments of such risks. Suitable controls and health survielance programme.	September 1st 2019	1st December 2019	
	WORKSTREAM 2						
2a	Electricity at Work Regulations The current system for undertaking portable appliance testing relies on external contractors testing everything that is available annually. Advice to site occupier to identify equipment to be tested is required and a risk based approach that reduces cost and manages risk more effectively. The permit to work system is required for specific activities. An Electrical Safety Policy is required to describe the safe systems of work being implemented.	Rod Taylor	Sam Newitt	Electricity safety policy will describe how the system for management of electrical installations working dead and electrical items will be tested.	September 1st 2019	1st June 2020	
2b	Control of Noise at Work regulations. Noise control will require appropriate policy or guidance along with an additional evaluation by an external consultant who can also provide evidence of vibration levels. Zoning of areas to ensure clear identification, including personal protective equipment and reducing risks were possible implement adequate engineering controls.	Rod Taylor	Clare Jones	The Noise Policy will be used as a framework to identify those staff who may be at risk provide appropraite assessment and Health Survielance for staff identified at risk. Suitable controls require implementing and monitoring.	September 1st 2019	1st January 2020	
2c	Workplace (Health Safety and Welfare Regulations) Workplace vehicular movement, deliveries and pedestrian walkways are a particular concern. A clear Driving at Work Policy is required. Delivery areas require suitable risk assessments that are monitored and controlled. Workplace welfare policy is required and a Lone Worker Policy that sits under the Security Policy is required with specific risk assessments in place for those deemed to be lone workers and at potential risk.	Rod Taylor	Simon Talbot/Susan Morgan/Stephen Roscoe	All vehicle management systems require a Driving at Work Policy and delivery areas require a specific risk assessment to be implemented. As part of the security review a Lone Working Policy will require implementing and monitored through an appropraite Audit system and consideration of additional equipment.	September 1st 2019	1st March 2020	
2d	Occupational Health Survielance. The Health Surveillance Policy requires developing and further information for staff regarding health surveillance. The recently work undertaken by the H&S Team and OH requires evidencing and further review of latex, night workers, immunisation, noise, vibration etc. is required to support staff who may be exposed to substances, equipment or work environments that may cause ill health from the workplace.	Sarah Wynne Jones	Wendy Calveley	OH Survielance is required in areas were there is a recognised ill health condition associated with the work activity substance or product. Ensure the range of questionaires targets high risk groups and audits the numbers of staff who are exposed. Implement suitable systems for testing which requires additional equipment and training will be required within OH Department.	September 1st 2019	1st Novemeber 2020	
2e	Manual Handling Regulations.A separate manual handling action plan is required to include. The manual handling champion's course review. Each manual handling champion should be is allocated 10 staff members per workplace to train, monitor and review. This will improve locally managed manual handling risks specific to the workplace. Additional support will be required to observe group sessions run by champions and annual update of training to aid the reduction of MSD's. The champions should collate an inventory of equipment used in their work areas. They would be expected to self-report on work activities including training and evidence of competence of staff, LOLER requirements and ensure 6 monthly sling registers are kept up to date for washable slings. Identification of cost for disposable slings used against cost to purchase and launder washable slings should be assessed including environmental impact of disposable slings. The Policy will require updating to include simple to use guides on how to undertake TILE risk assessments and review of bariatric pathway and care plan process.	Rod Taylor/Debra Carter	Jill Hughes/Steve Roscoe	The Manual Handling Policy will be evaluated as a framework to improve those at risk of MSD's in the workplace. Sickness absence and targeting of high risk areas is required to improve patient care increasing mobility and aiding staff in reducing harm. Bariatric patients require a suitable care plan and access to equipment in a timely manner.	September 1st 2019	1st March 2020	
	WORKSTREAM 3						

3a	COSHH. A review of the COSHH Policy along with safety critical substances that have whole time equivalent exposure limits (WEL) or short term exposure (STL) limits should be reviewed and eliminated if possible to avoid any risks of staff being exposed to carcinogens. The risk assessments for substances that remain high risk require engineering controls and health surveillance implemented. Latex products should be removed from the procurement list and as an exception to purchase latex will only be given when a specific risk assessment is provided. A systematic review of the COSHH system and policy is required to ensure a consistent approach across all service areas. The	Rod Taylor	Susan Morgan	The COSHH risk assessment system requires centrally managing to avoid products being purchased at location that pose a risk to staff. Risk assessments clearly identify risks and controls effectively implemented.	September 1st 2019	1st August 2020	
3b	Ionising Radiation. Ensure the planned review of the community sites is undertaken as planned and local rules and arrangements implemented. This will ensure that this element of legislation is fully compliant in all service areas.	Helen Hughes	Clare Jones	Ionising Radiation Policy implemented on all premises with local rules and risk assessments in place.	September 1st 2019	1st January 2020	
3c	Confined Spaces. The definition and clarity on confined spaces access and control requires implementing with the current Policy development work currently undertaken. Contractors risk assessment and method systems appropriately reviewed prior to work taking place. A permit to work system is required and site specific risk assessments required to ensure contractors can be monitored against such documents when entering confined spaces.	Rod Taylor	Sam Newitt	A Confined Spaces policy to be implemented and clear identification and risk assessment of such areas of work. Permit to work system implemented in all service areas.	September 1st 2019	1st November 2020	
3d	Stress Management. A pro-active training program is required to enable managers and staff to recognise the key elements of stress including demands, control, relationships, culture, change and environment. The policy and process will require simplifying to enable managers to pro-actively manage this most significant area of ill health within the Board. Training for managers and teams to target specific high risk areas. A review of Policy is required to ensure it is user friendly and is supportive of the changes required in this area of concern within BCUHB.	Sarah Wynne Jones Peter Bohan	Jack Jackson	Stress management plan in place and simple to use risk assessment. All staff reffered to OH for stress have stress risk assesments in place. High risk areas are targeted and evidence reduction in stress sickness absence evidenced.	September 1st 2019	1st September 2020	
	WORKSTREAM 4 -						
4a	Fire safety. Ensure all fire risk assessments that require updating in a number of service areas are done so in a timely manner. A program of work that provides evidence of the number of fire drills undertaken and those services that have not carried out a drill will be required to report to the Strategic OHS meeting. The fire risk assessment and evacuation plans require reviewing in those services that are not compliant.	Rod Taylor	Simon Talbot	Fire Policy implemented in all services. Actions identified in risk assessment fully implemented along with fire drill undertaken.	September 1st 2019	1st July 2020	
4b	The Provision and Use of Work Equipment Regulations (PUWER). There is a requirement to identify all items of workshop equipment that requires maintaining. Local inventories and management is required in each department or area. Estates should develop an inventory of power tools or other equipment to ensure vibration rates, exposure rates for noise are evidenced and maintenance records available. A policy specifically for the PUWER equipment across all service areas is required.	Rod Taylor	Clare Jones	The PUWER policy to be implemented with inventory of equipment and maintenance records evidenced in all service areas.	September 1st 2019	1st March 2020	
4c	LOLER There is a requirement to ensure all lifting equipment, hoists, slings etc. are consistently managed across all service areas to ensure they comply with the thorough examination required by the law. The policy for LOLER will require development to describe the process in place that is centrally managed and consistent.	Rod Taylor	Sam Newitt/Jill Hughes	The LOLER Polcy is required to ensure all lifting equipment is suitable maintained in all service areas and specific risk assessments undertaken as required.	September 1st 2019	1st April 2020	
	WORKSTREAM 5						
5a	Management of H&S at Work Regulations. Risk assessments require to be site specific and deal directly with the hazards in the workplace. A range of risk assessments should be developed to assist staff develop skills in this area. Training should be specific to the risks posed in the service area. A policy or guide is required to help staff understand how the risk assessments can be used as working document that assists in the implementation of safe systems of work.	Peter Bohan	Susan Morgan	The risk assessment process should be integrated with the Risk Management Policy and a program of site specific risk assessments in all service areas. Adequate training is required for those undertaking the risk assessment process.	September 1st 2019	1st June 2020	

5b	Corporate Manslaughter A review of all training needs for OHS across the organisation is required as staff in senior positions where not aware of their responsibilities in many cases. A program based on senior leaders receiving the IOSH Directing safely course, senior leads being accredited with the IOSH managing safely course will provide assurance of quality assured training and development of the OHS Lead role within the organisation to develop a pro-active safety culture.	CEO/Sue Green Peter Bohan Associate Director of Health, Safety and Equality.	Sam Newitt	Specific training identified for senior leaders not just Board members requires implementing such as Directing Safely for staff above 8c. Additional training is required for staff who are responsible for safety management within the service areas.	September 1st 2019	1st May 2020	
	WORKSTREAM 6						
6a	RIDDOR All service areas required to provide adequate information to the OHS Team to ensure BCUHB are compliant with the regulations. The OHS Team will review all incidents to ensure that RIDDORs are initially identified information will be provided to the Strategic OHS Group on progress with the requirements. Further work is also required on the quality of RCA's and review of process and Policy. A series of never events should be developed as part of the RIDDOR reporting process that is reviewed by the Strategic OHS Group and effectively monitored. RIDDOR training should form part of the IOSH managing safely course proposed for OHS Leads.	Peter Bohan	Clare Jones/Sam Newitt	RIDDOR guidance to be provided to staff and training. The OHS Team will review all incidents to ensure that they do not miss RIDDOR incidents.	September 1st 2019	1st March 2020	
6b	Slips, trips and falls. There was evidence of hazard checklist being completed by a number of services. Clinical are working hard on blackspots/reasons for patient falls but hazard spotting walk rounds are not seen in all areas. A few departments had full score for completing a STF risk assessment or for completing any hazard identification checks. The new STF checklist might help with this and the corporate H&S reviews should start flagging the requirement to do these. There was very little evidence of staff making an external check of other areas outside their area of work. External car parks to review process for managing external spaces and ranking system for repair work if not already in place.	Rod Taylor-Debra Carter	Sam Newitt	The Slips, Trips and Falls Policy to be continually reviewed to ensure lessons are learned and reduction in numbers of staff who slip trip and fall is significantly reduced.	September 1st 2019	1st September 2019	
6c	First Aid at Work Regulations A clear policy or guidance based on risk assessment is required to identify first aiders on both the acute and community sites is required. A review of areas and individuals at risk particularly none clinical areas is required to ensure adequate control measures are in place in an emergency, this is particularly relevant in remote locations.	Rod Taylor	Simon Talbot	The First Aid at work policy reqiuires developing to ensure suitable risk assessments are in place and emergency plans in place across all services.	September 1st 2019	1st August 2020	
	WORKSTREAM 7						
7a	Pressure systems. A systematic review of outliers is required to be built into the central contract to ensure adequate controls are in place. The lack of systems in smaller sites resulted in the poor scoring on this issue and therefore requires further control measures. .	Rod Taylor	Susan Morgan	A Pressure Systems guide is required to ensure there is a consistant appraoch to the management of pressure systems and this is evidenced at local sites.	September 1st 2019	1st May 2020	
7b	Management of Waste. Waste stores require securing in all service areas and monitoring of these areas is required for security and potential fire risks. Vigilance and security of compounds requires additional work that has also been highlighted by the security gap analysis.	Rod Taylor	Clare Jones	Waste Management Policy implemented and security of waste stores deemed to be appropraite.	September 1st 2019	1st Novemebr 2019	
7c	Personal Protective Equipment. Specific guidance on PPE and how to undertake specific risk assessments in non-clinical areas to minimise the risks to staff and avoid incorrect PPE being provided without considering elimination of the hazard in the first place a guidance document is required to give staff the knowledge required to undertake such assessments.	Rod Taylor-Debra Carter	Sam Newitt	The PPE Policy in place and specific risk assessments identify hazards and control measures associated with the PPE.	September 1st 2019	1st March 2020	

7d	Gas Safety Regulations A gas safety Policy or guidance document is required to describe the system in place to manage gas safety and ensure annual checks of equipment can be evidenced in all service areas.	Rod Taylor	Simon Talbot	A gas safety Policy or guidance document is required to describe the system in place to manage gas safety and ensure annual checks of equipment can be evidenced in all service areas.	September 1st 2019	1st January 2020	
7e	Safey Representative and Communication systems. An education program for representatives to ensure levels of competence are increased is required and Trade Union Partners clearly identify who representative are in the workplace. The numbers require increasing to support the culture change required in several service areas. Clear guidlines on roles and responsibilities to be implemented in all service areas.	Jan Tomlinson	Clare Jones	A safety represenatives guide is required and there should be clarity on numbers of safety representatives within service areas and their remit.	September 1st 2019	1st September 2020	
	WORKSTREAM 8						
8a	Sharps Safety Regualtions. A continual review of sharps safety is required in high risk areas such as theatres and ED etc. Disposal of sharps is still a concern with a number of staff receiving sharps injuries. Regular audits and feedback to the Strategic OHS group is required to continually review processes and systems currently in place.	Sarah Wynne Jones	Wendy Calverley	The Sharps Safety Policy procurement and systems to be constantly updated and reviewed to ensure high risk areas reduce the numbers and severity of sharps in the workplace. Proper RCA process that learns lessons implemented.	September 1st 2019	1st January 2020	
8b	Display Screen Equipment. A review of policy and guidance with self-help guides to be implemented in service areas to reduce the risk associated with work related upper limb disorders.	Peter Bohan	Sue Morgan /Sarah Wynne Jones	The DSE Policy to be effectively implemented within service areas and individuals have appropriate assessment and controls in place. Fast track policy effectively implemented for staff to get physio service early.	September 1st 2019	1st September 2020	
8c	Safety Signs and Signals Regulations. Remove inappropriate signs from workshops and ensure zoned areas in plant rooms have adequate identification and signage in place. A guidance document would be recommended of types and signage required in all service areas to ensure consistency of the BCUHB approach.	Rod Taylor	Simon Talbot	Ensure suitable safety are in place and guidance document available for staff when signs are purcahsed.	September 1st 2019	1st February 2020	
8d	CDM An effective system of gathering safety files after completion of work is required and updating central plans is required. The role of the client will also require further review under the legislation to ensure the client (BCUH) is aware of their roles and responsibilities. Ensure the CDM Policy is reviewed to reflect the findings.	Neil Bradshaw	Sam Newitt/Steve Roscoe	The CDM Policy continually monitored and clear roles and responsibilities adhered to sample plans and ensure safety file delivered on work carried out and modifies or supports previous plans in place.	September 1st 2019	1st September 2020	
8e	Policy systems and document control The BCUHB Policy on Policies (PoP) will be launched in September 2019. Running parallel to this is the review and development of the new BCUHB Policies, Procedures, Guidance and other written control documentation internet page. The project aims to develop a central and authoritative location for the storage of all pan BCUHB WCDs. This will act as a point of assurance enabling the Health Board to review its internal control framework and provide further confidence in its operational working. The Occupational Health and Safety Policies could be used as a pilot in the development of the central control process required.	Peter Bohan	Sara Jones/Bethan Wassle	Policy and guidance fit for purpose evidence of local mangagement in all service areas.	September 1st 2019	1st October 2020	
8f	Intranet site with self help guides. The intranet site for Occupational Health and Safety requires easy helpful guidance and policies available that are agreed and controlled centrally as described above. Staff require simple self-help guides and information developing on what is required in a safety file and what an audit will be looking for.	Peter Bohan	All OHS Team to contribute Sara Jones to manage system.	Develop an effective intranet site that provides easy to access guidance for staff that is specific to BCUHB requirements.	September 1st 2019	1st September 2020	
	WORKSTREAM 9						

9a	Training Needs Analysis. The purpose is to identify what level of training is currently in place across all service areas, key areas may need specific training, asbestos, electrical safety, managing safely, induction etc. The evaluation will require all services to be assured that the training delivers the competence required in all service areas.	Peter Bohan	Susan Morgan	Undertake a TNA and all services are 85% compliant with the plans in place ensure the training is specific to the needs of the organisation.	September 1st 2019	1st July 2020	
9b	Audit system and Key Performance Indicators. The current system requires reviewing to ensure the reviews undertaken by H&S Team and Self Assessments are accurate. KPI's should be cleraly stipulated such as number of training events, reviews undertaken, accident investigations, policies guidance developed etc.	Peter Bohan	Sam Newitt /Sara Jones	Ensur the audit system provides assurance that all safety risks are being managed a comprehensive KPI system is implemented and can be evidenced as improving safety performance and culture.	September 1st 2019	1st February 2020	
9c	SEQOSH accreditation. This will require additional project plan and timeline clearly indicating the individuals who are responsible. There is approximetely 200+ documents required to achieve SEQOSH accreditation. The Quality assured system will provide the organisation with the evidence that the OHS Service delivers improvements to staff health and wellbeing.	Peter Bohan Sarah Wynne Jones	Janet Jones	Ensure SEQOSH systems are implemented and evidence of performance reviewed to maintain the quallity assured system.	September 1st 2019	1st October 2020	
9d	Safety Leads. The current system for H&S Leads relies on volunteers to undertake the OHS Lead role for the service areas. It is recommended that a Service Manager with appropriate skills and training are designated to take responsibility as Leads. They will require appropriate authority to implement safe systems of work and hold individuals to account for safety performance. The Leads should be provided with tasks that can be centrally monitored and reported to the Strategic OHS Group. This may include numbers of reviews undertaken, training events, risk assessments and incident reviews. They should as a minimum receive IOSH 4 day managing safely course or similar accredited course.	Peter Bohan	Clare Jones	Ensure OHS Leads have the The Safety Leads require the skills and training necessary to support the OHS agenda. The Safety Leads group should be the focus of the actions required by the strategic OHS Group and should provide evidence of safety culture improvements in all service areas.	September 1st 2019	1st February 2020	

Quality, Safety & Experience (QSE) Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	HMP Berwyn : Health and Wellbeing Service Her Majesty's Inspectorate of Prisons Inspection Report and Action Plan
Report Author:	Mr Simon Newman, Head of Healthcare
Responsible Director:	Dr Chris Stockport, Executive Director, Primary & Community Services
Public or In Committee	Public
Purpose of Report:	To provide the QSE Committee with a copy of HMP Berwyn's first Her Majesty's Inspectorate of Prisons inspection report. The report includes a joint inspection with Health Inspectorate Wales of the Health and Wellbeing Services at HMP Berwyn. The subsequent action plan is also provided.
Approval / Scrutiny Route Prior to Presentation:	No prior scrutiny or consultation prior to QSE. Report is for information only
Governance issues / risks:	No risks or governance issues. An overall positive inspection for BCUHB's Health and Wellbeing Services at HMP Berwyn.
Financial Implications:	No financial risks relating to inspection
Recommendation:	The Committee is asked to receive and 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 Leadership and governance			
Equality Impact Assessment EqIA not applicable to the submitted report			

HMP Berwyn : Health and Wellbeing Service
Her Majesty's Inspectorate of Prisons Inspection Report and Action Plan

Her Majesty's Inspectorate of Prisons (HMIP) conducted a full, unannounced inspection of HMP Berwyn between 4th and 14th March 2019. This was HMP Berwyn's first inspection since opening in February 2017.

As part of all HMIP inspections, there is an inspection of health services. In Wales, HMIP health inspectors are joined by Health Inspectorate Wales (HIW) inspectors to conduct the inspection in partnership.

Services are inspected against a suite of far ranging HMIP expectations.

The format of the inspection includes the submission of data and documentation to evidence compliance with the HMIP expectations. This is provided one week before the onsite visit. Inspectors are on site for five full days and have full access to all of the prison. During the week prior to the inspection, a HMIP research team visit the prison to conduct service user feedback known as Measuring the Quality of Prisoners Life (MQPL)

Formal verbal feedback was received for health services on the penultimate day of inspection week. The formal report was published on 18th July 2019. It is important to note that only part of the verbal feedback is included in the final report. An opportunity to comment on factual accuracy was afforded to the Health Board.

A comprehensive action plan has been developed based upon both the verbal feedback and the formal recommendations indicated in the final report.

Our action plans are formally monitored, and progress tracked, at the monthly Local Health Delivery Group and Quality, Safety and Performance meetings and tabled for information at the quarterly Prison Health, Wellbeing and Social Care Partnership Board. The latter has Health Board Executive Director membership.

The outcome of the inspection was very positive for BCUHB's services at HMP Berwyn

Attached for the QSE Committee are the following appendices:

1. HMP Action Plan Recommendations
2. HMP Berwyn Report
3. HM Prison & Probation Services Action Plan

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

Health & Wellbeing Service at HMP Berwyn
Her Majesty's Inspectorate of Prisons (HMIP) Action Plan **APPENDIX 1**

OFFICIAL RECOMMENDATIONS FROM HMIP INSPECTION – MARCH 2019

Date Added	ID		Action	Action Owner	Response to HMIP	Update	Deadline	Action Overdue	Status	Date closed
25/06/2019	OHMIP1	55	There should be a prison-wide strategy to support health promotion. (2.52)	Governor / Head of Healthcare	BCUHB have made links with Public Health Wales and are developing a secondment opportunity for a member of Public Health Wales to develop and lead on implementing a Health Promotion Strategy for the Residents at HMP Berwyn. This Healthy Prison Strategy will be cross organisational	The Head of Healthcare has been working with Public Health Wales to progress a secondment	Dec-19	Within deadline	Ongoing	
25/06/2019	OHMIP2	57	Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs. (2.60)	Head of Healthcare	All Residents who attend external hospital appointments are now added to the daily handover sheet. The Shift Co-ordinator is responsible for allocating a member of staff to review them on return to the establishment following their appointment. A Standard Operating Procedure is being developed to document/ formalise this process.	A process has been implemented where shift co-ordinators allocate a member of health and wellbeing staff to see all men on return from external hospital appointments. The Health & Wellbeing Peer Mentors are also carrying out welfare checks on men who have attended external appointments to ascertain if men have any concerns or if there is information they need to pass onto the H&W team. A formal SOP is being developed to support and strengthen the current arrangements. This SOP will be reviewed by LHDG in October.	Aug-19	No closed within deadline	Closed	30/08/2019

25/06/2019	OHMIP3	59	The prison should ensure that suitable occupational therapy equipment and adaptations are provided and installed promptly. (2.66)	Head of Healthcare / Adult Social Care Service Manager / Amey	Occupational Therapy Staff identify Equipment and Adaptations that are required through an assessment of individual needs. Some of this Equipment can be provided by the Occupational Therapist through the Community Equipment Store and is obtained within a timely manner. Once at site the Occupational Therapist will fit the equipment as required. Other Equipment may be required that is not available through the Community Equipment Store but may be considered under Reasonable Adjustments and Equalities. This is discussed with Social Services and the Prison to ascertain which area are responsible for the provision of this Equipment. Any Equipment agreed to be provided by Social Services will be delivered and fitted by the Occupational Therapy Team. Other equipment that falls under Reasonable Adjustments will be provided by the Prison. Occupational Therapists will liaise with the Prison Equalities Team and Business Hub to identify appropriate Equipment and arrange any fitting/delivery either through the Team or through the Facilities Management Services if required. The Prison are currently revising their Reasonable Adjustments Policy to provide additional clarity and Occupational Therapy Services are supporting this review in terms of defining Reasonable Adjustments and providing clarity on the various funding thresholds/likely demands for service/adjustment		Sep-19	Within deadline		

25/06/2019	OHMIP4	61	The substance use services should have the necessary rooms to deliver therapeutic treatment. (2.79)	Governor	The lack of sufficient and suitable space in which to deliver group and one to one work has been identified and is on the HMP Berwyn Health, Wellbeing & Social Care Partnership Board Risk Register. A request for an Accommodation Review has been made through Partnership Board and a response is awaited. There are funding implications to fulfilling against this recommendation due to the current limitations in infrastructure therefore it can only be Partly Agreed.		Dec-19	Within deadline		
25/06/2019	OHMIP5	63	There should be a formal and robust procedure to follow up patients who miss medicine doses. (2.87)	Lead Pharmacist	All formal and robust procedure is being developed and will be communicated to all staff.	Medicines use reviews, have and are being carried out by pharmacists with patients at HMP Berwyn. They occur on an as and when needed basis with appointment ledgers set-up accordingly by the administration team. The reviews are undertaken from within the pharmacy's consultation room. The room offers a confidential space for pharmacists to help patient's get the most from their medicines and support their understanding of them. A wide range of printed materials are also available for patients in the room, these cover a number of the long-term conditions prevalent within the prison's population. Also available are devices to explain and demonstrate the administration of certain medicines such as new, complex inhalers.	Sep-19	Complete Within deadline	Closed	03/09/19

						Access to a pharmacist for a medicines use review is publicised to patients through a number of ways. Patient's can self-refer via a Unilink® application where in the FAQs, the service is described. Healthcare professionals can also refer a patient for a review. The service is also advertised when patients arrive at the induction health and wellbeing presentation.				
25/06/2019	OHMIP6	63	Pharmacists should carry out medicines use reviews with patients. (2.88)	Lead Pharmacist	All Residents have the opportunity to request an appointment with a Pharmacist using the Uni Link system and all On Site Pharmacists are fully involved in the Medicines Review Process. Resident Information surrounding Medication Review and Pharmacy Provision is being revised and improvements made.	BCUHB's procedure for the timely administration of medicines has been implemented at HMP Berwyn. It aims to ensure that critical medicines are not delayed or omitted without a clinical reason that has been discussed with a doctor or non-medical prescriber. Availability to such staff exists 24/7, through a GP virtual surgery in-hours and outside this the out of hours GP service provided by the same in-hours team with full remote access to clinical records. Adherence to this procedure is monitored by pharmacists conducting clinical checks on a minimum monthly basis on all medicines and electronic medication reviews by general practitioners every 3-6 months.	Sep-19	Within deadline		

25/06/2019	OHMIP7	64	Prisoners should have access to dental treatment within community-equivalent waiting times. (2.91)	Lead Dentist	.	The waiting list has been reviewed by the Lead Dentist and a decision was made by the Local Health Delivery Group to remove men who have less than 6 months to serve from the waiting list. Oral health promotion advice has been sent to these men along with leaflets being readily available for all men on oral health / hygiene. The Dental Therapist has commenced a toothbrush exchange programme which a number of men have attended.	Dec-19	Within deadline	Ongoing	

Report on an unannounced inspection of

HMP Berwyn

by HM Chief Inspector of Prisons

4–14 March 2019

This inspection was carried out with assistance from colleagues at the General Pharmaceutical Council and in partnership with the following bodies:

Arolygiaeth Ei Mawrhydi dros Addysg a Hyfforddiant yng Nghymru
Her Majesty's Inspectorate for Education and Training in Wales

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Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Introduction

This report records our first inspection of HMP Berwyn. Located near Wrexham in North Wales, Berwyn opened in 2017. It is the first prison to open under the management of the public sector for several years and will be the largest prison in the country. Designated a category C training prison, the establishment held 1,273 prisoners at the time of the inspection. They were held in three residential units, which in turn were subdivided in to a total of eight communities. In time the prison will be able to hold 2,106 prisoners, although we were told that currently numbers are capped to allow for the build up of staff as well as additional activity for prisoners.

Opening a new prison is a big challenge especially when that process is the subject, quite rightly, of significant public interest. The challenges can be practical, but they can also be cultural. The prison opened with a very clear rehabilitative vision which has faced resistance at times. The leadership team are still working hard to find and maintain the right balance between rehabilitation and security, freedom and control, and sanctions and reward. As this report will show, some mistakes have been made and we identify some important weaknesses, but we also acknowledge the great effort that has been made to give this prison a good start. The prison is generally ordered and settled, and when measured against our tests of a healthy prison we found Berwyn to be a reasonably respectful place. Against our other tests there was more to do.

Despite Berwyn being a Welsh prison, about 75% of those held were from England. Arrangements for the reception and induction of new arrivals were impressive and the clear majority felt safe on their first night. Our survey, however, revealed that about 23% of prisoners felt unsafe at the time we asked them; a figure comparable with other training prisons. Prisoner-on-prisoner assaults were lower than expected, but in contrast, prisoner on staff assaults were higher. Both measures seemed to be on a downward trajectory. Some work was being done to reduce violence. However, other than an interesting initiative on Glyndwr community aimed at supporting some challenging prisoners, delivery often lacked drive and needed to be implemented more effectively. We found, for example, 25 self-isolating prisoners who were completely unsupported. Schemes to incentivise good behaviour were similarly ineffective.

Use of force was higher than in similar prisons and incidents usually involved the full application of restraints. Oversight was satisfactory and new strategies to minimise the need for force were being developed. The environment and quality of supervision in the segregation unit was generally good, but the regime was limited. Security arrangements were proportionate and supported by good police liaison. Drugs had been too readily available, but actions by the prison to reduce drugs supply seemed to have had some impact, and the drug testing rate had reduced to 21.49%. This was, however, still too high and supply reduction initiatives required greater coordination and drive. There had been no self-inflicted deaths since the prison opened and self-harm was comparatively low, but arrangements to support and safeguard those who were vulnerable were not very good. Strategic leadership was weak, case management of those in crisis needed improvement and those at risk we spoke to did not feel well cared for.

Most staff at Berwyn were inexperienced but those we observed were doing their best and contributing to a relaxed and positive atmosphere. Many prisoners felt frustrated by staff inconsistency and uncertainty. We also observed some poor behaviour go unchallenged. The prison had, however, recognised the need to support staff with their attention to the basics of prisoner management. Formal consultation with prisoners, prisoner applications and formal complaints were delivered with similar inconsistency and reflected the staff's inexperience.

Except for poor toilet screens in double cells, the quality of accommodation and the general environment were very good. In-cell showers, telephones and access to amenities and equipment were all very positive. The prison had been successful in its aim to make such a large prison feel small. There was a real sense of community in most of the wings, and staff teams and prisoners spoke

of their 'community' rather than their 'wing'. The promotion of diversity and equality in contrast was poor, although health care provision was good overall.

Employed prisoners had reasonable time out of cell, but it was much worse for those without employment, who had about two and a half hours per day. During spot checks we found 28% of prisoners locked up during the working day, which for a new training prison was very disappointing. Routines were rarely curtailed, but often delayed, and not all staff and prisoners understood fully the requirements of the daily schedule or regime.

One of the greatest challenges facing the prison was the lack of activity places. It is difficult to understand how and why the procurement of work and training places for a new prison could be so delayed. Facing a rising population and too few activity places, prison managers had created a range of activities and there were sufficient places for the current population, but some were of inadequate quality and lacked challenge. Even those that were available were not fully used. Many prisoners were unemployed or failed to attend, and staff did too little to support a sound work ethic. In contrast, those attending education or vocational training generally received excellent teaching, made useful progress and achieved well. Our partners in Estyn assessed provision to be 'good' or 'excellent' in four of their measures and 'adequate and requiring improvement' in just leadership and management.

The prison was struggling to develop its approach to offender management and resettlement. The make up of the population was not as had been originally envisaged; there had been no assessment of the current need. Many prisoners were serving long sentences, presented a high risk of harm and too many prisoners did not have an up-to-date assessment of risk (OASys). Offender management caseloads were too high and case management was inconsistent and reactive. Public protection measures were similarly weak and the prison lacked sufficient offending behaviour interventions to meet the needs of the population. Work to resettle prisoners was better, but about half of those currently being released returned to England. At the time of the inspection resettlement support for these prisoners was due to end in April which was a concern.

At this inspection we met many managers and staff who were working hard to make a success of this new prison. Senior managers described themselves as 'being on a journey' and we saw lots of work, many policies and numerous plans. What was needed was better oversight, better coordination and more sustained delivery. The staff seemed to us to be a strength of the prison, but they needed support in delivering the basics consistently. We thought the prison had made a good start. We were impressed by the energy and optimism we observed and there was clearly the potential to move on rapidly. We hope that our encouragement to focus on the basics and the few recommendations we make will assist that process, and guide Berwyn to becoming an enduringly safe and rehabilitative prison.

Peter Clarke CVO OBE QPM May 2019
HM Chief Inspector of Prisons

Fact page

Task of the establishment
A category C training and resettlement establishment holding adult males.

Certified normal accommodation and operational capacity[1]
Prisoners held at the time of inspection: 1,273
Baseline certified normal capacity: 2,106
In-use certified normal capacity: 1,584
Operational capacity: 1,300 (currently capped at this number while awaiting more staffing and provision).

Notable features from this inspection

Only a quarter of the population were Welsh.

The prison's capacity was 2,106 prisoners but it held 1,273.

Just over three-quarters of the population were serving four years or more.

Almost half of prisoners said drugs were easily available.

Three-quarters of officers had been in service for less than two years and about a third for less than a year.

All cells had a shower, telephone and laptop computer.

Levels of self-harm were low for the type of prison.

Prison status (public or private) and key providers
Public

Physical health provider: Betsi Cadwaladr University Health Board
Mental health provider: Betsi Cadwaladr University Health Board
Substance misuse provider: Betsi Cadwaladr University Health Board
Learning and skills provider: Novus Cambria
Community rehabilitation company (CRC): Seetec Justice (Kent, Surrey and Sussex CRC)
Escort contractor: GEOAmey

Prison group
North Wales

Brief history
In 2014, permission was granted for a prison to be built in Wrexham, and Berwyn opened on 27 February 2017. Built on a former Firestone Tyre site, Berwyn (when full) is the largest prison in England and Wales and the second largest in Europe.

[1] Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Short description of residential units
There are three houses. Alwen, Bala and Ceiriog, each divided into eight communities that can accommodate up to 88 general population residents, including the following.

Alwen C Uppers	life-sentenced/indeterminate sentence for public protection
Alwen D Uppers	enhanced life-sentenced
Bala B Lowers	healthy living
Bala C Lowers	Glyndŵr: progressive unit
Bala D Lowers	Gobaith: resettlement unit
Bala B Uppers	Menai: assisted living
Bala C Uppers	Shaun Stocker: veterans and first-timers
Bala D Uppers	improving family futures
Ceiriog A Lowers	Snowdon: mature residents
Ceiriog D Lowers	induction and first night unit.
Ogwen	care and support (segregation) unit (up to 21 prisoners)

Name of governor and date in post
Danny Khan, October 2018

Independent Monitoring Board chair
Eileen Darbyshire

Date of last inspection
This was the prison's first inspection.

About this inspection and report

A1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

A2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests are:

Safety	Prisoners, particularly the most vulnerable, are held safely.
Respect	Prisoners are treated with respect for their human dignity.
Purposeful activity	Prisoners are able, and expected, to engage in activity that is likely to benefit them.
Rehabilitation and release planning	Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

A4 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

- **Outcomes for prisoners are good.**
  There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

- **Outcomes for prisoners are reasonably good.**
  There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

- **Outcomes for prisoners are not sufficiently good.**
  There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

- **Outcomes for prisoners are poor.**
  There is evidence that the outcomes for prisoners are seriously affected by current

practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

A5 Our assessments might result in one of the following:

- **recommendations**: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections

- **examples of good practice**: impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for prisoners.

A6 Five key sources of evidence are used by inspectors: observation; prisoner surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

A7 Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

A8 All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission, the General Pharmaceutical Council (GPhC) and HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

A9 This explanation of our approach is followed by a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons (Version 5, 2017)*.[2] The reference numbers at the end of some recommendations indicate that they are repeated, and provide the paragraph location of the previous recommendation in the last report. Section 5 collates all recommendations and examples of good practice arising from the inspection.

A10 Details of the inspection team and the prison population profile can be found in the appendices.

A11 Findings from the survey of prisoners and a detailed description of the survey methodology can be found in the final appendix of this report. Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant.[3]

2 https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/

3 The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Summary

S1 This was our first inspection of HMP Berwyn. As such, there were no previous recommendations for us to report progress on. In future inspections of Berwyn, we will report on outcomes for the recommendations made in this and the following reports.

Safety

S2 *Reception and early days arrangements were excellent; new arrivals were well informed and there was a suitable focus on risk. Levels of violence were slightly lower than in similar prisons but too many prisoners still felt unsafe and experienced violence. Violence and drug use had reduced recently, but there was no coordinated approach to drive and monitor actions. Self-isolating prisoners were poorly cared for. Use of force was very high and opportunities to de-escalate incidents were missed. Security arrangements were good and the prison felt well ordered. Drugs were too easily available and psychoactive substances in particular posed a threat. Levels of self-harm were relatively low but the care of prisoners at risk of self-harm required improvement.* ***Outcomes for prisoners were not sufficiently good against this healthy prison test.***

S3 Support for new arrivals during their early days was impressive. Reception was clean, bright, calm and welcoming. There was good support for new arrivals from peer workers, and reception staff were friendly and efficient. All new arrivals received a first night interview in private, which focused well on risks and vulnerabilities.

S4 In our survey, 87% of prisoners said they felt safe on their first night, and our findings supported this view. First-night accommodation was well equipped and clean, and staff carried out enhanced checks on new arrivals. Induction was well coordinated and comprehensive. Prisoners' time during induction was spent purposefully.

S5 In our survey, 23% of prisoners said they currently felt unsafe, which was similar to other category C prisons. Assaults on prisoners were lower than in similar prisons, but the rate of assaults on staff was higher. There were signs that both were gradually reducing. Although information was gathered to understand the pattern of violence in the prison, there was no analysis of its causes, and no violent incidents had been investigated in the previous three months. The violence reduction strategy did not address the prison's specific issues, and there was no associated plan to drive and monitor actions to reduce violence and make the prison safer. The challenge, support and intervention plan (CSIP)[4] casework model to support victims and address violent behaviour was poorly understood and not yet operating effectively. The Glyndŵr progressive community provided a good intervention for more challenging prisoners. Prisoner violence reduction representatives offered potentially useful support through mediation between prisoners and contact with self- isolating prisoners, but they had not been trained, were unpaid and lacked oversight.

S6 At the time of the inspection, 25 prisoners were isolating themselves in their cells, some for up to 10 months. Their managerial oversight was inadequate, they were not supported

[4] Challenge, support and intervention plan (CSIP) is a system used by some prisons to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners who are identified as the perpetrator of serious or repeated violence, or who are vulnerable due to being the victim of violence or bullying behaviour, are managed and supported on a plan with individualised targets and regular reviews.

and they spent most of their time locked up without meaningful contact from staff. They told us they had difficulties in getting their meals and opportunities to exercise safely outside.

S7 The rewards and responsibility scheme was not working effectively and did not incentivise good behaviour.

S8 The number of adjudications was slightly lower than in similar prisons. Nevertheless, some could have been dealt with more informally through the rewards and responsibility scheme. There was insufficient oversight of the adjudication process. Too many adjudications were remanded, and some were outstanding from 2018. This undermined the challenge of poor behaviour.

S9 Use of force was far higher than we see for similar prisons but was slowly reducing. Full control and restraint was used in 90% of cases, and the records showed that opportunities for de-escalation were often missed. The monthly use of force meeting provided managerial oversight, and analysed the reasons and locations of incidents well. A helpful restraint minimisation strategy had been developed but not yet implemented.

S10 Reintegration planning for segregated prisoners was not well developed, but most returned to normal location following segregation. The segregation unit was bright and clean, but the regime was too restricted and not aligned to prisoners' behaviour Relationships between staff and prisoners in the unit were good.

S11 Security procedures were broadly proportionate for a category C prison. The security meeting was effective, supported by an excellent flow of information from across the prison, and gave attention to the known and emerging risks. While there had been a substantial number of individual disciplinary incidents during the previous six months, most had been low level, there had been no recorded incidents of concerted indiscipline, and the prison felt well ordered. The prison's police information officers provided good support, and there was an appropriate focus on the risks posed by staff corruption, extremism and the high number of prisoners from organised crime groups.

S12 Drugs were too readily available. In our survey, 48% of prisoners said that drugs were easy to get. A substantial number of health emergencies were related to psychoactive substances,[5] and one death in custody had been attributed to their use. The prison had taken a wide range of actions to address drug supply and demand, and there was evidence that drug availability was reducing. The number of drug finds had declined, and in the year to the inspection, the mandatory drug testing positive rate had reduced to 21.49%, although this was high for the type of prison. The substance use strategy was weak and not supported by a plan to coordinate, drive and measure the effectiveness of actions taken.

S13 There had been no self-inflicted deaths since the prison opened. Levels of self-harm were below those of other category C prisons. The strategic management of suicide and self-harm required improvement. Strategic meetings were poorly attended and too little was done to analyse, understand and take action to address the causes of self-harm. Most of the at-risk prisoners on assessment, care in custody and teamwork (ACCT) case management did not feel sufficiently cared for. ACCT documents required improvement, and initial assessments and care plans were weak. Quality assurance was in place but had not addressed these issues. There were sufficient Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) but prisoners had limited access to them overnight.

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[5] Drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and may have unpredictable and life-threatening effects.

S14 The prison had a safeguarding adults policy but it was out of date, and many staff were unaware of how to raise a safeguarding concern.

Respect

S15 Staff treated prisoners with respect, but they failed to challenge some low-level poor behaviour and their inexperience affected many areas of prison life. Prisoners had very good living conditions and access to basic essentials. Prisoner consultation arrangements were weak, and applications and complaints were not managed well enough. The food was good. The management and oversight of equality work was weak. Faith provision was sound. The quality of health care was very good overall. ***Outcomes for prisoners were reasonably good against this healthy prison test.***

S16 At the time of the inspection, 77% of officers had less than two years' service, and about a third had less than one year. This inexperience had presented significant practical challenges to Berwyn's aim to create a rehabilitative culture. The prison had recognised the need to refocus staff on the basics of security and behaviour management, while preserving its ethos. Staff were committed and treated prisoners with respect. We observed some good interactions with prisoners, and this contributed to the relaxed atmosphere in communities. However, staff inexperience was having an adverse impact on many aspects of prison life and causing considerable frustration for prisoners. We saw some low-level poor behaviour go unchallenged by staff.

S17 The prison provided very good, decent living conditions. Outside areas were reasonably tidy and communal areas were bright and clean. Cells were clean and generally very well equipped, including provision of in-cell showers, telephones and laptop computers – which enabled prisoners to have some control over their day-to-day needs. Most prisoners shared double cells, and there was inadequate screening of shared toilet/shower facilities. Prisoners had good access to cleaning materials, clean clothing and bedding. The monitoring of cell call bells showed that most were answered promptly.

S18 The food was good, and serveries were clean and well supervised. There was effective consultation of prisoners about the food, and actions were taken promptly when issues were raised. Prisoners could spend up to £250 of their money on shop items, creating risks that were not being managed.

S19 Consultation on general community and residential matters was inconsistent. Too many consultation meetings did not take place, and some actions were repeatedly carried over. Prison-wide consultation meetings had just been introduced, which was a helpful development.

S20 The quality of many responses to applications was poor and reflected staff inexperience. Responses to complaints were generally reasonable, but too many were late and some complaints had not been responded to at all.

S21 The leadership and strategic oversight of equality work was weak. Action planning and analysis of data were insufficient. Prisoners lacked confidence in the discrimination complaints process, and the discrimination incident reporting forms we looked at did not show evidence of thorough investigations. There was limited consultation of prisoners with protected characteristics, and there was little involvement from community groups specialising in equality and diversity work. The lack of consultation left the prison poorly placed to offer appropriate support to these groups.

S22 Around 20% of the population was identified as black or minority ethnic. These prisoners reported to us, and our survey showed, little disproportionality in treatment compared with white prisoners. There were major gaps in the provision for prisoners with disabilities. Prisoners who were employed to care for these prisoners were untrained and unsupervised, which raised the risk of exploitation. The veterans' unit was a good environment, and prisoners valued the fact that they could have regular contact with external forces charities. The chaplaincy provided a valuable service and was well integrated into the prison. Good pastoral and resettlement support was available.

S23 The quality and governance of the integrated health provision was very good overall. Clinical environments were clean and well used to meet the needs of the population. A wide range of primary care services were available, and waiting times for these were acceptable. More community-based nurse-led clinics and provision for prisoners with long-term conditions were being developed. The oversight of social care was inadequate, and there were delays in accessing equipment and adaptations for some prisoners. Mental health services were good, providing a wide range of relevant evidence-based therapeutic interventions. The integrated substance use service was good, and provision was responsive and patient-centred. The pharmacy provision was developed. The robust medicines management process was clinically sound, but it was unpopular with some prisoners. The quality of dental care was good but the 42-week waiting time for routine care was excessive.

Purposeful activity

S24 Time unlocked was reasonably good for employed prisoners but poor for others. Too many prisoners were locked up during the working day. The regime was predictable and mostly ran to time. Library and PE facilities were good but attendance was not monitored effectively. There were sufficient activity places for the current population but the range of education, training and work did not yet meet the needs of prisoners. Many jobs lacked purpose, and too many prisoners were unemployed or failed to attend their allocated activity. The quality of teaching and learning was excellent, and prisoners who attended generally made effective progress and achieved well.
Outcomes for prisoners were not sufficiently good against this healthy prison test.

S25 Fully employed prisoners had a reasonable amount of time unlocked, but for the substantial number who were unemployed, and particularly for those self-isolating, it was poor. Unplanned regime curtailments were rare, but there was some slippage. Routine delays in medicines administration meant that some prisoners could be up to an hour late for activities. In our spot checks, we found approximately 28% of prisoners locked up during the core day, which was too high for a training prison.

S26 The library provided a welcoming environment but the promotion of literacy was underdeveloped. Gym facilities were very good. Prisoners could achieve a range of higher qualifications, and provision for physiotherapy was excellent. Neither the gym or library analysed attendance to understand use and drive improvement.

S27 The standard of education, training and work was good. In vocational workshops and in education sessions, prisoners made effective progress towards their learning goals. Prisoners' success rates were good overall, although a few groups were underperforming. Learners were clear about what they have achieved and knew what they needed to do to make further progress. Most learners made strong progress in literacy and numeracy, and a few made progress in developing digital skills. Coursework and practical work were completed to a high standard, and demonstrated improvement over time.

S28 Prisoners in education, training and work behaved very well, participated well in sessions, were motivated to learn and were respectful to staff and each other. Nearly all prisoners worked well together and supported each other in their learning. Peer mentors gained confidence and self-esteem through helping others.

S29 Most learners who attended sessions regularly completed their courses successfully. However, too many did not attend regularly enough. Learners took pride in their work and understood how they were improving their employability. Several programmes helped prisoners develop awareness of healthy living, such as street football and food preparation. Art, music, digital skills and other creative courses helped with their emotional well-being.

S30 The quality of teaching and learning was excellent. In nearly all classes, teachers used a broad range of skills tailored to individuals' learning needs. Many teachers and tutors inspired prisoners to achieve, express emotions and develop new skills. Teachers and peer mentors worked very well together to give prisoners individual support. Sessions were planned well, and learners were assessed effectively and given constructive feedback, which motivated them to progress further. Teachers and tutors monitored and tracked prisoners' skills and qualification achievements well. The range and level of qualifications offered broadly met prisoners' needs.

S31 Induction to education was very thorough in assessing prisoners' needs, recognising their prior achievements and helping them choose the opportunities that best suited their long-term plans. Early access to careers advice helped new arrivals to make informed decisions about the options available. Prisoners with additional learning needs were identified at induction then referred to specialist support services.

S32 All courses were aimed at giving prisoners the skills they needed to progress to higher learning or to work and thrive beyond the gates. A recent employment fair had increased their awareness of employment opportunities. The prison had developed many effective partnerships to help prisoners gain skills and improve their experience and employability.

S33 The leadership and management of education, skills and work required improvement. Since the prison opened, the range of education, training and work had not met the needs of the population. Provision had been modified, and some useful and creative contingency arrangements had been put in place to occupy prisoners.

S34 There were enough activity places for the current population, although some were insufficiently challenging and did not keep prisoners occupied or develop a sound work ethic. Activity places were not fully used. A substantial number of prisoners were unemployed, and many who were allocated to an activity failed to attend. Staff did not do enough to challenge those who chose not to participate. Only two-thirds of prisoners engaged in activities during the working day.

S35 The education and training self-assessment report identified key strengths and areas for improvement. The development plan did not make clear the criteria by which success would be judged. Education facilities were well equipped, and staff had good access to training. There was no effective strategy to promote the Welsh language.

Rehabilitation and release planning

S36 *Prisoners were given excellent support to maintain family ties. The strategic management of reducing reoffending was underdeveloped. Too many prisoners did not have an up-to-date offender assessment system (OASys) assessment. The quality of offender management was variable. Prison offender manager contact with prisoners was too inconsistent to drive sentence progression. Too many prisoners were released late on home detention curfew (HDC). Public protection arrangements were weak. There were too few offending behaviour programmes to meet prisoner need. Planning for prisoners' release was timely and they could currently access good support with housing, and finance, benefit, debt issues.* ***Outcomes for prisoners were not sufficiently good against this healthy prison test.***

S37 There were excellent support services and courses to help prisoners build and maintain relationships with their families. The visitors' centre and visits hall were welcoming. Prisoners on visits could buy items from the shop for their families and supervise their children in the play area, which they valued. There was too little visits provision at weekends. Staff did not collect prisoners' incoming mail regularly, which caused significant delays in them receiving their post.

S38 The prison had struggled to plan work to reduce reoffending effectively. Its location, a mix of prisoners that was not as originally intended, and a lack of clarity about the future make-up of the population presented major challenges. There was no comprehensive analysis of the current population's needs to inform provision and future direction. About three-quarters of the population were serving long sentences and 40% were assessed as high risk. Forty-three per cent of the population had been at Berwyn for less than six months, and around three-quarters were from England.

S39 Too many prisoners did not have an up-to-date OASys assessment of their risk and needs. This had a direct impact on their access to offending behaviour programmes and progression. Prison offender manager caseloads were high, and their contact with prisoners was reactive and too inconsistent to drive sentence progression effectively. The quality of offender management was variable, and in half the cases we checked it was insufficient. The latest HDC processes had not been introduced effectively, and too many eligible prisoners were released late. There had been some good work to assess the needs of prisoners on indeterminate sentence for public protection (IPP) held beyond their sentence tariff, but there was not yet adequate provision to help this group.

S40 Public protection arrangements were weak. Almost half of all prisoners due for release in the following three months were assessed as high risk, but the inter-departmental risk management meeting did not systematically consider this group to provide assurance that their risks would be properly managed. There were efforts to confirm prisoners' multi-agency public protection arrangements (MAPPA) management levels before their release. Arrangements to conduct and review telephone monitoring of prisoners were ineffective and potentially placed the public at risk.

S41 Recategorisation reviews were frequently late, and too many category D prisoners did not move promptly to open prisons, often due to the lack of spaces nationally.

S42 There were not enough offending behaviour programmes to meet the needs of the population, with only enough places in the coming year for about a third of prisoners who met the criteria for treatment. There were some short-term interventions to help prisoners address their attitudes, thinking and behaviour. The prison had introduced

release on temporary licence (ROTL) for a few category D prisoners. ROTL processes had improved but still needed to be more robust.

S43 On average, 40 prisoners a month were released from Berwyn. Around half were released to Wales and half to England. At the time of the inspection, St Giles Trust offered all prisoners very good, timely support to address their resettlements needs. However, this would cease for prisoners released to England from April 2019, and there was no realistic plan to address the resettlement needs of these prisoners, which was a significant gap. At the time of the inspection, all prisoners received support to find accommodation on release and open bank accounts.

Main concerns and recommendations

S44 Concern: Strategic management of violence reduction was weak. The prison did not analyse information gathered about violent behaviour to understand the causes, and violent incidents had not been investigated for the previous three months. The prison had no action plan to tackle the causes of violence and monitor this for its effectiveness in reducing violence.

Recommendation: **The prison should develop a strategy to reduce violence based on an analysis of the causes of violence, supported by an action plan to drive and monitor a reduction in violent incidents.**

S45 Concern: At the time of the inspection, 25 prisoners were isolating themselves in their cells, some for many months. Some told us they had little contact with staff, and there had been difficulties in getting their meals and the opportunity to exercise safely outside. The prison had not addressed the reasons for them self- isolating, and there were no plans to resolve the issues affecting their safety.

Recommendation: Prisoners who are self-isolating should have their basic needs for food, hygiene, social contact and fresh air are met. A plan to work towards ending their isolation should be agreed with them and regularly reviewed.

S46 Concern: Drugs were too readily available. Although there was a range of measures to reduce drug supply and demand, the prison did not routinely measure actions to assess their effectiveness and they were not yet reducing drug availability sufficiently.

Recommendation: **The prison should continue its focus on drug supply and demand reduction, but should better coordinate and embed actions to reduce the availability and demand for drugs, and measure their impact.**

S47 Concern: Staff inexperience was having a negative impact on many aspects of prison life. There was inconsistency in the application of rules, some low-level poor behaviour went unchallenged, and staff could struggle to answer even basic questions from prisoners. Prisoners told us this caused them considerable frustration, which was also evident in our review of prison applications and complaints and in ACCT documentation.

Recommendation: Prisoners should be supported and managed effectively by a responsive and capable staff group.

S48 Concern: The strategic leadership of equality work was weak and this area was not promoted sufficiently. There was limited consultation with prisoners in most protected characteristics groups, which left the prison poorly placed to identify potential concerns.

Recommendation: Senior leaders should promote the importance of equality work in the prison. There should be a robust strategy and oversight of equality work, informed by routine consultation, to identify and address the needs of prisoners in protected characteristics groups.

S49 Concern: The balance of education, training and work places did not meet the needs of the population; too many work places were insufficiently challenging and did not keep prisoners occupied.

Recommendation: The balance and range of education, training and work places should reflect the needs of the population, keep prisoners occupied and be sufficiently challenging.

S50 Concern: Despite sufficient activity places, a substantial number of prisoners were unemployed or failed to attend their allocated education, training or work place. Staff did not do enough to challenge those who chose not to participate.

Recommendation: All eligible prisoners should be allocated to an education, training or work placement, and should be encouraged and expected to attend.

S51 Concern: Many prisoners were high risk and/or serving long sentences. Too many eligible prisoners did not have an up-to-date assessment that identified their risks and needs. The lack of current assessment directly affected prisoner access to offending behaviour programmes and their ability to progress to open conditions.

Recommendation: All eligible prisoners should have an up-to-date assessment that identifies their risks and needs.

S52 Concern: Prison offender manager caseloads were high, and contact with prisoners was reactive and too inconsistent to drive their sentence progression effectively.

Recommendation: Prison offender managers should have regular, good quality contact with prisoners, which drives their risk reduction and sentence progression.

S53 Concern: Public protection measures were weak. Arrangements to conduct and review telephone monitoring were ineffective and potentially placed the public at risk. The interdepartmental risk management meeting did not consider all high-risk releases systematically to provide assurance that their risks would be managed.

Recommendation: Public protection procedures should be given urgent and sustained attention to ensure that prisoners' risks, both in custody and on release, are managed effectively.

S54 Concern: About 40 prisoners a month were released - about half to Wales and half to England. There was no realistic plan to address the resettlement needs of prisoners to be released to England from April 2019.

Recommendation: All prisoners released from Berwyn should receive support to review and address their resettlement needs.

Section 1. Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes:
Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

1.1 The prisoner escort vehicles were reasonably clean, free of graffiti and well equipped. Prisoners were disembarked promptly from vehicles on arrival; they were routinely handcuffed when moved to reception. Escort and reception staff communicated well and there was an effective handover of information to inform initial risk assessments.

1.2 The reception was clean, calm and welcoming, and support for new arrivals was impressive. Holding areas were not routinely locked and prisoners could move freely, which created a relaxed atmosphere. Reading materials and up-to-date information were readily available. All arrivals were offered hot drinks and food, and were welcomed by friendly and efficient staff and peer workers. In our survey, 90% of prisoners said they were treated well in reception.

1.3 First night staff interviewed arrivals in private and identified their immediate needs, risks and vulnerabilities effectively. First night processes were streamlined and well coordinated. Searching was appropriate and prisoners' property was logged in front of them and returned promptly for their first night. All new arrivals were supported by staff and peer workers to access first night essentials and, positively, they had the opportunity to purchase some items from the prison shop.

1.4 First night arrangements were good and 87% of prisoners in our survey said they felt safe on their first night, which was significantly more than the comparator. Arrivals were taken to the dedicated first night centre. Staff and peer workers on the centre actively engaged with prisoners to meet their practical and welfare needs. First night cells were clean and contained essential items. In our survey, 85% of prisoners said their cell was clean on their first night, significantly more than the comparator of 36%. All prisoners could have a shower and make a telephone call on their first night. There were effective shift handovers with night staff, and additional welfare checks of new arrivals during the night.

1.5 The 'Welcome Week' induction began the day after arrival, lasted up to six consecutive days and was purposeful. As well as delivery by officers, on the first morning peer workers, under the oversight of staff, presented a comprehensive, interactive and useful overview of relevant information about prison services, the daily regime and life at Berwyn. The timetable was well coordinated and enabled prisoners to meet key staff through structured individual or small group meetings. Prisoners were inducted into use of the prison-issue laptop computer, through which they could manage their finances, applications, book visits and undertake enrichment activities. Induction sessions were rarely delayed or cancelled, and the use of an 'induction passport' was an effective tracking system to ensure all prisoners attended all aspects of their induction.

Good practice

1.6 *All new arrivals were welcomed into a relaxed and supportive environment in reception. The dedicated first night centre provided a safe place for prisoners to settle in. The comprehensive and well-coordinated induction occupied prisoners purposefully during their early days.*

Managing behaviour

Expected outcomes:
Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

1.7 Prisoner-on-prisoner assaults in the previous six months were lower than in other category C prisons, although assaults on staff were much higher. In our survey, 23% of prisoners said they currently felt unsafe, which was similar to other category C prisons. Prison Service data indicated a gradually reducing trend in assaults overall.

1.8 The strategic management of violence was weak. While detailed information about the location and type of violence was well collated, there was not enough analysis of its causes. The safer custody team had been poorly resourced and no incidents of violence had been investigated in the previous three months. A generic violence reduction strategy set out developmental objectives but there was no prison-specific action plan to reduce violence and make the prison safer. (See main recommendation S44.)

1.9 The prison had introduced challenge, support and intervention plans (CSIP)[6] to support prisoners who felt unsafe and to challenge perpetrators. The plans we examined had been poorly completed, and staff had limited understanding of their purpose and operation. The use of CSIP was overseen by a weekly multidisciplinary safety interventions meeting designed to provide cross-departmental planning to meet the needs of the most challenging prisoners. This meeting had not been effective in ensuring that planned outcomes were delivered, but it was being restructured to involve operational staff and hold them accountable.

1.10 At the time of the inspection, there were 25 prisoners who would not leave their cells, mostly due to fears for their safety. Some had self-isolated for up to 10 months, and some told us they could not exercise outside safely and had difficulties getting meals. Staff had inadequate contact with these prisoners, and there was no systematic process to ensure that their day-to-day needs for human contact, fresh air or access to a regime were met. There were no regularly reviewed reintegration plans to address the causes of their isolation or plan for their return into the main prison community. (See main recommendation S45.)

1.11 There were prisoner violence reduction representatives on each community who told us that they mediated between prisoners in conflict and tried to maintain contact with those who had self-isolated. Their role had not been properly defined or developed and they lacked training, a detailed job description or regular meetings with safer custody officers.

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[6] Challenge, Support and Intervention Plan (CSIP) is a system used by some prisons to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners who are identified as the perpetrator of serious or repeated violence, or who are vulnerable due to being the victim of violence or bullying behaviour, are managed and supported on a plan with individualised targets and regular reviews.

1.12 The Glyndŵr progressive community was a well-constructed intervention targeted at challenging prisoners who presented the greatest risk of violent behaviour. Residents undertook a 10-week programme of constructive activity, individual programmes and groupwork informed by forensic psychologists before planned reintegration to the main communities.

1.13 The rewards and responsibility scheme was not working effectively. The scheme was not yet well implemented, and was applied inconsistently, largely due to the inexperience of staff (see main recommendation S47). In our survey, only 40% of prisoners felt they had been treated fairly under the scheme. Prisoners were not always warned of formal warnings. Too many reviews of prisoners on the basic level were late, or did not taken place at all. There were not enough individual targets to improve behaviour. Some prisoners were left on the basic level for far too long, without effective intervention to address their behaviour. In particular, there was insufficient management of prisoners who refused to attend work, education, or training (see main recommendation S50). The quality assurance arrangements for the scheme were not yet embedded. In our survey, only 41% of prisoners said the scheme encouraged good behaviour. The prison was beginning to consult prisoners about the best ways they could incentivise good behaviour.

Recommendations

1.14 Challenge, support and intervention plans (CSIP) should be used effectively to address violent behaviour and support victims.

1.15 The rewards and responsibility scheme should incentivise prisoners to take responsibility and behave well, and provide effective and timely sanctions for poor behaviour.

Good practice

1.16 *The Glyndŵr progressive community was a well-planned and targeted facility to address violent behaviour by prisoners presenting the greatest risk.*

Adjudications

1.17 There had been 2,046 adjudications in the previous six months, slightly lower than we see in similar prisons. Some could have been dealt with more informally through the rewards and responsibility scheme, which again reflected the inexperience of some staff (see main recommendation S47). The prison had recognised this problem and was seeking to address it, and the number of adjudications had been falling in recent months.

1.18 There was insufficient oversight of the adjudication process. Monthly adjudication meetings were poorly attended and none had taken place since November 2018. When they did meet, they considered a range of data, and there was evidence that they had identified and addressed some key problems with the process.

1.19 There were 346 remanded adjudications at the time of the inspection, which was too many; 163 of these had been outstanding since 2018. Inefficiencies in the process also meant that 16% of adjudications had not been proceeded with. These problems undermined the effectiveness of challenging poor prisoner behaviour.

Recommendation

1.20 There should be effective governance of the adjudications process to ensure it provides active challenge to poor behaviour.

Use of force

1.21 In the previous six months there had been 574 use of force incidents, far higher what we see in similar prisons. In our survey, 22% of prisoners said they had been physically restrained by staff, significantly more than the 13% comparator. Recorded use of batons in the previous six months was also comparatively high.

1.22 Prison records indicated that 90% of incidents involved full control and restraint. The use of force records we reviewed showed too many missed opportunities to de-escalate situations. The use of handcuffs was high, mostly justified because prisoners had to be taken across large open areas to the segregation unit. Prison Service data showed that the use of force was reducing, and managers told us they believed this was due to increasing confidence among newer staff and a more stable prisoner population.

1.23 There was good oversight of the use of force by a monthly meeting. Incidents were mapped by time, reasons and location to identify patterns and agree action. A new use of force coordinator was developing a robust process to provide feedback and training in relevant practice. The prison was also introducing a potentially useful restraint minimisation strategy, which detailed de-escalation methods.

Recommendation

1.24 Full control and restraint and use of batons should be kept to a minimum through application of de-escalation techniques wherever possible.

Segregation

1.25 In the previous six months, 204 prisoners had been segregated, a similar rate as other category C establishments. At the beginning of the inspection, 17 prisoners were segregated and four had been in the segregation unit for more than a month. Those who had been in the unit for lengthy periods had been recategorised and were waiting a transfer or refusing to leave the unit. Most prisoners only stayed in the unit for a short time, with an average of nine days in the previous two months. Although formal reintegration planning through segregation reviews was not well developed, we observed informal discussions with residents who had been refusing to leave that resulted in their return to the main communities. In the previous two months, only two prisoners had been transferred to other establishments and 21 had returned to the main prison communities.

1.26 Living conditions in the segregation unit were good. It was clean and bright with in-cell showers, and a small library and radios were available. Exercise areas were large with open views. Relationships between unit staff and prisoners were good.

1.27 The regime was too limited. Beyond daily access to telephones and outdoor exercise, prisoners were locked up all day and could not exercise together (subject to a risk assessment) or use prison facilities such as the library or gym. The televisions and communal dining provided when the unit opened had been withdrawn due to disruptive behaviour, but no improved regime was offered to individual prisoners who had demonstrated compliance.

Recommendation

1.28 Segregated prisoners should have access to a regime appropriate to their risk and behaviour.

Security

Expected outcomes:
Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance misuse and effective drug supply reduction measures are in place.

1.29 Following a recent security audit, a range of actions had been taken to improve security arrangements and we found security procedures were broadly proportionate for the type of prison. The prisoner movement we observed around the site was well managed and not unduly restricted, and visits restrictions were imposed correctly in response to trafficking activity.

1.30 The monthly security meeting was effective and focused on known and emerging threats to the prison. It identified actions to address and offset these, which were allocated and followed up. There was also support by the team of police information and support officers, and a focus on the risks posed by organised crime groups and extremism.

1.31 A very good flow of security information was received from across the prison and efficiently processed by the intelligence team. Although there had been a large number of recorded disciplinary incidents in the previous six months, most had been low level and there were no recorded incidents of concerted indiscipline, and the prison was well ordered.

1.32 Drugs, violence and individual procedural security failures were the most prevalent topics in the intelligence reports received. There were direct correlations between the peaks in procedural security failures and the entry of high numbers of newly recruited staff. The prison had responded to this pattern by increased mentoring and security training. It had also focused strongly on preventing corruption by targeted awareness training of the dangers posed by experienced and manipulative prisoners.

1.33 In our survey, almost half of all prisoners said that it was easy to get drugs at Berwyn. Almost one in four said they had developed a drug problem while at the prison. The prison took a wide range of actions to meet these threats, such as intelligence-led searching and drug testing, out-of-hours searches, use of drug testing technology and drug detection dogs, and information sharing with local and regional police forces.

1.34 A reduction in the number of drug finds, a reducing mandatory drug testing (MDT) random positive rate and fewer referrals to the prison's drug treatment team provided some evidence that drug availability was reducing, but drugs remained too readily available. The misuse of psychoactive substances[7] continued to result in a substantial number of health emergencies, and one death had been attributed to their use in the previous year. (See main recommendation S46.) The prison had produced excellent prisoner information videos on the dangers and effects of these substances.

[7] Drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines and may have unpredictable and life-threatening effects.

1.35 MDT was well managed. The team of testers had recently been increased to ensure consistency of testing and to meet the demand for suspicion testing, as fewer than 30% of requested tests had been completed. Random testing was carried out throughout the month and the positive rate for all drugs had fallen steadily throughout the year to 21.49%, although this was high for a category C prison.

1.36 The substance misuse strategy was weak and predominantly treatment-focused. There was no dynamic regularly monitored action plan to measure the effectiveness of actions taken. (See main recommendation S46.)

Recommendation

1.37 The prison should ensure that, where practicable, all intelligence-led drug testing takes place.

Safeguarding

Expected outcomes:
The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

1.38 In the previous six months, there had been 248 self-harm incidents carried out by 163 prisoners, which was fewer than in other category C prisons. There were investigations into near-fatal incidents of self-harm and the sharing of practice and lessons learned.

1.39 The strategic management of suicide and self-harm was underdeveloped. Strategic safer communities' meetings were poorly attended. The safer communities' strategy was out of date, and there were no current analysed data to identify trends and patterns of behaviour and lead an effective action plan.

1.40 There was no consistent recording of the causes of self-harm. Prisoners and staff attributed some cases of self-harm to frustrations with the medicines management regime, debt and the prison's lack of responses to day-to-day requests.

1.41 A weekly safer interventions meeting (see paragraph 1.9) was attended by staff and Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) but it did not always follow up actions promptly or discuss systematically the care for the more complex prisoners on assessment, care in custody and teamwork (ACCT) case management.

1.42 There had been 446 ACCTs opened in the previous six months, which was high for the type of prison. Most prisoners on an open ACCT said they did not feel sufficiently cared for. The quality of ACCT documents was variable and often not good enough. Initial assessments did not always translate into the delivery of care, triggers that could increase the risk of suicide and self-harm were not always identified, case reviews not always carried out and actions in care plans were weak and not always followed through robustly. The quality assurance measures had not addressed these specific issues.

1.43 There were sufficient Listeners for the size of the population. Although there were Listener suites on each community, they were often used for storage rather than the purpose designed for. Prisoners had limited access to Listeners during the night; only 15 had seen a Listener at night during 2018. Night staff often told prisoners to use their in-cell telephones to call the Samaritans instead.

Recommendations

1.44 The prison should record and analyse the causes of self-harm incidents, and use this material to inform the strategic management of safeguarding and suicide and self-harm prevention.

1.45 Assessment, care in custody and teamwork (ACCT) casework management documentation should be of a consistently good quality. Care maps for individual prisoners should identify objectives to address their risk of self-harm and ensure they receive the necessary care and support.

Protection of adults at risk[8]

1.46 The prison had developed a safeguarding adults policy but it was out of date. A nominated manager was responsible for protecting adults at risk, and attended the Wrexham Safeguarding Adults Board. There was a procedure for making safeguarding referrals and one referral had been made in the previous six months, but staff were generally unaware of how to raise a concern or make a referral to the local authority.

Recommendation

1.47 All staff should understand their adult safeguarding responsibilities.

[8] Safeguarding duties apply to an adult who:
- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Section 2. Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

Expected outcomes:
Prisoners are treated with respect by staff throughout their time in custody, and are encouraged to take responsibility for their own actions and decisions.

2.1 At the time of the inspection, 77% of officers had less than two years' service and about a third had less than one year. There were 21 supervising officers who were temporarily promoted. This inexperience had presented significant practical challenges to the prison's founding aim to create a rehabilitative culture. However, it had recognised the need to re-focus staff on the basics of security and behaviour management, while preserving its ethos.

2.2 In our survey, 64% of prisoners said staff treated them with respect, which was similar to other category C prisons. We observed a staff group who were committed to treating prisoners well and some good staff interactions with prisoners, which contributed to the relaxed atmosphere in the prison.

2.3 Despite this, the lack of staff experience was having an adverse effect on many aspects of prison life. Some staff struggled to answer prisoners' basic questions. As one prisoner in our survey commented: 'The staff need to be a lot more experience as most of them have never been in prison before and haven't got a clue how to deal with prisoners.' Staff were inconsistent in the application of rules, and we saw some low-level poor behaviour by prisoners go unchallenged. Prisoners told us this caused considerable frustration, which was also evident in our review of prison applications, complaints and in at-risk case management documentation. (See main recommendation S47.)

2.4 At the time of the inspection, less than half of prisoners had a keyworker, as introduced under the new offender management in custody (OMiC) model (see footnote 10). Most (around three-quarters) weekly keyworker meetings went ahead. The record of some meetings lacked detail and were superficial, although some notes showed helpful engagement from keyworkers.

Daily life

Expected outcomes:
Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

2.5 The prison provided very good, decent living conditions. Outside areas were reasonably tidy, and communal areas were bright, clean and well decorated (see Appendix III: Photographs). In our survey, 69% of prisoners said the communal areas of their wing was normally clean, against the comparator of 59%. One prisoner commented: 'The most positive thing here at

Berwyn is how clean the living spaces are.' The prison made good use of Welsh-themed imagery to create a community feel, and in some specialist communities, such as the one for veterans, there had been efforts to personalise the environment with murals. (See Appendix III: Photographs.)

2.6 There were some problems with the fabric of the building, with peeling paint in some areas, and unreliable hot water and heating systems. The prison was managing these issues while seeking a solution with the building contractors.

2.7 Cells were clean, generally in reasonable decoration and very well equipped, and all had showers. They included in-cell telephones and laptop computers, which enabled prisoners to have some control over their day-to-day needs (see also paragraph 1.5). Over two-thirds of cells were shared and were cramped, as they could not easily accommodate furniture for two people. Toilets had no seats and many had no covers, and toilets and showers were inadequately screened. (See Appendix III: Photographs.)

2.8 Prisoners had access to cleaning materials, clean clothing and bedding. Community laundries were left unlocked, and some prisoners complained this led to some clothes going missing and misuse of laundry equipment.

2.9 In our survey only 21% of prisoners said they could access their stored property if they needed it. Data on applications in the previous six months showed there had been a significant delay in responses to property applications. The prison had introduced measures to address this, and there was no backlog of applications at the time of the inspection

2.10 Response times to cell call bells were monitored and showed the most were answered promptly.

Residential services

2.11 Prisoners were offered a wide choice of food, including cultural, religious and medical diets, and chose their meals from a four-week rolling menu through their in-cell laptops. Prisoners could have two hot meals a day, but breakfast packs were given out the night before and were often eaten before the morning. In our survey, 48% of prisoners said the quality of food in the prison was good, which was similar to other category C prisons.

2.12 There was effective consultation with prisoners about the food, with regular surveys through in-cell laptops. We saw good staff supervision of meal times, with clean serveries, and prisoners had the opportunity to eat out of their cell.

2.13 New arrivals could spend or have an advance of £25.50 to spend on telephone credit, vaping materials and basic groceries. In our survey, 78% of prisoners said they had access to the prison shop in their first few days, significantly above the 40% for similar prisons.

2.14 Prisoners could spend up to £250 of their money each week. This presented a real risk of extortion and bullying which, at the time of inspection, the prison had no processes to manage. Prisoners could also shop from a range of catalogues, including hobby materials, on the basis of their reward and recognition level.

Prisoner consultation, applications and redress

2.15 Consultation arrangements for general community and residential matters were inconsistent. Two house blocks held consultation meetings in each community, although most did not take

place when scheduled. The third house block had opted out of such meetings because they were considered ineffective. Actions decided in the meetings that took place were repeatedly carried forward. Prison-wide consultation meetings had just been introduced, which was a promising development.

2.16 Prisoners could make applications quickly and conveniently through their in-cell laptops, which also facilitated tracking and monitoring of the process. Nevertheless, only 46% of prisoners in our survey who had made an application said they were dealt with fairly, and only 39% said they received a response within seven days. The quality of many responses to applications was poor, indicating staff inexperience and lack of familiarity with the technology. As a result, prisoners often had to make more than one application to resolve a matter, and some resorted to the complaints process to address their needs. A quality assurance process was not yet working effectively.

2.17 There had been 3,614 complaints in the previous six months, a much higher level than we usually see. Staff attributed this to the inexperience of many staff and ineffective operation of the applications process, and this was evident in some of the complaints we reviewed. There was a complaint handling guide for staff, and the quality of responses was generally reasonable, with some responses excellent. Most responses addressed the issues raised, although some were terse and apologies were not always offered when due.

2.18 In our survey, only 27% of prisoners who had made complaints said they were usually dealt with within seven days. We found that too many responses to complaints were late. Sixteen complaints made in January 2018 had had no responses at all; four of these, were more serious 'confidential access' complaints made directly to the governor. The complaints process was monitored and there was evidence that some systemic problems, such as prisoners' access to stored property, were identified and addressed.

2.19 There were no dedicated legal support staff, although prison offender managers could signpost prisoners to local lawyers. The library stocked some legal textbooks that were out of date, which was poor practice. In-cell telephones helped prisoners to contact their lawyers. Facilities for legal visits were good.

Recommendations

2.20 There should be effective and consistent consultation with prisoners.

2.21 Responses to complaints should be prompt.

Equality, diversity and faith

Expected outcomes:
There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics[9] and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

Strategic management

2.22 The leadership and strategic oversight of equality work were weak. The two managers for the area were also responsible for other key areas in the prison, and other members of the team were often cross-deployed. As a result, there was insufficient attention to equality work. (See main recommendation S48.)

2.23 The monthly equality meeting did not have a high enough profile and was rarely chaired by the governor or deputy governor. Although senior managers were lead officers for protective characteristics they did not always attend, and there was no prisoner representation.

2.24 The strategic plan was not specific to the prison and did not detail specific actions required. Data on equality monitoring were collected but not brought to the equality meeting for analysis of trends. Many actions were long outstanding and were not effective in changing outcomes for prisoners or promoting equality. (See main recommendation S48.)

2.25 The number of discrimination incident reporting forms (DIRFs) submitted in the previous six months was far higher than we usually see in similar prisons. However, the issues raised were low level and some could have been dealt with informally. In our focus groups with prisoners, they knew how to submit a DIRF but were not confident in the investigation process. We found that investigations were often answered by the equality manager or officer but were not investigated thoroughly enough, often lacked one-to-one meetings and some answers were unhelpful and curt. Responses were prompt but, until recently, they had had insufficient quality assurance and no independent scrutiny.

2.26 There were few external community representatives providing advice and support for prisoners, and limited consultation for prisoners with protected characteristics. Although there were three prisoner equality representatives, prisoners were not aware of them or clear about their roles. The lack of consultation left the prison poorly placed to offer relevant support to these groups. (See main recommendation S48.)

Protected characteristics

2.27 Approximately 20% of prisoners were from a black or minority ethnic background. Prisoners reported to us, and our survey showed, little disproportionality of treatment with white prisoners. There had been infrequent focus groups for this group of prisoners, and actions agreed were long outstanding.

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[9] The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

2.28 In our survey, 2% of prisoners identified as coming from a Gypsy, Roma or Traveller background. Although the prison had held one focus group meeting that identified that these prisoners would benefit from more regular meetings, these had not happened. Only one prisoner attended the focus group meeting we held, and he was not aware of any support available to him.

2.29 Foreign national prisoners made up just over 3% of the population. A foreign national policy described the support available, but consultation was poor and prisoners we spoke with were confused about what was available. Foreign national prisoners received an extra five minutes' telephone credit a month, and if they did not have regular visits they could apply for additional credit, but they were not all were aware of this or how to apply for it. There was an active foreign national prisoner representative but his role and access to him was not well promoted. Home Office officials continued to hold regular sessions for foreign national prisoners they needed to see, but no independent legal advice was available.

2.30 The prison had a supported living community, where most prisoners with the most acute physical disabilities lived. In our survey, 36% of prisoners considered themselves to have a disability. We found major gaps in provision for some disabled prisoners that needed to be addressed. Some had not had reasonable adjustments made for several months, and the equality team did not have sufficient oversight of these prisoners (see also section on Social care and recommendation 2.66). An equality meeting had identified poor provision for disabled prisoners, but no action had yet been taken to address the issues.

2.31 In our survey, prisoners who identified themselves as having a disability were more negative than those without a disability in several areas. Most notably, 59% said they had felt unsafe at the prison compared with 37% of prisoners without a disability. Personal emergency evacuation plans (PEEPs) were clearly located on the community wings, but while information was gathered, evacuation plans were not always completed, which was concerning. Where PEEPS were completed, staff were not always aware of their details in case of evacuation. Prisoners employed to care for prisoners with disabilities did not have any clear remit and were untrained and unsupervised, which raised the risk of exploitation.

2.32 There was one community in the prison for mature and older prisoners. Consultation with older prisoners had only taken place recently. The prisoners we spoke with were positive about living with their peer group, and the facility was good. Retired prisoners were unlocked during the day and could attend an over-50s class at the gym, although there was little else specifically to meet the needs of this group or provide recreational activity

2.33 The prison had held only one focus group for the small known number of prisoners who identified as gay or bisexual. Prisoners had raised that they found it hard to be open about their sexuality in prison, but nothing had been done to support this group. In our survey, 2% of prisoners identified themselves as transgender or transsexual, although the prison was not aware of them.

2.34 There was a veterans' unit, which had a good environment, and prisoners could have regular contact with external support groups, which was valued.

Recommendations

2.35 Personal emergency evacuation plans should always be fully completed and known to staff.

2.36 Prisoner carers should be trained, have job descriptions and be supervised.

Faith and religion

2.37 The chaplaincy provided a valuable service, and prisoners had good access to religious services and pastoral care. In our survey, 72% of those who had a religion said their religious beliefs were respected, and 86% said they could attend a religious service if they wanted to. Chaplains had a high profile across the establishment. They visited new arrivals within their first 24 hours, and made daily visits to prisoners in the segregation unit. Prisoners could also apply to see a chaplain through their in-cell laptop.

2.38 There were two multi-faith rooms for worship, which were clean, private and suitably equipped with excellent washing facilities. Services for all the main religions were well attended, and there were arrangements for members of minority faiths. The managing chaplain was part of the senior management team and attended relevant prison meetings.

2.39 There were links to chaplaincy teams in the community to provide ongoing support for prisoners on release. The chaplaincy ran the official prison visitors' scheme, which was well established to support prisoners. At the time of our inspection, there were four volunteers who were visiting six prisoners.

Health, well-being and social care

Expected outcomes:
Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

2.40 The inspection of health services was jointly undertaken by Healthcare Inspectorate Wales[10] and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies.

Strategy, clinical governance and partnerships

2.41 Betsi Cadwaladr University Health Board (BCUHB) was responsible for health services, and directly employed most of the health staff. The general practitioner (GP) service in and out of hours was provided by Gables Medical (Offender Health), and the optician service by Pen Optical Trust.

2.42 Health provision had been informed by a health needs assessment published in May 2015. Although it had its limitation, the service specification was comprehensive and in line with the needs of the growing population. Positively, there had been a new health needs assessment, which was due to be published.

2.43 The health provision was integrated and well led, and its quality and governance were very good overall. Governance meetings included an area health board, quarterly partnership board and local quality assurance meetings. Medicines management, clinical governance and integrated health operational meetings reported to the higher governance structures, and daily staff safety meetings covered daily risks.

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[10] HIW is the independent regulator of health care in Wales. For information on HIW, please visit: http://hiw.org.uk/?lang=en

2.44 There had been no recent infection control audits, but they were planned as part of the developing audit cycle with the health board. All clinical areas were clean and well maintained, but there were no cleaning schedules evident.

2.45 A strong culture of incident reporting informed practice. Serious and untoward incidents were thoroughly investigated within the NHS national serious incident framework, and actions were progressed. The health complaints system was advertised and well managed. Responses to health complaints were apt and prompt, and apologetic when required.

2.46 There were well-attended health service user forums, mostly monthly, with clear actions and completion records for items raised.

2.47 Although there were ongoing health service vacancies, the integrated model enabled services to be flexible and respond to changing demand, and be maintained to a good level. Staff were well trained and supervised, although clinical supervision needed refining. Clinical records were maintained on SystmOne (the clinical IT system) but were not always comprehensive.

2.48 Emergency equipment was well maintained and monitored. Officers knew about appropriate emergency responses, and had access to first aid equipment and defibrillators. During the inspection, there was a two-week pilot project with the Welsh Ambulance Service Trust, with a paramedic deployed for 12 hours a day in the prison. The aim was to reduce the need for unnecessary ambulance attendance, and to work alongside health care staff to provide training and develop a minor injuries service. In the six shifts that had taken place during our inspection, 11 emergency calls had been managed without the need for further ambulance input, which was impressive. A substantial proportion of emergencies were related to psychoactive substances.

Promoting health and well-being

2.49 There was no overarching health promotion strategy or action plan, Health promotion literature was available in the health care centre and some other key areas, but was limited elsewhere.

2.50 Smoking cessation support, vaccinations, immunisations and health screening initiatives were provided, but there was no bowel screening. Condoms were available on request and on release, and there were weekly sexual health clinics. There were contingency plans for outbreaks of infectious diseases.

2.51 Although the health department and wider prison did not work in collaboration to promote health and well-being, the physiotherapist used the gym for twice weekly sessions.

Recommendation

2.52 There should be a prison-wide strategy to support health promotion.

Primary care and inpatient services

2.53 All new arrivals received a comprehensive health assessment in reception from a registered nurse. Onward referrals were made where needed, and as there was also a pharmacy technician in reception, medicines reconciliation was prompt. Health care staff had access to medical records on SystmOne.

2.54 There was a wide range of primary care services, which included GP, nurse clinics, optician, physiotherapy, speech therapy and occupational therapy. An impressive radiology suite, staffed by a full-time radiographer, ensured good access to X-rays and ultrasound services.

2.55 Prisoners had good access to all primary care services and waiting times were reasonable. GPs were available daily, and the same team provided an out-of-hours service, which promoted continuity of care. There was good access to nursing staff, and a new daily wing-based nurse-led 'see and treat' clinic was a promising initiative.

2.56 The electronic appointments system was well managed. Prisoners could use their in-cell laptops to make appointments, and a peer-run health and well-being telephone service enabled prisoners to cancel and rearrange their appointments. However, non-attendance rates were very high, at 17.2%, but it was not clear why. Work was under way by the health and well-being peer mentors, facilitated by health staff, to reduce it.

2.57 At the time of inspection, there were 147 prisoners with long-term conditions. The majority had comprehensive up-to-date care plans, but some patients did not have one at all and some reviews were overdue. The primary care team was aware of this and more nurse-led clinics had been booked to address it.

2.58 The prison facilitated four external hospital appointments a day, in addition to any emergency escorts. Appointments were rarely cancelled due to lack of escorting staff. Health staff did not see all prisoners returning from an external hospital appointment, and so could miss ongoing treatment plans.

2.59 Health staff saw all prisoners being discharged from the prison. Prisoners were given a summary of their care, medication where relevant, information on how to register with community dental and GP services, health promotion leaflets and condoms.

Recommendation

2.60 Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs.

Good practice

2.61 *The presence of a member of the pharmacy team in reception enabled prompt medicines reconciliation and easy access to medicines information for new arrivals.*

Social care

2.62 Wrexham County Borough Council provided social services to the prison, with an agreement with BCUHB that the health care team would provide any social care required. There was a memorandum of understanding between BCUHB, the borough council and the prison, which was due for review.

2.63 Two social workers were allocated to work with the prison and visited twice a week. There was no named senior prison lead for social care, and attendance by all key stakeholders at governance and partnership board meetings was inconsistent. The prison's oversight of social care required improvement.

2.64 There were effective processes for prisoner referral to social services. In the previous six months, 90 referrals had been received from prisoners themselves, health care staff and prison officers. Thirty prisoners were still waiting for allocation and assessment following referral, but had been prioritised. The borough council was unable to tell us how long prisoners waited for assessment. However, it noted that requests for social services support were mainly for low-level information, advice and assistance, which would not qualify for assessment under the Social Services and Well-being (Wales) Act 2014.

2.65 At the time of inspection, no prisoners were receiving social care. Some prisoners had been referred to the occupational therapist for assessment and support, which was positive, but we found too many delays in obtaining specialist equipment and aids.

Recommendation

2.66 The prison should ensure that suitable occupational therapy equipment and adaptations are provided and installed promptly.

Mental health care

2.67 BCUHB provided good mental health services, with a wide range of evidence-based therapeutic interventions to meet the needs of prisoners. The team included mental health nurses, psychologists, psychology assistants and a full-time consultant psychiatrist. Joint work between mental health services, health care and the prison was very good. A weekly multidisciplinary meeting reviewed new referrals and allocated or signposted them promptly, and a daily team meeting discussed urgent referrals.

2.68 In our survey, 46% of prisoners said they had a mental health problem, of who 34% said they were receiving help. Support for prisoners with mild to moderate mental health problems was good, with the provision of a wide variety of evidence-based therapies in group and one-to-one settings. A selection of self-help material for prisoners was also available. Trained professionals delivered dialectical behaviour therapy (specifically designed to treat people with borderline personality disorder) and an art therapist was providing weekly sessions.

2.69 Prisoners with severe and enduring mental health problems were managed through the Mental Health (Wales) Measure 2010, and clinical records contained agreed care plans and reviews. The team regularly reviewed these patients' physical health and medication.

2.70 The mental health team supported prisoners before release through effective liaison with external health professionals to ensure continuity of care. There had been one transfer to hospital under the Mental Health Act in the previous six months, which took place promptly.

2.71 Thirty-five custody staff had received mental health first aid training provided by the team, and there were plans to roll this out further.

Substance use treatment

2.72 BCUHB provided an integrated clinical and psychosocial substance use service, which was patient centred. The team was fully staffed, had the required competencies and was well managed.

2.73 The prison's substance use strategy was weak and there was no action plan to coordinate, drive and measure its effectiveness. (See also paragraph 1.35 and main recommendation S46.)

2.74 Psychosocial support was good. Prisoners were seen promptly and there was no waiting list. An active and well-managed peer support scheme enhanced service provision.

2.75 The substance use service delivered a good range of individual and group psychosocial interventions and patient-centred clinical treatments, which were reviewed regularly. Specific therapies had been developed in response to clinical need, with the setting up of groups to improve motivation around change and encourage harm reduction using cognitive behavioural strategies. However, access to rooms across the prison to deliver group and individual therapies was routinely a problem.

2.76 A substance use health care professional assessed all new arrivals, and peer workers provided information on the substance use service and harm reduction. Support was offered to all prisoners suspected of using illicit substances, including hooch (illegally brewed alcohol).

2.77 At the time of inspection, 171 patients were receiving opiate substitutes, mostly on a maintenance basis, and we saw well-supervised controlled drug administration. Treatment was individual, regularly reviewed and well integrated. There was very good joint working with the wider health care team, and a dual-diagnosis nurse (substance use and mental health) supported patients.

2.78 The substance use service was embedded in the wider prison and worked closely with offender managers, resettlement and the security team, and was involved in ACCT reviews. Custody staff we spoke to had received substance use training during induction and knew how to refer prisoners. The service had good links with local community services, and worked jointly to ensure treatment continuation for prisoners after their discharge. On release and where indicated, prisoners were given naloxone to treat opiate overdose.

Recommendation

2.79 The substance use services should have the necessary rooms to deliver therapeutic treatment.

Medicines optimisation and pharmacy services

2.80 Pharmacy provision was well developed and well managed. Patients received medicines promptly from the in-house pharmacy. Pharmacy technicians administered medicines alongside nurses on weekdays, and patients could seek advice from them at the administration hatch. Patients could also make an application to speak to a pharmacist. Pharmacists clinically screened prescriptions and monitored prescribing, but did not hold medicines use reviews with patients. Pharmacy policies were in place and followed, although some staff had not signed training records for the pharmacy's standard operating procedures.

2.81 Around 80% of patients received their medicines in possession. There was no facility for administering medicines after 7pm and so night time medicines were always supplied in possession. All prisoners could store their medicines in lockable cupboards. Pharmacy technicians carried out intelligence-led cell checks, reporting any cases of missing or unauthorised medicines. Risk assessments of the patient and their medicines were completed and available on SystmOne, and were reviewed.

2.82 Very few prisoners were prescribed tradeable medicines. All new arrivals on prescribed medicines were reviewed to see if their prescription was clinically sound. Inappropriate prescribing practices, such as off-licence drugs or multiple drug use, were managed robustly.

Some prisoners had complained that this had happened without consulting them. There was little evidence of this, but there needed to be work to engage with these complex prisoners and manage their perceptions.

2.83 Some prisoners received supervised administration up to twice daily at 7.15am and 5.30pm. Pharmacy technicians had been trained to administer medicines and administrations were well supervised by officers, although on some wings routine delays could result in some prisoner being late getting to activities. Health care staff recorded supplies of medicines on SystmOne. However, there was no missed dose policy and where prisoners had missed doses of high-risk medicines this was not always followed up promptly, which was a risk.

2.84 Medicines were stored and transported securely, and temperature-sensitive medicines were kept in suitable fridges that were monitored. Pharmacy staff said that they carried out monthly checks of all medicines in the prison, although we could only see the date of the most current check during the inspection. Controlled drugs were very well managed.

2.85 Patient group directions (which enable nurses to supply and administer prescription-only medicines) were limited to vaccinations and salbutamol inhalers. Prisoners could request a wide range of over-the-counter remedies from nurses or pharmacy technicians, and supplies were correctly recorded. Prisoners could also buy basic painkillers from the prison shop. Prisoners could access medicines out of hours.

2.86 The medicines management group met monthly and was well attended. The group discussed clinical audits and prescribing trends, and ratified policies.

Recommendations

2.87 There should be a formal and robust procedure to follow up patients who miss medicine doses.

2.88 Pharmacists should carry out medicines use reviews with patients.

Dental services and oral health

2.89 The quality of dental care was good but waiting times for routine care were excessive, at 42 weeks when we inspected. This wait was partly due to the dental practice not being fit for use initially, as well as difficulty in recruiting dental staff. Urgent dental care was managed well, but with 440 prisoners waiting for a routine appointment, dental outcomes were often affected.

2.90 Oral health advice and information was provided. The new dental facility was spacious, clean and had a separate decontamination room. All equipment was maintained correctly. Staff were directly employed by BCUHB and managed under its governance structures.

Recommendation

2.91 Prisoners should have access to dental treatment within community-equivalent waiting times.

Section 3. Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes:
All prisoners have sufficient time out of cell and are encouraged to engage in activities which support their rehabilitation.

3.1 Fully employed prisoners could expect to have about nine hours a day out of cell on most weekdays and over six hours at weekends. However, the many unemployed prisoners only had about two and a half hours out of cell on weekdays. Unlock time was particularly poor for self-isolating prisoners. In our spot checks, we found approximately 28% of prisoners locked up during the core day, which was too high for a training prison.

3.2 Although unplanned regime curtailments were very rare, there was some slippage in the regime and not all staff or prisoners were aware of unlock times. Routine delays in medicines administration meant that some prisoners could be up to an hour late for activities (see paragraph 2.83).

3.3 In our survey, more prisoners than in similar prisons said they had association, domestic time and outside exercise more than five days in a typical week. However, on weekdays, outdoor exercise was limited to 45 minutes.

3.4 There was a small range of 'enrichment activities', such as singing classes and a chess club. However, places were limited and only a small percentage of prisoners attended them.

3.5 The library, run by Wrexham County Council, provided a welcoming environment and was open from Monday to Saturday. In our survey, only 40% of prisoners said they attended the library once a week or more. Some evening and Saturday sessions were regularly cancelled due to officer staffing issues. Although the library had recently started collecting the reasons why sessions were cancelled, it did not monitor or analyse which prisoners attended. The legal books stocked in the library were out of date (see paragraph 2.19). The library facilitated Storybook Dads (enabling prisoners to record a story for their children) and reading groups, but had struggled to deliver the Shannon Trust reading programme due to prison staffing problems, and there was little else to promote literacy.

3.6 The PE facilities were very good, with a varied timetable that did not disadvantage prisoners in work. Evening sessions for full-time workers allowed up to 120 prisoners to attend. Prisoners could achieve a wider range of vocational sports qualifications. Twice-weekly physiotherapy sessions supported prisoners with injuries. The gym made reasonable adjustments for disabled prisoners, and there was an over-50s class and social events for retired prisoners. The PE department did not analyse attendance at the gym to identify and address any exclusion of particular communities or groups with protected characteristics.

Recommendation

3.7 Prisoner attendance at the library and the gym should be analysed routinely to identify if any groups are excluded and to develop provision.

Education, skills and work activities (Estyn)[11]

Expected outcomes:
All prisoners can engage in activities that are purposeful, benefit them and increase their employability. Prisoners are encouraged and enabled to learn both during and after their sentence. The education, skills and work provision is of a good standard and is effective in meeting the needs of all prisoners.

3.8	*Estyn made the following assessments about the education, skills and work provision:*	
	Standards	*Good*
	Well-being and attitudes to learning	*Good*
	Teaching and learning experiences	*Excellent*
	Care, support and guidance	*Good*
	Leadership and management	*Adequate and needs improvement*

Standards

3.9 In vocational workshops and in education sessions, nearly all prisoners made effective progress towards their learning goals. Their success rates were good overall, although those from a few minority groups had success rates slightly below the overall figure.

3.10 Nearly all prisoners understood the qualification framework towards which they were working. They were clear what they had already achieved and knew what they needed to do to make further progress.

3.11 Most prisoners made strong progress in literacy and numeracy, and many appreciated how these skills improved their employability. A minority, who had not succeeded in traditional education, were proud that they had now gained qualifications in these skills and this had motivated them to progress to higher levels of learning. Learner files showed that their literacy improved further as a result of their involvement in education. A few made effective progress in developing digital skills, such as in a media classes where they worked on industry-standard equipment.

3.12 Most prisoners' coursework and practical work were completed to a high standard. In a bench carpentry workshop, they produced doors and staircases to a high level of precision and quality. In a music class, many were able to develop their theory and practical skills to the point where they were able and confident to perform to their peers. Food preparation learners, a minority of whom had never cooked food before, demonstrated a sound practical application of skills when preparing dishes.

[11] This part of the inspection is conducted by Estyn inspectors using Estyn's common inspection framework. This ensures that prisons are held accountable to the same standard of performance as further education colleges in the community.

Well-being and attitudes to learning

3.13 Prisoners in education, training and work behaved very well, participated well in sessions, were motivated to learn, and were respectful to staff and each other. Nearly all worked together collaboratively and supported each other effectively in their learning. They were comfortable in discussing their personal attitudes to their work and their lives. All prisoners took an immense pride in their work and their achievements, and understood how they were improving their knowledge, skills and employability.

3.14 Peer mentors gained personal confidence, self-esteem and empathy for others through helping their fellow prisoners. They also gained useful accredited practical skills, such as teaching and coaching, by working closely with teachers.

3.15 Many prisoners improved their self-worth and ability to plan for a different future through academic and business courses and by improving their literacy, numeracy and IT skills. Resettlement courses provided many with the skills needed to reintegrate into life outside.

3.16 Many prisoners developed awareness of healthy living through programmes such as food preparation, food hygiene and health and safety. The understanding they developed about healthy, nutritious food and the implications of legal requirements would assist them in gaining employment. In street football and sports courses, a majority learned the importance of staying fit and active, how to work as a team, and how to coach and train others.

3.17 A few prisoners told us that they improved their mental health and emotional well-being through taking part in art, music, digital skills and other creative courses. Teachers told us that many prisoners on these courses developed new ways of thinking and seeing the world. A few prisoners took part in competitions and projects, such as a Tate Liverpool art exhibition, which they told us raised their esteem with their families and gained external recognition for their talents.

3.18 Most learners who attended sessions regularly completed their courses successfully and were keen to progress to other learning opportunities.

Teaching and learning experiences

3.19 The range and level of qualifications broadly met most prisoners' needs and enabled them to progress to higher levels of study. A few prisoners were working towards degree-level qualifications.

3.20 In nearly all sessions, teachers used a wide range of highly developed skills that were tailored to prisoners' individual learning needs. Nearly all used resources that appealed to a wide range of learning styles. They used directed questioning well and took care to ensure that all prisoners were engaged with their learning.

3.21 Many teachers and tutors inspired prisoners to achieve, express emotions, develop new skills and to value learning. We observed that they developed many prisoners' confidence and resilience to extend their ambitions and goals.

3.22 Education peer mentors made a valuable contribution to many classes. Teachers and mentors worked very well together to give nearly all prisoners individual support, settling newer prisoners into learning quickly and helping others to overcome learning barriers.

3.23 Nearly all teachers and tutors planned sessions very well. Where appropriate, they planned activities in short bursts and provided a variety of tasks to engage nearly all prisoners. This

enabled many learners to focus on their work for several hours. Nearly all staff were well informed about individuals' learning needs, and used this information very effectively to plan learning.

3.24 Teachers and tutors monitored and tracked prisoners' skills and qualification achievements very closely. They assessed prisoners' abilities and progress effectively, giving them constructive feedback that motivated most to progress further. Most prisoners' individual learning and work plans were up to date, included personal targets and occasionally made helpful reference to their behaviour.

3.25 Many teachers were successful in managing risks when prisoners used tools and equipment to enhance their learning experiences.

Care, support and guidance

3.26 Prisoners received a detailed and well-designed induction to education that was very thorough in assessing their education needs. Staff made determined efforts to obtain and recognise prisoners' prior achievements, tested their skill levels and helped them choose the learning opportunities that best suited their long-term plans. Mentors played a major supportive role in this process. New arrivals had early access to careers advice that helped them to make informed decisions about the education courses to take and the employment options available in the prison or on release.

3.27 Staff identified prisoners with additional learning needs promptly at induction, and referred them to specialist support services provided by a partner organisation.

3.28 All courses aimed to give prisoners the skills, attitudes and behaviour that they needed to progress to higher learning or work, and equip them to cope on their release.

3.29 A recent successful employment fair had increased some prisoners' awareness of employment opportunities and given them the opportunity to speak with employers and discuss options. Prisoners told us that this helped to change their perceptions of themselves and understand opportunities that they could take advantage of on release.

3.30 Families and resettlement courses (see also section on Rehabilitation and release planning) supported prisoners to be more confident to return to their families and communities at the end of their sentence.

3.31 There was a sensitive approach to the promotion of democratic values that supported prisoners to discuss issues openly, acknowledge their own attitudes and agree common understandings. Each course took an individual approach to the delivery of this topic, which helped many prisoners to relate the issues to their chosen learning.

3.32 There were only a few prisoners on many of the courses. Those who were present and engaged in education were given effective support.

Leadership and management

3.33 Since the prison had opened, the range of education, training and work had not met the needs of the population. Leaders and managers had adapted provision and had developed useful and creative contingency plans to occupy prisoners in the absence of suitable provision. For example, Interserve had set up temporary work and training facilities in residential accommodation, although this did not represent a realistic workplace. However,

while these contingency arrangements created enough activity places for the current population, too many were not challenging enough and did not encourage prisoners to develop a sound work ethic. Further workshop provision was planned to open during May 2019. (See main recommendation S49.)

3.34 Staff did not do enough to challenge prisoners who chose not to participate in education, training or work. Activity places were not fully used. Almost 200 prisoners were unemployed, and many who were allocated to an activity failed to attend. Only around two-thirds of prisoners were engaged in activities at any time, and this was compounded by the fact that 20% of those engaged were undertaking wing work, which was largely unskilled and failed to keep them occupied for the working day. (See main recommendation S50.)

3.35 The prison had developed many effective partnerships to help prisoners gain skills and improve their experience and employability. A DHL warehouse on site enabled a few prisoners to gain work experience and the possibility of an employment interview on release. The prison had started to use release on temporary licence to enable a few prisoners to access employment opportunities and improve their prospects of gaining work (see paragraph 4.28).

3.36 Prisoner pay policies did not always provide an incentive for them to attend education, training and work. The prison had recently revised the policy, but it was too early to evaluate its impact.

3.37 The self-assessment report for education and vocational provision identified key strengths and areas for improvement, which informed the quality development plan. However, the objectives in the plan did not define the criteria to judge success clearly enough. Leaders and managers had developed task-and-finish groups to progress issues that the learning and skills team had communicated to the quality improvement group. It was too early to judge the effectiveness of these groups in developing solutions.

3.38 The education facilities were well equipped, and a few resources were bilingual. However, there was no effective strategy to promote the Welsh language. Nearly all staff had good access to training.

Recommendations

3.39 Work and training should take place in realistic work environments.

3.40 There should be a clear strategy to promote the Welsh language and the Welsh dimension in activities for prisoners that encourages all prisoners, especially Welsh speakers, to use and develop their Welsh language skills.

Section 4. Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes:
The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

4.1 The impressive visitors' centre, run by the Prison Advice and Care Trust (PACT), was staffed by friendly, helpful workers and open seven days a week. The team was well resourced and provided a social worker, family engagement and a family support worker, as well as a play specialist in the visits hall. Outdoor and indoor children's play areas were provided.

4.2 Visits generally started and finished on time. The visits hall provided a welcoming environment, and it was spacious, bright and well equipped, with a soft-play area and a tea bar. Prisoners valued that they could wear their own clothes, sit next to their families, buy items from the tea bar and supervise their children in the play area, and visits were far more relaxed than we often see.

4.3 There was too little provision to meet the need for weekend visits, with a three-week delay in booking these during our inspection. Prison managers were aware of this problem and looking at making improvements.

4.4 There was an excellent range of courses to help prisoners build and maintain relationships with their families. Delivered through the education department and PACT, these included a weekly evening homework club, and 'Building Better Futures and Families', which enabled prisoners and their families to spend family days together arranged for prisoners who had completed these courses and to demonstrate skills they had learned. The education provider Novus also offered a range of family courses on the Improving Family Futures community (a community focusing on improving family relationships), although there had been no family days for prisoners there for several months.

4.5 Prisoners complained to us that they did not receive their mail regularly, and in our survey, 69% said that they had problems with sending or receiving mail, which was significantly more than the 57% in similar prisons. We found that staff in several communities were not collecting incoming mail regularly enough to distribute to prisoners promptly. Mail had not been collected for 15 consecutive days in one month in one area of the prison.

Recommendation

4.6 Prisoners should receive their incoming mail within 24 hours of its arrival at the prison.

Reducing risk, rehabilitation and progression

Expected outcomes:
Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

4.7 Managers at Berwyn had struggled to plan work to reduce reoffending effectively due to several major challenges. High-risk prisoners made up about 40% of the population, which was a much larger number than anticipated. About three-quarters of prisoners were serving sentences of four years or more, and many were transient; 43% had been at Berwyn for less than six months. The prison's location in North Wales also created contractual complexities for funding for the majority of prisoners, as about three-quarters came from outside Wales. The lack of clarity about the composition of the population had also made planning difficult for the programmes team and the offender management unit (OMU).

4.8 Just over two years after opening, there was still no comprehensive analysis of the population's needs to inform provision and future direction. There was also no reducing reoffending strategy that considered the challenges which Berwyn had faced in its early days, and which set out future priorities. There had been only two reducing reoffending meetings in the previous six months, which was too infrequent for a new prison with further challenges ahead. Although there were up-to-date action plans for each resettlement pathway, the meetings did not routinely use these to assess resettlement provision.

4.9 Too many prisoners did not have an up-to-date offender assessment system (OASys) assessment of their risk and needs. There were 160 prisoners with no assessment at all, so their transfer to Berwyn had not been informed by a sentence plan. A further 350 prisoners had not had an up-to-date assessment completed in the previous 12 months. The lack of current assessment directly affected prisoner access to offending behaviour programmes and their ability to progress to open conditions. (See main recommendation S51.)

4.10 Uniformed prison offender managers were rarely cross-deployed to other duties, which was unusual and positive. Prison offender managers who had trained as probation officers held virtually all the 514 high-risk cases. However, caseloads overall were high. Some prison offender managers carried 70 cases and, until recently, caseloads of 90 or 100 prisoners had been typical. The OMU had now taken the very unusual step of refusing to accept any more high-risk prisoners from England.

4.11 Recorded offender manager contact with prisoners was too inconsistent to drive their sentence progression effectively, and tended to be in reaction to events such as parole or recategorisation. There was no expectation of minimum level of contact with prisoners. The quality of offender management was variable, and in half the cases we looked at it was insufficient. Sentence plan objectives did not usually relate to Berwyn's specific provision, and there was too little evidence that interventions were sequenced correctly. (See main recommendation S52.)

4.12 In January 219, the OMU fully introduced the new offender management in custody (OMiC)[12] model for the prisoners from Wales, about a quarter of the population. Under this model, high-risk prisoners in this group were supposed see their prison offender manager for 60 minutes a month. Although it was early days, in the cases we looked at there was not yet a demonstrably better service from the OMU for these prisoners. Relevant entries by wing-based keyworkers in prisoners' case notes were not sufficiently in depth (see paragraph 2.4). An OMU clinic to improve communication with prisoners had been introduced, which was a sensible step.

4.13 The latest home detention curfew (HDC) processes had not been introduced effectively, and too many eligible prisoners were released late on HDC. Only 22% of prisoners were serving under four years and were therefore eligible to be considered for HDC. In the six months to the end of February 2019, 162 prisoners had been considered for HDC but only 58% (94) had been approved, an unusually low level under the new processes. In the same period, nearly half of the 71 prisoners released on HDC were released after their eligibility date. Prompt release was affected by factors such as HDC boards being held after the eligibility date, inadequate responses from community offender managers about the suitability of accommodation, prisoners arriving at Berwyn inside their HDC window, and a lack of bail accommodation and support services (BASS) beds. Managers had recently recognised deficiencies in the process and were taking steps to address them.

4.14 Indeterminate sentence prisoners made up 12% of the population (158 prisoners), and most lived in two adjacent lifer communities. Apart from the benefit of being co-located, there was too little provision for these prisoners. Many were unhappy at the prospect of sharing cells as the prison's population increased. However, the introduction of a prison offender manager with responsibility for indeterminate sentence prisoners was positive.

4.15 There were 46 prisoners serving an indeterminate sentence for public protection (IPP) and many were past their tariff (the minimum time to serve, set by the court, before they can be considered for release). There had been some work at regular sentence progression meetings to identify the unmet needs of these prisoners, but as yet no further work had been undertaken. There were plans to introduce dedicated support for these prisoners, but funding was not yet in place.

Recommendations

4.16 Prisoners who are suitable for home detention curfew should be released on time.

4.17 There should be adequate provision to address the unmet needs of prisoners on indeterminate sentence for public protection post tariff.

Public protection

4.18 Public protection arrangements were weak overall. Arrangements to conduct and review telephone monitoring of prisoners who potentially posed a risk to the public were ineffective. There was a two-month backlog of calls that had not been monitored, and the monitoring logs we looked at had typically ended two months' previously (in January 2019). The backlog meant that risks to the public were not promptly identified. The lack of

[12] Following a review of offender management in 2015, HMPPS began to introduce a new offender management model from 2017. The new model is being implemented in stages, starting with new prison officer key workers. The second phase, core offender management, and the introduction of prison offender managers (POMs) is being introduced gradually, from 2019.

up-to-date risk information resulted in monthly reviews to determine whether monitoring should continue or cease being rolled over to the following month, creating even more pressure on staff listening to calls. Where risk information, such as the breach of a restraining order, was belatedly identified, this was not always referred to the police for investigation or to the prison's internal disciplinary procedures for punishment. The prison had also struggled to have Welsh language telephone calls translated. (See main recommendation S53.)

4.19 Although the OMU had a reasonably good process for assessing whether prisoners presented an ongoing risk to children, some assessments were not completed adequately and about 40% were out of date. Some restrictions had been inherited from sending prisons without a full assessment. The ineffective telephone monitoring arrangements undermined the effectiveness of assessments.

4.20 Almost half of prisoners due for release in the following three months were assessed as high risk. The monthly interdepartmental risk management meeting did not systematically consider this group to provide assurance that their risks would be properly managed. (See main recommendation S53.) Although this was a significant gap, in the individual cases we looked at there was evidence of good communication between prison and community offender managers to address public protection issues and manage some of these risks.

4.21 The OMU made efforts to confirm prisoners' multi agency public protection arrangements (MAPPA) management levels before their release, which allowed prison offender managers to contribute to release arrangements. Written contributions from prison offender managers to MAPPA meetings in the community were of a sufficiently good quality.

Categorisation and transfers

4.22 Recategorisation reviews were frequently late. Decisions were both evidence-based and defensible, with good contributions from prison offender managers and the security department, and approval by a residential manager.

4.23 Too many category D prisoners were not moved promptly to open prisons. In 2018, the prison had tried to create a category D community to allow prisoners to access release on temporary licence (ROTL), but this had quickly been abandoned, partly because there were not enough ROTL opportunities. Moving these prisoners on afterwards had contributed to a backlog. Seven category D prisoners were still held at the prison to access ROTL (see paragraph 4.28).

4.24 In the previous six months, 108 prisoners had been awarded category D status and 117 had been transferred to open conditions, which was positive. However, there were still 72 category D prisoners at Berwyn during the inspection, and most needed to move on. There was a lack of spaces in the open prison estate nationally, with very limited availability at Thorn Cross, Berwyn's closest open prison.

Interventions

Expected outcomes:
Prisoners are able to access interventions designed to promote successful rehabilitation.

4.25 The prison offered three accredited offending behaviour programmes: the Thinking Skills Programme (TSP), Resolve (a moderate-intensity programme to address violence) and Kaizen Intimate Partner Violence (IPV) (a high-intensity programme to tackle domestic

abuse). A fourth programme, Kaizen General Violence (also high intensity), was due to be introduced in summer 2019.

4.26 There were not enough places on these programmes to meet the needs of the population. The programmes team had identified 406 prisoners who met the risk and need criteria for treatment and who had sufficient time left in custody. In 2019-20, there would be capacity for only 134 prisoners to start a programme, only about a third of those with a need for the programmes. The arrival of a further 300 prisoners in the following few months would add to the demand for programmes.

4.27 There were some short-term interventions to help prisoners address their attitudes, thinking and behaviour. These included Positive Thinking, which 72 prisoners had completed since April 2018. However, this course was not routinely linked to sentence plans, which was a missed opportunity. The chaplaincy offered the Sycamore Tree victim awareness course, which was well attended, with four further groups of prisoners due to start it in 2019.

4.28 Unusually, the prison had introduced ROTL for a small number (currently seven) of low- and medium-risk category D prisoners. While we would generally expect category D prisoners to move promptly to an open prison to access ROTL, there was a good argument for prisoners resettling to Wales to stay at Berwyn for this purpose, as there were no open prisons in North Wales.

4.29 The prison's ROTL policy was not robust and did not reflect national guidance. Assessments and boards to allow prisoners ROTL were adequate, but there was a lack of proper progression through the different stages of ROTL and weaknesses in safeguarding arrangements while prisoners were out in the community; managers had recognised these deficiencies.

4.30 St Giles Trust provided support for prisoners to address financial problems and open bank accounts before release. In the two years since the prison opened, it had opened 294 bank accounts for prisoners. Jobcentre Plus attended the prison twice a week. Although prisoners could not begin an online application for universal credit in the prison, an appointment at their local jobcentre was made for their day of release.

4.31 St Giles Trust also supported prisoners to find accommodation on release, although it estimated that about 7% of prisoners were homeless on their day of release. Outcomes for prisoners sustaining their accommodation 12 weeks after release were not monitored to assess the effectiveness of provision.

4.32 Due to contractual restrictions, the support that St Giles Trust currently offered on accommodation and finance, benefit and debt to prisoners resettling outside Wales was due to cease from April 2019, with no realistic plan to address this gap (see also paragraph 4.35 and main recommendation S54).

Recommendation

4.33 There should be enough accredited offending behaviour programmes to meet the needs of the population.

Release planning

Expected outcomes:
The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

4.34 Berwyn released an average of 40 prisoners a month. Around half were released to Wales and half to England. Seetec (formerly Working Links) had commissioned St Giles Trust to address prisoners' resettlement needs, and it offered all prisoners very good and prompt support. Trust workers reviewed resettlement plans 16 weeks before release and made appropriate referrals, and could also meet the needs of prisoners who transferred into Berwyn just before their release. St Giles Trust workers communicated well with community offender managers, providing them with prisoners' resettlement plans. There was a monthly multiagency resettlement needs meeting, and all prisoners had a pre-release check seven days before release.

4.35 Since the prison opened, St Giles Trust had worked outside its contract to deliver resettlement support to all prisoners. However, because the population was due to increase and it would shortly be required to deliver enhanced through-the-gate services to prisoners resettling in Wales, the trust had informed the prison that, from 1 April 2019, it could no longer work with prisoners released to England. There was no realistic plan to address the resettlement needs of these prisoners after this date. (See main recommendation S54.)

4.36 The prison had begun to establish a resettlement community for prisoners to move on to 16 weeks ahead of release. So far, about 60% of the unit's population fitted this criterion. Resettlement peer workers were available, but otherwise provision was still developing.

4.37 Practical release arrangements were very good. There was an extensive stock of second-hand clothing available to prisoners being discharged, and a St Giles Trust staff member met prisoners in reception with their reporting instructions and travel plans - there was a nearby bus route or a taxi could be ordered at the visitors' centre. PACT also met a few of the most complex prisoners at the gate to assist their return to the community.

Section 5. Summary of recommendations and good practice

The following is a listing of repeated and new recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report, and in the previous report where recommendations have been repeated.

Main recommendation — To HMPPS

5.1 All prisoners released from Berwyn should receive support to review and address their resettlement needs. (S54)

Main recommendations — To the governor

5.2 The prison should develop a strategy to reduce violence based on an analysis of the causes of violence, supported by an action plan to drive and monitor a reduction in violent incidents. (S44)

5.3 Prisoners who are self-isolating should have their basic needs for food, hygiene, social contact and fresh air are met. A plan to work towards ending their isolation should be agreed with them and regularly reviewed. (S45)

5.4 The prison should continue its focus on drug supply and demand reduction, but should better coordinate and embed actions to reduce the availability and demand for drugs, and measure their impact. (S46)

5.5 Prisoners should be supported and managed effectively by a responsive and capable staff group. (S47)

5.6 Senior leaders should promote the importance of equality work in the prison. There should be a robust strategy and oversight of equality work, informed by routine consultation, to identify and address the needs of prisoners in protected characteristics groups. (S48)

5.7 The balance and range of education, training and work places should reflect the needs of the population, keep prisoners occupied and be sufficiently challenging. (S49)

5.8 All eligible prisoners should be allocated to an education, training or work placement, and should be encouraged and expected to attend. (S50)

5.9 All eligible prisoners should have an up-to-date assessment that identifies their risks and needs. (S51)

5.10 Prison offender managers should have regular, good quality contact with prisoners, which drives their risk reduction and sentence progression. (S52)

5.11 Public protection procedures should be given urgent and sustained attention to ensure that prisoners' risks, both in custody and on release, are managed effectively. (S53)

Recommendations

To the governor

Managing behaviour

5.12 Challenge, support and intervention plans (CSIP) should be used effectively to address violent behaviour and support victims. (1.14)

5.13 The rewards and responsibility scheme should incentivise prisoners to take responsibility and behave well, and provide effective and timely sanctions for poor behaviour. (1.15)

5.14 There should be effective governance of the adjudications process to ensure it provides active challenge to poor behaviour. (1.20)

5.15 Full control and restraint and use of batons should be kept to a minimum through application of de-escalation techniques wherever possible. (1.24)

5.16 Segregated prisoners should have access to a regime appropriate to their risk and behaviour. (1.28)

Security

5.17 The prison should ensure that, where practicable, all intelligence-led drug testing takes place. (1.37)

Safeguarding

5.18 The prison should record and analyse the causes of self-harm incidents, and use this material to inform the strategic management of safeguarding and suicide and self-harm prevention. (1.44)

5.19 Assessment, care in custody and teamwork (ACCT) casework management documentation should be of a consistently good quality. Care maps for individual prisoners should identify objectives to address their risk of self-harm and ensure they receive the necessary care and support. (1.45)

5.20 All staff should understand their adult safeguarding responsibilities. (1.47)

Daily life

5.21 There should be effective and consistent consultation with prisoners. (2.20)

5.22 Responses to complaints should be prompt. (2.21)

Equality, diversity and faith

5.23 Personal emergency evacuation plans should always be fully completed and known to staff. (2.35)

5.24 Prisoner carers should be trained, have job descriptions and be supervised. (2.36)

Health, well-being and social care

5.25 There should be a prison-wide strategy to support health promotion. (2.52)

5.26 Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs. (2.60)

5.27 The prison should ensure that suitable occupational therapy equipment and adaptations are provided and installed promptly. (2.66)

5.28 The substance use services should have the necessary rooms to deliver therapeutic treatment. (2.79)

5.29 There should be a formal and robust procedure to follow up patients who miss medicine doses. (2.87)

5.30 Pharmacists should carry out medicines use reviews with patients. (2.88)

5.31 Prisoners should have access to dental treatment within community-equivalent waiting times. (2.91)

Time out of cell

5.32 Prisoner attendance at the library and the gym should be analysed routinely to identify if any groups are excluded and to develop provision. (3.7)

Education, skills and work activities

5.33 Work and training should take place in realistic work environments. (3.39)

5.34 There should be a clear strategy to promote the Welsh language and the Welsh dimension in activities for prisoners that encourages all prisoners, especially Welsh speakers, to use and develop their Welsh language skills. (3.40)

Children and families and contact with the outside world

5.35 Prisoners should receive their incoming mail within 24 hours of its arrival at the prison. (4.6)

Reducing risk, rehabilitation and progression

5.36 Prisoners who are suitable for home detention curfew should be released on time. (4.16)

5.37 There should be adequate provision to address the unmet needs of prisoners on indeterminate sentence for public protection post tariff. (4.17)

Interventions

5.38 There should be enough accredited offending behaviour programmes to meet the needs of the population. (4.33)

Examples of good practice

5.39 All new arrivals were welcomed into a relaxed and supportive environment in reception. The dedicated first night centre provided a safe place for prisoners to settle in. The comprehensive and well-coordinated induction occupied prisoners purposefully during their early days. (1.6)

5.40 The Glyndŵr progressive community was a well-planned and targeted facility to address violent behaviour by prisoners presenting the greatest risk. (1.16)

5.41 The presence of a member of the pharmacy team in reception enabled prompt medicines reconciliation and easy access to medicines information for new arrivals. (2.61)

Section 6. Appendices

Appendix I: Inspection team

Martin Lomas	Deputy Chief Inspector
Alison Perry	Team leader
Natalie Heeks	Inspector
Angus Mulready-Jones	Inspector
Alice Oddy	Inspector
Jade Richards	Inspector
Deri Hughes-Roberts	Inspector
Andy Rooke	Inspector
Paul Rowlands	Inspector
Jonathan Tickner	Inspector
Caroline Wright	Inspector
Amilcar Johnson	Researcher
Catherine Shaw	Researcher
Joe Simmonds	Researcher
Holly Tuson	Researcher
Tania Osborne	Lead health and social care inspector
Elizabeth Walsh	Health and social care inspector
Shaun Thomson	Health inspector
Helen Boniface	Pharmacist
Alun Connick	Estyn inspector
Lin Howells	Estyn inspector
Martyn Griffiths	Offender management inspector

Appendix II: Prison population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Population breakdown by:

Status	**21 and over**	**%**
Sentenced	1210	*95.1*
Recall	63	*4.9*
Total	**1273**	***100***

Sentence	**21 and over**	**%**
Less than six months	12	*0.9*
Six months to less than 12 months	22	*1.7*
12 months to less than 2 years	41	*3.2*
2 years to less than 4 years	202	*15.9*
4 years to less than 10 years	653	*51.3*
10 years and over (not life)	185	*14.5*
ISPP (indeterminate sentence for public protection)	46	*3.6*
Life	112	*12.4*
Total	**1273**	***100***

Age	**Number of prisoners**	**%**
21 years to 29 years	456	*35.8*
30 years to 39 years	431	*33.9*
40 years to 49 years	267	*21.0*
50 years to 59 years	95	*7.5*
60 years to 69 years	19	*1.5*
70 plus years: *maximum age=80*	5	*0.4*
Total	**1273**	***0***

Nationality	**21 and over**	**%**
British	1229	*96.5*
Foreign nationals	44	*3.5*
Total	**1273**	***100***

Security category	**21 and over**	**%**
Category B	1	*0.1*
Category C	1204	*94.6*
Category D	68	*5.3*
Total	**1273**	***100***

Ethnicity	21 and over	%
White		
British	1009	*79.3*
Irish	7	*0.5*
Gypsy/Irish Traveller	14	*1.1*
Other white	20	*1.6*
Mixed		
White and black Caribbean	26	*2.0*
White and Asian	6	*0.5*
Other mixed	10	*0.8*
Asian or Asian British		
Indian	13	*1.0*
Pakistani	53	*4.2*
Bangladeshi	8	*0.6*
Chinese	2	*0.2*
Other Asian	12	*0.9*
Black or black British		
Caribbean	48	*3.8*
African	18	*1.4*
Other black	23	*1.8*
Other ethnic group		
Arab	1	*0.1*
Other ethnic group	2	*0.2*
Not stated	1	*0.1*
Total	**1273**	***100***

Religion	21 and over	%
Baptist	2	*0.2*
Church of England	193	*15.2*
Roman Catholic	296	*23.3*
Other Christian denominations	130	*10.2*
Muslim	139	*10.9*
Sikh	9	*0.7*
Hindu	1	*0.1*
Buddhist	15	*1.2*
Jewish	14	*1.1*
Other	21	*1.6*
No religion	453	*35.6*
Total	**1273**	***100***

Other demographics	21 and over	%
Veteran (ex-armed services)	22	*1.73*
Total	**22**	***1.73***

Sentenced prisoners only

Length of stay	**21 and over**	
	Number	**%**
Less than 1 month	68	*5.3*
1 month to 3 months	180	*14.1*
3 months to six months	295	*23.2*
six months to 1 year	341	*26.8*
1 year to 2 years	387	*30.4*
2 years to 4 years	2	*0.2*
Total	**1273**	***100***

Main offence	**21 and over**	**%**
Violence against the person	431	*33.86*
Burglary	118	*9.27*
Robbery	180	*14.14*
Theft and handling	13	*1.02*
Fraud and forgery	8	*0.63*
Drugs offences	376	*29.60*
Other offences	146	*11.47*
Offence not recorded /holding warrant	1	*0.01*
Total	Not available	

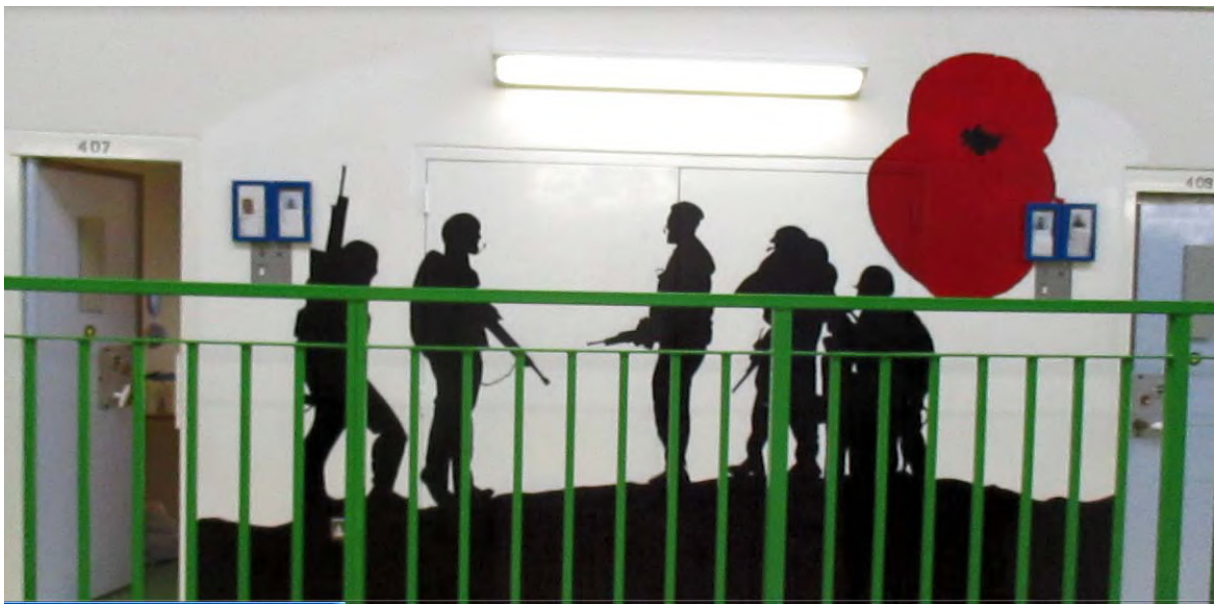
Appendix III: Photographs

Alwen house

Bala reception

Cell

Mural



Mural

Inadequate screening

Appendix IV: Prisoner survey methodology and results

Prisoner survey methodology

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection.

HM Inspectorate of Prisons (HMI Prisons) researchers have developed a self-completion questionnaire to support HMI Prisons' *Expectations*. The questionnaire consists of structured questions covering the prisoner 'journey' from reception to release, together with demographic and background questions which enable us to compare responses from different sub-groups of the prisoner population. There are also three open questions at the end of the questionnaire which allow prisoners to express, in their own words, what they find most positive and negative about the prison.[13]

The questionnaire is available in 14 languages and can also be administered via a telephone translation service if necessary.

The questionnaire was revised during 2016–17, in consultation with both inspectors and prisoners. The current version has been in use since September 2017.

Sampling

On the day of the survey a stratified random sample is drawn by HMI Prisons researchers from a P-NOMIS prisoner population printout ordered by cell location. Using a robust statistical formula HMI Prisons researchers calculate the minimum sample size required to ensure that the survey findings can be generalised to the entire population of the establishment.[14] In smaller establishments we may offer a questionnaire to the entire population.

Distributing and collecting questionnaires

HMI Prisons researchers distribute and collect the questionnaires in person. So that prisoners can give their informed consent to participate, the purpose of the survey is explained and assurances are given about confidentiality and anonymity. [15] Prisoners are made aware that participation in the survey is voluntary; refusals are noted but not replaced within the sample. Those who agree to participate are provided with a sealable envelope for their completed questionnaire and told when we will be returning to collect it. We make arrangements to administer the questionnaire via a face-to-face interview for respondents who disclose literacy difficulties.

Survey response

At the time of the survey on 4 March 2019, the prisoner population at HMP Berwyn was 1,273. Using the sampling method described above, questionnaires were distributed to 225 prisoners. We received a total of 184 completed questionnaires, a response rate of 81%. This included two questionnaires completed via face-to-face interviews. Fifteen prisoners declined to participate in the survey and 27 questionnaires were either not returned at all, or returned blank.

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[13] Qualitative analysis of these written comments is undertaken by HMI Prisons researchers and used by inspectors.

[14] 95% confidence interval with a sampling error of 7%. The formula assumes a 75% response rate (65% in open establishments).

[15] For further information about the ethical principles which underpin our survey methodology, please see *Ethical principles for research activities* which can be downloaded from HMI Prisons' website http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Survey results and analyses

Over the following pages we present the full survey results followed by various comparative analyses for HMP Berwyn. For the comparator analyses, each question was reformulated into a binary 'yes/no' format and affirmative responses compared. [16] Missing responses have been excluded from all analyses.

Full survey results

A full breakdown of responses is provided for every question. Percentages have been rounded and therefore may not add up to 100%.

Responses from HMP Berwyn 2019 compared with those from other HMI Prisons surveys[17]

- Survey responses from HMP Berwyn in 2019 compared with survey responses from other category C training prisons inspected since September 2017.

Comparisons between sub-populations of prisoners within HMP Berwyn 2019[18]

- White prisoners' responses compared with those of prisoners from black or minority ethnic groups.
- Responses of prisoners who reported that they had a disability compared with those who did not.
- Responses of prisoners who reported that they had mental health problems compared with those who did not.
- Responses of prisoners aged 25 and under compared with those over 25.

Please note that we only carry out within-prison comparator analysis where there are sufficient responses in each sub-group.[19]

In the comparator analyses, statistically significant differences are indicated by shading.[20] Results that are significantly more positive are indicated by green shading and results that are significantly more negative are indicated by blue shading. Orange shading has been used to show a statistically significant difference in demographic or other background details. If there is no shading, any difference between the two results is not statistically significant and may have occurred by chance. Grey shading indicates that there is no valid comparative data for that question.

Filtered questions are indented and preceded by an explanation in italics of how the filter has been applied. In the comparator analyses, percentages for filtered questions refer to the number of respondents filtered to that question. For all other questions, percentages refer to the total number of valid responses to the question.

16 Using the Chi-square test (or Fisher's exact test if there are fewer than five responses in a group).

17 These analyses are carried out on summary data from all survey questions. As we have been using a new version of the questionnaire since September 2017, we do not yet have full comparator data for all questions.

18 These analyses are carried out on summary data from selected survey questions only.

19 A minimum of 10 responses which must also represent at least 10% of the total response.

20 A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p<0.01$ is considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

Survey summary

Background information

1.1 What wing or house block are you currently living on?

Alwen	71 (39%)
Bala	80 (44%)
Ceiriog	30 (16%)
Ogwen (care and segregation unit)	2 (1%)

1.2 How old are you?

Under 21	1 (1%)
21 - 25	29 (16%)
26 - 29	45 (25%)
30 - 39	55 (31%)
40 - 49	32 (18%)
50 - 59	14 (8%)
60 - 69	2 (1%)
70 or over	0 (0%)

1.3 What is your ethnic group?

White - English/ Welsh/ Scottish/ Northern Irish/ British	138 (77%)
White - Irish	3 (2%)
White - Gypsy or Irish Traveller	2 (1%)
White - any other White background	1 (1%)
Mixed - White and Black Caribbean	8 (4%)
Mixed - White and Black African	1 (1%)
Mixed - White and Asian	2 (1%)
Mixed - any other Mixed ethnic background	2 (1%)
Asian/ Asian British - Indian	2 (1%)
Asian/ Asian British - Pakistani	6 (3%)
Asian/ Asian British - Bangladeshi	2 (1%)
Asian/ Asian British - Chinese	2 (1%)
Asian - any other Asian Background	1 (1%)
Black/ Black British - Caribbean	5 (3%)
Black/ Black British - African	2 (1%)
Black - any other Black/ African/ Caribbean background	0 (0%)
Arab	1 (1%)
Any other ethnic group	2 (1%)

1.4 How long have you been in this prison?

Less than 6 months	53 (30%)
6 months or more	126 (70%)

1.5 Are you currently serving a sentence?

Yes	164 (92%)
Yes - on recall	14 (8%)
No - on remand or awaiting sentence	0 (0%)
No - immigration detainee	0 (0%)

1.6 How long is your sentence?

Less than 6 months	5 (3%)
6 months to less than 1 year	5 (3%)
1 year to less than 4 years	37 (21%)
4 years to less than 10 years	81 (46%)
10 years or more	33 (19%)
IPP (indeterminate sentence for public protection)	4 (2%)
Life	12 (7%)
Not currently serving a sentence	0 (0%)

Arrival and reception

2.1 Were you given up-to-date information about this prison before you came here?

Yes	43 (24%)
No	125 (71%)
Don't remember	9 (5%)

2.2 When you arrived at this prison, how long did you spend in reception?

Less than 2 hours	53 (30%)
2 hours or more	116 (66%)
Don't remember	7 (4%)

2.3 When you were searched in reception, was this done in a respectful way?

Yes	141 (81%)
No	24 (14%)
Don't remember	10 (6%)

2.4 Overall, how were you treated in reception?

Very well	68 (39%)
Quite well	90 (51%)
Quite badly	14 (8%)
Very badly	3 (2%)
Don't remember	1 (1%)

2.5 When you first arrived here, did you have any of the following problems?

Problems getting phone numbers	29 (17%)
Contacting family	22 (13%)
Arranging care for children or other dependants	1 (1%)
Contacting employers	5 (3%)
Money worries	25 (14%)
Housing worries	15 (9%)
Feeling depressed	35 (20%)
Feeling suicidal	9 (5%)
Other mental health problems	34 (19%)
Physical health problems	19 (11%)
Drug or alcohol problems (e.g. withdrawal)	11 (6%)
Problems getting medication	52 (30%)
Needing protection from other prisoners	8 (5%)
Lost or delayed property	47 (27%)
Other problems	14 (8%)
Did not have any problems	61 (35%)

2.6 Did staff help you to deal with these problems when you first arrived?

Yes	32 (19%)
No	79 (46%)
Did not have any problems when I first arrived	61 (35%)

First night and induction

3.1 Before you were locked up on your first night here, were you offered any of the following things?

Tobacco or nicotine replacement	111 (65%)
Toiletries / other basic items	98 (57%)
A shower	102 (60%)
A free phone call	63 (37%)
Something to eat	127 (74%)
The chance to see someone from health care	105 (61%)
The chance to talk to a Listener or Samaritans	51 (30%)
Support from another prisoner (e.g. Insider or buddy)	40 (23%)
Wasn't offered any of these things	15 (9%)

3.2 On your first night in this prison, how clean or dirty was your cell?

Very clean	77 (44%)
Quite clean	74 (42%)
Quite dirty	15 (8%)
Very dirty	9 (5%)
Don't remember	2 (1%)

3.3 Did you feel safe on your first night here?

Yes	153 (87%)
No	14 (8%)
Don't remember	8 (5%)

3.4 In your first few days here, did you get:

	Yes	No	Don't remember
Access to the prison shop / canteen?	134 (78%)	29 (17%)	9 (5%)
Free PIN phone credit?	82 (48%)	73 (43%)	15 (9%)
Numbers put on your PIN phone?	102 (62%)	49 (30%)	13 (8%)

3.5 Did your induction cover everything you needed to know about this prison?

Yes	104 (59%)
No	69 (39%)
Have not had an induction	2 (1%)

On the wing

4.1 Are you in a cell on your own?

Yes	79 (44%)
No, I'm in a shared cell or dormitory	99 (56%)

4.2 Is your cell call bell normally answered within 5 minutes?

Yes	66 (38%)
No	85 (49%)
Don't know	23 (13%)
Don't have a cell call bell	1 (1%)

4.3 Please answer the following questions about the wing or house block you are currently living on:

	Yes	No	Don't know
Do you normally have enough clean, suitable clothes for the week?	132 (76%)	39 (23%)	2 (1%)
Can you shower every day?	172 (98%)	3 (2%)	1 (1%)
Do you have clean sheets every week?	125 (73%)	45 (26%)	2 (1%)
Do you get cell cleaning materials every week?	92 (53%)	75 (44%)	5 (3%)
Is it normally quiet enough for you to relax or sleep at night?	125 (72%)	47 (27%)	1 (1%)
Can you get your stored property if you need it?	35 (20%)	92 (54%)	44 (26%)

4.4 Normally, how clean or dirty are the communal / shared areas of your wing or house block (landings, stairs, wing showers etc.)?

Very clean	31 (18%)
Quite clean	90 (51%)
Quite dirty	39 (22%)
Very dirty	15 (9%)

Food and canteen

5.1 What is the quality of food like in this prison?

Very good	11 (6%)
Quite good	72 (42%)
Quite bad	54 (31%)
Very bad	35 (20%)

5.2 Do you get enough to eat at mealtimes?

Always	18 (10%)
Most of the time	32 (18%)
Some of the time	79 (44%)
Never	49 (28%)

5.3 Does the shop / canteen sell the things that you need?

Yes	116 (66%)
No	53 (30%)
Don't know	8 (5%)

Relationships with staff

6.1 Do most staff here treat you with respect?

Yes	113 (64%)
No	63 (36%)

6.2 Are there any staff here you could turn to if you had a problem?

Yes	105 (60%)
No	70 (40%)

6.3 In the last week, has any member of staff talked to you about how you are getting on?

Yes	45 (26%)
No	127 (74%)

6.4 How helpful is your personal or named officer?

Very helpful	23 (14%)
Quite helpful	31 (18%)
Not very helpful	26 (15%)
Not at all helpful	47 (28%)
Don't know	31 (18%)
Don't have a personal / named officer	10 (6%)

6.5 How often do you see prison governors, directors or senior managers talking to prisoners?

Regularly	14 (8%)
Sometimes	44 (25%)
Hardly ever	102 (59%)
Don't know	13 (8%)

6.6 Do you feel that you are treated as an individual in this prison?

Yes	64 (37%)
No	108 (63%)

6.7 Are prisoners here consulted about things like food, canteen, health care or wing issues?

Yes, and things sometimes change	27 (16%)
Yes, but things don't change	72 (42%)
No	55 (32%)
Don't know	18 (10%)

Faith

7.1 What is your religion?

No religion	78 (45%)
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	68 (39%)
Buddhist	5 (3%)
Hindu	2 (1%)
Jewish	0 (0%)
Muslim	17 (10%)
Sikh	2 (1%)
Other	2 (1%)

7.2 Are your religious beliefs respected here?

Yes	68 (39%)
No	11 (6%)
Don't know	16 (9%)
Not applicable (no religion)	78 (45%)

7.3 Are you able to speak to a chaplain of your faith in private, if you want to?

Yes	63 (36%)
No	9 (5%)
Don't know	24 (14%)
Not applicable (no religion)	78 (45%)

7.4 Are you able to attend religious services, if you want to?

Yes	82 (47%)
No	6 (3%)
Don't know	7 (4%)
Not applicable (no religion)	78 (45%)

Contact with family and friends

8.1	**Have staff here encouraged you to keep in touch with your family / friends?**	
	Yes	52 (30%)
	No	121 (70%)
8.2	**Have you had any problems with sending or receiving mail (letters or parcels)?**	
	Yes	119 (69%)
	No	53 (31%)
8.3	**Are you able to use a phone every day (if you have credit)?**	
	Yes	170 (97%)
	No	6 (3%)
8.4	**How easy or difficult is it for your family and friends to get here?**	
	Very easy	12 (7%)
	Quite easy	55 (32%)
	Quite difficult	48 (28%)
	Very difficult	51 (29%)
	Don't know	8 (5%)
8.5	**How often do you have visits from family or friends?**	
	More than once a week	2 (1%)
	About once a week	34 (19%)
	Less than once a week	89 (51%)
	Not applicable (don't get visits)	50 (29%)
8.6	**Do visits usually start and finish on time?**	
	Yes	46 (38%)
	No	76 (62%)
8.7	**Are your visitors usually treated respectfully by staff?**	
	Yes	87 (73%)
	No	32 (27%)

Time out of cell

9.1	**Do you know what the unlock and lock-up times are supposed to be here (or roll check times if you are in an open prison)?**	
	Yes, and these times are usually kept to	82 (47%)
	Yes, but these times are not usually kept to	79 (45%)
	No	14 (8%)
9.2	**How long do you usually spend out of your cell on a typical weekday (including time spent at education, work etc.)?**	
	Less than 2 hours	22 (13%)
	2 to 6 hours	53 (31%)
	6 to 10 hours	69 (41%)
	10 hours or more	10 (6%)
	Don't know	16 (9%)

9.3 How long do you usually spend out of your cell on a typical Saturday or Sunday?

Less than 2 hours	20 (12%)
2 to 6 hours	112 (65%)
6 to 10 hours	25 (15%)
10 hours or more	2 (1%)
Don't know	12 (7%)

9.4 How many days in a typical week do you have time to do domestics (shower, clean cell, use the wing phones etc.)?

None	7 (4%)
1 or 2	17 (10%)
3 to 5	15 (9%)
More than 5	114 (67%)
Don't know	16 (9%)

9.5 How many days in a typical week do you get association, if you want it?

None	7 (4%)
1 or 2	2 (1%)
3 to 5	14 (8%)
More than 5	139 (80%)
Don't know	11 (6%)

9.6 How many days in a typical week could you go outside for exercise, if you wanted to?

None	7 (4%)
1 or 2	5 (3%)
3 to 5	21 (12%)
More than 5	135 (78%)
Don't know	5 (3%)

9.7 Typically, how often do you go to the gym?

Twice a week or more	99 (57%)
About once a week	16 (9%)
Less than once a week	9 (5%)
Never	49 (28%)

9.8 Typically, how often do you go to the library?

Twice a week or more	28 (16%)
About once a week	40 (23%)
Less than once a week	28 (16%)
Never	76 (44%)

9.9 Does the library have a wide enough range of materials to meet your needs?

Yes	62 (38%)
No	26 (16%)
Don't use the library	76 (46%)

Applications, complaints and legal rights

10.1 Is it easy for you to make an application?

Yes	132 (76%)
No	29 (17%)
Don't know	12 (7%)

10.2 If you have made any applications here, please answer the questions below:

	Yes	No	Not made any applications
Are applications usually dealt with fairly?	65 (41%)	77 (49%)	16 (10%)
Are applications usually dealt with within 7 days?	54 (35%)	83 (54%)	16 (10%)

10.3 Is it easy for you to make a complaint?

Yes	109 (63%)
No	38 (22%)
Don't know	25 (15%)

10.4 If you have made any complaints here, please answer the questions below:

	Yes	No	Not made any complaints
Are complaints usually dealt with fairly?	30 (19%)	81 (50%)	50 (31%)
Are complaints usually dealt with within 7 days?	28 (18%)	75 (49%)	50 (33%)

10.5 Have you ever been prevented from making a complaint here when you wanted to?

Yes	37 (22%)
No	97 (57%)
Not wanted to make a complaint	35 (21%)

10.6 In this prison, is it easy or difficult for you to...

	Easy	Difficult	Don't know	Don't need this
Communicate with your solicitor or legal representative?	88 (52%)	32 (19%)	25 (15%)	25 (15%)
Attend legal visits?	75 (47%)	17 (11%)	38 (24%)	29 (18%)
Get bail information?	22 (14%)	26 (16%)	50 (31%)	61 (38%)

10.7 Have staff here ever opened letters from your solicitor or legal representative when you were not present?

Yes	83 (49%)
No	51 (30%)
Not had any legal letters	34 (20%)

Health care

11.1 How easy or difficult is it to see the following people?

	Very easy	Quite easy	Quite difficult	Very difficult	Don't know
Doctor	10 (6%)	58 (34%)	49 (28%)	41 (24%)	15 (9%)
Nurse	16 (10%)	64 (39%)	39 (24%)	27 (16%)	19 (12%)
Dentist	4 (2%)	18 (11%)	41 (25%)	86 (51%)	18 (11%)
Mental health workers	7 (4%)	23 (14%)	32 (19%)	44 (26%)	61 (37%)

11.2 What do you think of the quality of the health service from the following people?

	Very good	Quite good	Quite bad	Very bad	Don't know
Doctor	27 (16%)	57 (33%)	39 (23%)	31 (18%)	17 (10%)
Nurse	33 (20%)	75 (44%)	21 (12%)	23 (14%)	17 (10%)
Dentist	22 (13%)	38 (23%)	20 (12%)	38 (23%)	48 (29%)
Mental health workers	20 (12%)	25 (15%)	26 (16%)	27 (16%)	66 (40%)

11.3 Do you have any mental health problems?

Yes	79 (46%)
No	92 (54%)

11.4 Have you been helped with your mental health problems in this prison?

Yes	28 (16%)
No	54 (31%)
Don't have any mental health problems	92 (53%)

11.5 What do you think of the overall quality of the health services here?

Very good	14 (8%)
Quite good	66 (39%)
Quite bad	44 (26%)
Very bad	29 (17%)
Don't know	16 (9%)

Other support needs

12.1 Do you consider yourself to have a disability (long-term physical, mental or learning needs that affect your day-to-day life)?

Yes	63 (36%)
No	110 (64%)

12.2 If you have a disability, are you getting the support you need?

Yes	19 (11%)
No	43 (25%)
Don't have a disability	110 (64%)

12.3 Have you been on an ACCT in this prison?

Yes	29 (17%)
No	142 (83%)

12.4 If you have been on an ACCT in this prison, did you feel cared for by staff?

Yes	8 (5%)
No	18 (11%)
Have not been on an ACCT in this prison	142 (85%)

12.5 How easy or difficult is it for you to speak to a Listener, if you need to?

Very easy	28 (16%)
Quite easy	38 (22%)
Quite difficult	11 (6%)
Very difficult	7 (4%)
Don't know	83 (49%)
No Listeners at this prison	4 (2%)

Alcohol and drugs

13.1	**Did you have an alcohol problem when you came into this prison?**	
	Yes	20 (12%)
	No	151 (88%)
13.2	**Have you been helped with your alcohol problem in this prison?**	
	Yes	7 (4%)
	No	10 (6%)
	Did not / do not have an alcohol problem	151 (90%)
13.3	**Did you have a drug problem when you came into this prison (including illicit drugs and medication not prescribed to you)?**	
	Yes	37 (22%)
	No	133 (78%)
13.4	**Have you developed a problem with illicit drugs since you have been in this prison?**	
	Yes	32 (19%)
	No	136 (81%)
13.5	**Have you developed a problem with taking medication not prescribed to you since you have been in this prison?**	
	Yes	20 (12%)
	No	151 (88%)
13.6	**Have you been helped with your drug problem in this prison (including illicit drugs and medication not prescribed to you)?**	
	Yes	23 (14%)
	No	32 (19%)
	Did not / do not have a drug problem	111 (67%)
13.7	**Is it easy or difficult to get illicit drugs in this prison?**	
	Very easy	60 (35%)
	Quite easy	22 (13%)
	Quite difficult	11 (6%)
	Very difficult	6 (3%)
	Don't know	73 (42%)
13.8	**Is it easy or difficult to get alcohol in this prison?**	
	Very easy	35 (20%)
	Quite easy	29 (17%)
	Quite difficult	8 (5%)
	Very difficult	9 (5%)
	Don't know	91 (53%)

Safety

14.1	**Have you ever felt unsafe here?**	
	Yes	79 (45%)
	No	95 (55%)
14.2	**Do you feel unsafe now?**	
	Yes	40 (23%)
	No	133 (77%)

14.3 Have you experienced any of the following types of bullying / victimisation from other prisoners here?

Verbal abuse	50 (30%)
Threats or intimidation	52 (31%)
Physical assault	34 (20%)
Sexual assault	7 (4%)
Theft of canteen or property	35 (21%)
Other bullying / victimisation	30 (18%)
Not experienced any of these from prisoners here	97 (58%)

14.4 If you were being bullied / victimised by other prisoners here, would you report it?

Yes	53 (31%)
No	116 (69%)

14.5 Have you experienced any of the following types of bullying / victimisation from staff here?

Verbal abuse	54 (33%)
Threats or intimidation	46 (28%)
Physical assault	24 (15%)
Sexual assault	3 (2%)
Theft of canteen or property	13 (8%)
Other bullying / victimisation	37 (23%)
Not experienced any of these from staff here	85 (52%)

14.6 If you were being bullied / victimised by staff here, would you report it?

Yes	86 (51%)
No	84 (49%)

Behaviour management

15.1 Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?

Yes	71 (41%)
No	82 (47%)
Don't know what the incentives / rewards are	20 (12%)

15.2 Do you feel you have been treated fairly in the behaviour management scheme (e.g. IEP) in this prison?

Yes	67 (39%)
No	80 (46%)
Don't know	21 (12%)
Don't know what this is	6 (3%)

15.3 Have you been physically restrained by staff in this prison in the last 6 months?

Yes	38 (22%)
No	136 (78%)

15.4 If you have been restrained by staff in this prison in the last 6 months, did anyone come and talk to you about it afterwards?

Yes	8 (5%)
No	29 (17%)
Don't remember	0 (0%)
Not been restrained here in last 6 months	136 (79%)

15.5 Have you spent one or more nights in the segregation unit in this prison in the last 6 months?

Yes	16 (9%)
No	156 (91%)

15.6 If you have spent one or more nights in the segregation unit in this prison in the last 6 months please answer the questions below:

	Yes	No
Were you treated well by segregation staff?	8 (57%)	6 (43%)
Could you shower every day?	12 (80%)	3 (20%)
Could you go outside for exercise every day?	12 (86%)	2 (14%)
Could you use the phone every day (if you had credit)?	9 (64%)	5 (36%)

Education, skills and work

16.1 Is it easy or difficult to get into the following activities in this prison?

	Easy	Difficult	Don't know	Not available here
Education	113 (68%)	24 (14%)	23 (14%)	6 (4%)
Vocational or skills training	58 (36%)	51 (31%)	48 (30%)	5 (3%)
Prison job	56 (34%)	86 (53%)	16 (10%)	5 (3%)
Voluntary work outside of the prison	5 (3%)	48 (31%)	73 (47%)	29 (19%)
Paid work outside of the prison	6 (4%)	43 (28%)	73 (47%)	34 (22%)

16.2 If you have done any of these activities while in this prison, do you think they will help you on release?

	Yes, will help	No, won't help	Not done this
Education	86 (53%)	44 (27%)	33 (20%)
Vocational or skills training	66 (42%)	32 (21%)	58 (37%)
Prison job	53 (33%)	78 (49%)	28 (18%)
Voluntary work outside of the prison	26 (17%)	24 (16%)	100 (67%)
Paid work outside of the prison	30 (20%)	21 (14%)	99 (66%)

16.3 Do staff encourage you to attend education, training or work?

Yes	96 (58%)
No	69 (42%)
Not applicable (e.g. if you are retired, sick or on remand)	1 (1%)

Planning and progression

17.1 Do you have a custody plan? (This may be called a sentence plan or resettlement plan.)

Yes	103 (61%)
No	66 (39%)

17.2 Do you understand what you need to do to achieve the objectives or targets in your custody plan?

Yes	91 (89%)
No	9 (9%)
Don't know what my objectives or targets are	2 (2%)

17.3 Are staff here supporting you to achieve your objectives or targets?

Yes	37 (38%)
No	59 (60%)
Don't know what my objectives or targets are	2 (2%)

17.4 If you have done any of the following things in this prison, did they help you to achieve your objectives or targets?

	Yes, this helped	No, this didn't help	Not done / don't know
Offending behaviour programmes	42 (45%)	12 (13%)	40 (43%)
Other programmes	32 (36%)	12 (13%)	45 (51%)
One to one work	18 (22%)	12 (14%)	53 (64%)
Being on a specialist unit	10 (13%)	6 (8%)	64 (80%)
ROTL - day or overnight release	3 (4%)	4 (5%)	73 (91%)

Preparation for release

18.1 Do you expect to be released in the next 3 months?

Yes	31 (19%)
No	124 (74%)
Don't know	12 (7%)

18.2 How close is this prison to your home area or intended release address?

Very near	3 (10%)
Quite near	9 (31%)
Quite far	9 (31%)
Very far	8 (28%)

18.3 Is anybody helping you to prepare for your release (e.g. a home probation officer, responsible officer, case worker)?

Yes	20 (67%)
No	10 (33%)

18.4 Are you getting help to sort out the following things for when you are released?

	Yes, I'm getting help with this	No, but I need help with this	No, and I don't need help with this
Finding accommodation	8 (29%)	8 (29%)	12 (43%)
Getting employment	2 (7%)	13 (46%)	13 (46%)
Setting up education or training	3 (11%)	10 (36%)	15 (54%)
Arranging benefits	9 (32%)	10 (36%)	9 (32%)
Sorting out finances	4 (14%)	9 (32%)	15 (54%)
Support for drug or alcohol problems	10 (36%)	4 (14%)	14 (50%)
Health / mental health support	8 (28%)	8 (28%)	13 (45%)
Social care support	3 (11%)	5 (19%)	19 (70%)
Getting back in touch with family or friends	6 (21%)	5 (17%)	18 (62%)

More about you

19.1 Do you have children under the age of 18?

Yes	78 (46%)
No	92 (54%)

19.2 Are you a UK / British citizen?

Yes	163 (96%)
No	7 (4%)

19.3	**Are you from a traveller community (e.g. Gypsy, Roma, Irish Traveller)?**	
	Yes	4 (2%)
	No	166 (98%)
19.4	**Have you ever been in the armed services (e.g. army, navy, air force)?**	
	Yes	14 (8%)
	No	156 (92%)
19.5	**What is your gender?**	
	Male	165 (98%)
	Female	1 (1%)
	Non-binary	0 (0%)
	Other	3 (2%)
19.6	**How would you describe your sexual orientation?**	
	Straight / heterosexual	160 (95%)
	Gay / lesbian / homosexual	2 (1%)
	Bisexual	2 (1%)
	Other	4 (2%)
19.7	**Do you identify as transgender or transsexual?**	
	Yes	3 (2%)
	No	162 (98%)

Final questions about this prison

20.1	**Do you think your experiences in this prison have made you more or less likely to offend in the future?**	
	More likely to offend	17 (10%)
	Less likely to offend	71 (43%)
	Made no difference	78 (47%)

HMP Berwyn 2019

Survey responses compared with those from other HMIP surveys of category C training prisons

In this table summary statistics from HMP Berwyn 2019 are compared with the following HMIP survey data:

- Summary statistics from surveys of category C training prisons conducted since the introduction of the new questionnaire in September 2017 (20 prisons). Please note that this does not include all local prisons.

Shading is used to indicate statistical significance*, as follows:

Green shading shows results that are significantly more positive than the comparator

Blue shading shows results that are significantly more negative than the comparator

Orange shading shows significant differences in demographics and background information

No shading means that differences are not significant and may have occurred by chance

Grey shading indicates that we have no valid data for this question

** less than 1% probability that the difference is due to chance*

	HMP Berwyn 2019	All other category C training prisons surveyed since September 2017
Number of completed questionnaires returned	183	3,409

n=number of valid responses to question (HMP Berwyn 2019)

	DEMOGRAPHICS AND OTHER BACKGROUND INFORMATION			
1.2	Are you under 21 years of age?	*n=178*	**1%**	**6%**
	Are you 25 years of age or younger?	*n=178*	**17%**	**27%**
	Are you 50 years of age or older?	*n=178*	**9%**	**12%**
	Are you 70 years of age or older?	*n=178*	**0%**	**1%**
1.3	Are you from a minority ethnic group?	*n=180*	**20%**	**33%**
1.4	Have you been in this prison for less than 6 months?	*n=179*	**30%**	**35%**
1.5	Are you currently serving a sentence?	*n=178*	**100%**	**100%**
	Are you on recall?	*n=178*	**8%**	**9%**
1.6	Is your sentence less than 12 months?	*n=177*	**6%**	**8%**
	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	*n=177*	**2%**	**3%**
7.1	Are you Muslim?	*n=174*	**10%**	**18%**
11.3	Do you have any mental health problems?	*n=171*	**46%**	**44%**
12.1	Do you consider yourself to have a disability?	*n=173*	**36%**	**33%**
19.1	Do you have any children under the age of 18?	*n=170*	**46%**	**50%**
19.2	Are you a foreign national?	*n=170*	**4%**	**10%**
19.3	Are you from a traveller community? (e.g. Gypsy, Roma, Irish Traveller)	*n=170*	**2%**	**5%**
19.4	Have you ever been in the armed services?	*n=170*	**8%**	**6%**
19.5	Is your gender female or non-binary?	*n=169*	**2%**	**1%**
19.6	Are you homosexual, bisexual or other sexual orientation?	*n=168*	**5%**	**4%**

Shading is used to indicate statistical significance*, as follows:

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19.7	Do you identify as transgender or transsexual? *n=165*	2%	2%
ARRIVAL AND RECEPTION			
2.1	Were you given up-to-date information about this prison before you came here? *n=177*	24%	15%
2.2	When you arrived at this prison, did you spend less than 2 hours in reception? *n=176*	30%	49%
2.3	When you were searched in reception, was this done in a respectful way? *n=175*	81%	82%
2.4	Overall, were you treated very / quite well in reception? *n=176*	90%	85%

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2.5	When you first arrived, did you have any problems? *n=175*	65%	73%
2.5	Did you have problems with:		
	- Getting phone numbers? *n=175*	17%	26%
	- Contacting family? *n=175*	13%	26%
	- Arranging care for children or other dependents? *n=175*	1%	2%
	- Contacting employers? *n=175*	3%	2%
	- Money worries? *n=175*	14%	16%
	- Housing worries? *n=175*	9%	13%
	- Feeling depressed? *n=175*	20%	30%
	- Feeling suicidal? *n=175*	5%	9%
	- Other mental health problems? *n=175*	19%	21%
	- Physical health problems? *n=175*	11%	13%
	- Drugs or alcohol (e.g. withdrawal)? *n=175*	6%	11%
	- Getting medication? *n=175*	30%	20%
	- Needing protection from other prisoners? *n=175*	5%	6%
	- Lost or delayed property? *n=175*	27%	22%
	For those who had any problems when they first arrived:		
2.6	Did staff help you to deal with these problems? *n=111*	29%	32%
FIRST NIGHT AND INDUCTION			
3.1	Before you were locked up on your first night, were you offered:		
	- Tobacco or nicotine replacement? *n=171*	65%	66%
	- Toiletries / other basic items? *n=171*	57%	51%
	- A shower? *n=171*	60%	43%
	- A free phone call? *n=171*	37%	44%
	- Something to eat? *n=171*	74%	75%
	- The chance to see someone from health care? *n=171*	61%	60%
	- The chance to talk to a Listener or Samaritans? *n=171*	30%	27%
	- Support from another prisoner (e.g. Insider or buddy)? *n=171*	23%	22%
	- None of these? *n=171*	9%	7%
3.2	On your first night in this prison, was your cell very / quite clean? *n=177*	85%	36%

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3.3	Did you feel safe on your first night here?	*n=175*	**87%**	**72%**
3.4	In your first few days here, did you get:			
	- Access to the prison shop / canteen?	*n=172*	**78%**	**40%**
	- Free PIN phone credit?	*n=170*	**48%**	**47%**
	- Numbers put on your PIN phone?	*n=164*	**62%**	**47%**
3.5	Have you had an induction at this prison?	*n=175*	**99%**	**94%**
	For those who have had an induction:			
3.5	Did your induction cover everything you needed to know about this prison?	*n=173*	**60%**	**55%**

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ON THE WING				
4.1	Are you in a cell on your own?	*n=178*	**44%**	**62%**
4.2	Is your cell call bell normally answered within 5 minutes?	*n=175*	**38%**	**30%**
4.3	On the wing or houseblock you currently live on:			
	- Do you normally have enough clean, suitable clothes for the week?	*n=173*	**76%**	**68%**
	- Can you shower every day?	*n=176*	**98%**	**89%**
	- Do you have clean sheets every week?	*n=172*	**73%**	**65%**
	- Do you get cell cleaning materials every week?	*n=172*	**54%**	**59%**
	- Is it normally quiet enough for you to relax or sleep at night?	*n=173*	**72%**	**67%**
	- Can you get your stored property if you need it?	*n=171*	**21%**	**25%**
4.4	Are the communal / shared areas of your wing or houseblook normally very / quite clean?	*n=175*	**69%**	**59%**
FOOD AND CANTEEN				
5.1	Is the quality of the food in this prison very / quite good?	*n=172*	**48%**	**40%**
5.2	Do you get enough to eat at meal-times always / most of the time?	*n=178*	**28%**	**35%**
5.3	Does the shop / canteen sell the things that you need?	*n=177*	**66%**	**61%**
RELATIONSHIPS WITH STAFF				
6.1	Do most staff here treat you with respect?	*n=176*	**64%**	**69%**
6.2	Are there any staff here you could turn to if you had a problem?	*n=175*	**60%**	**70%**
6.3	In the last week, has any member of staff talked to you about how you are getting on?	*n=172*	**26%**	**31%**
6.4	Do you have a personal officer?	*n=168*	**94%**	**83%**
	For those who have a personal officer:			
6.4	Is your personal or named officer very / quite helpful?	*n=158*	**34%**	**46%**
6.5	Do you regularly see prison governors, directors or senior managers talking to prisoners?	*n=173*	**8%**	**10%**
6.6	Do you feel that you are treated as an individual in this prison?	*n=172*	**37%**	**43%**
6.7	Are prisoners here consulted about things like food, canteen, health care or wing issues?	*n=172*	**58%**	**51%**
	If so, do things sometimes change?	*n=99*	**27%**	**32%**
FAITH				
7.1	Do you have a religion?	*n=174*	**55%**	**69%**
	For those who have a religion:			
7.2	Are your religious beliefs respected here?	*n=95*	**72%**	**70%**

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7.3	Are you able to speak to a chaplain of your faith in private, if you want to? *n=96*	**66%**	**69%**
7.4	Are you able to attend religious services, if you want to? *n=95*	**86%**	**88%**

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CONTACT WITH FAMILY AND FRIENDS				
8.1	Have staff here encouraged you to keep in touch with your family / friends?	*n=173*	**30%**	**27%**
8.2	Have you had any problems with sending or receiving mail (letters or parcels)?	*n=172*	**69%**	**57%**
8.3	Are you able to use a phone every day (if you have credit)?	*n=176*	**97%**	**88%**
8.4	Is it very / quite easy for your family and friends to get here?	*n=174*	**39%**	**35%**
8.5	Do you get visits from family/friends once a week or more?	*n=175*	**21%**	**17%**
	For those who get visits:			
8.6	Do visits usually start and finish on time?	*n=122*	**38%**	**50%**
8.7	Are your visitors usually treated respectfully by staff?	*n=119*	**73%**	**74%**
TIME OUT OF CELL				
9.1	Do you know what the unlock and lock-up times are supposed to be here?	*n=175*	**92%**	**91%**
	For those who know what the unlock and lock-up times are supposed to be:			
9.1	Are these times usually kept to?	*n=161*	**51%**	**57%**
9.2	Do you usually spend less than 2 hours out of your cell on a typical weekday?	*n=170*	**13%**	**17%**
	Do you usually spend 10 hours or more out of your cell on a typical weekday?	*n=170*	**6%**	**8%**
9.3	Do you usually spend less than 2 hours out of your cell on a typical Saturday or Sunday?	*n=171*	**12%**	**22%**
	Do you usually spend 10 hours or more out of your cell on a typical Saturday or Sunday?	*n=171*	**1%**	**3%**
9.4	Do you have time to do domestics more than 5 days in a typical week?	*n=169*	**88%**	**56%**
9.5	Do you get association more than 5 days in a typical week, if you want it?	*n=173*	**68%**	**65%**
9.6	Could you go outside for exercise more than 5 days in a typical week, if you wanted to?	*n=173*	**78%**	**65%**
9.7	Do you typically go to the gym twice a week or more?	*n=173*	**57%**	**53%**
9.8	Do you typically go to the library once a week or more?	*n=172*	**40%**	**49%**
	For those who use the library:			
9.9	Does the library have a wide enough range of materials to meet your needs?	*n=88*	**71%**	**56%**
APPLICATIONS, COMPLAINTS AND LEGAL RIGHTS				
10.1	Is it easy for you to make an application?	*n=173*	**76%**	**73%**
	For those who have made an application:			
10.2	Are applications usually dealt with fairly?	*n=142*	**46%**	**50%**
	Are applications usually dealt with within 7 days?	*n=137*	**39%**	**36%**
10.3	Is it easy for you to make a complaint?	*n=172*	**63%**	**62%**

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	For those who have made a complaint:			
10.4	Are complaints usually dealt with fairly?	*n=111*	**27%**	**30%**
	Are complaints usually dealt with within 7 days?	*n=103*	**27%**	**4%**
10.5	Have you ever been prevented from making a complaint here when you wanted to?	*n=134*	**28%**	**28%**

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	For those who need it, is it easy to:		
10.6	Communicate with your solicitor or legal representative? *n=145*	**61%**	**39%**
	Attend legal visits? *n=130*	**58%**	**47%**
	Get bail information? *n=98*	**22%**	**16%**
	For those who have had legal letters:		
10.7	Have staff here ever opened letters from your solicitor or legal representative when you were not present? *n=134*	**62%**	**58%**
HEALTH CARE			
11.1	Is it very / quite easy to see:		
	- Doctor? *n=173*	**39%**	**31%**
	- Nurse? *n=165*	**49%**	**52%**
	- Dentist? *n=167*	**13%**	**15%**
	- Mental health workers? *n=167*	**18%**	**23%**
11.2	Do you think the quality of the health service is very / quite good from:		
	- Doctor? *n=171*	**49%**	**47%**
	- Nurse? *n=169*	**64%**	**57%**
	- Dentist? *n=166*	**36%**	**34%**
	- Mental health workers? *n=164*	**27%**	**29%**
11.3	Do you have any mental health problems? *n=171*	**46%**	**44%**
	For those who have mental health problems:		
11.4	Have you been helped with your mental health problems in this prison? *n=82*	**34%**	**42%**
11.5	Do you think the overall quality of the health services here is very / quite good? *n=169*	**47%**	**42%**
OTHER SUPPORT NEEDS			
12.1	Do you consider yourself to have a disability? *n=173*	**36%**	**33%**
	For those who have a disability:		
12.2	Are you getting the support you need? *n=62*	**31%**	**31%**
12.3	Have you been on an ACCT in this prison? *n=171*	**17%**	**16%**
	For those who have been on an ACCT:		
12.4	Did you feel cared for by staff? *n=26*	**31%**	**44%**
12.5	Is it very / quite easy for you to speak to a Listener if you need to? *n=171*	**39%**	**39%**
ALCOHOL AND DRUGS			
13.1	Did you have an alcohol problem when you came into this prison? *n=171*	**12%**	**14%**

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	For those who had / have an alcohol problem:		
13.2	Have you been helped with your alcohol problem in this prison? *n=17*	41%	51%
13.3	Did you have a drug problem when you came into this prison (including illicit drugs and medication not prescribed to you)? *n=170*	22%	28%
13.4	Have you developed a problem with illicit drugs since you have been in this prison? *n=168*	19%	17%
13.5	Have you developed a problem with taking medication not prescribed to you since you have been in this prison? *n=171*	12%	10%
	For those who had / have a drug problem:		
13.6	Have you been helped with your drug problem in this prison? *n=55*	42%	48%
13.7	Is it very / quite easy to get illicit drugs in this prison? *n=172*	48%	49%
13.8	Is it very / quite easy to get alcohol in this prison? *n=172*	37%	32%

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SAFETY				
14.1	Have you ever felt unsafe here?	*n=174*	**45%**	**47%**
14.2	Do you feel unsafe now?	*n=173*	**23%**	**23%**
14.3	Have you experienced any of the following from other prisoners here:			
	- Verbal abuse?	*n=168*	**30%**	**34%**
	- Threats or intimidation?	*n=168*	**31%**	**30%**
	- Physical assault?	*n=168*	**20%**	**18%**
	- Sexual assault?	*n=168*	**4%**	**2%**
	- Theft of canteen or property?	*n=168*	**21%**	**25%**
	- Other bullying / victimisation?	*n=168*	**18%**	**17%**
	- Not experienced any of these from prisoners here	*n=168*	**58%**	**54%**
14.4	If you were being bullied / victimised by other prisoners here, would you report it?	*n=169*	**31%**	**33%**
14.5	Have you experienced any of the following from staff here:			
	- Verbal abuse?	*n=164*	**33%**	**30%**
	- Threats or intimidation?	*n=164*	**28%**	**23%**
	- Physical assault?	*n=164*	**15%**	**11%**
	- Sexual assault?	*n=164*	**2%**	**2%**
	- Theft of canteen or property?	*n=164*	**8%**	**9%**
	- Other bullying / victimisation?	*n=164*	**23%**	**17%**
	- Not experienced any of these from staff here	*n=164*	**52%**	**58%**
14.6	If you were being bullied / victimised by staff here, would you report it?	*n=170*	**51%**	**48%**
BEHAVIOUR MANAGEMENT				
15.1	Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?	*n=173*	**41%**	**40%**
15.2	Do you feel you have been treated fairly in the behaviour management scheme (e.g. IEP) in this prison?	*n=174*	**40%**	**37%**
15.3	Have you been physically restrained by staff in this prison, in the last 6 months?	*n=174*	**22%**	**13%**
	For those who have been restrained in the last 6 months:			
15.4	Did anyone come and talk to you about it afterwards?	*n=37*	**22%**	**20%**
15.5	Have you spent one or more nights in the segregation unit in this prison in the last 6 months?	*n=172*	**9%**	**9%**
	For those who have spent one or more nights in the segregation unit in the last 6 months:			
15.6	Were you treated well by segregation staff?	*n=14*	**57%**	**58%**

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	Could you shower every day? *n=15*	**80%**	**76%**
	Could you go outside for exercise every day? *n=14*	**86%**	**77%**
	Could you use the phone every day (if you had credit)? *n=14*	**64%**	**66%**

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EDUCATION, SKILLS AND WORK			
16.1	In this prison, is it easy to get into the following activities:		
	- Education? *n=166*	68%	61%
	- Vocational or skills training? *n=162*	36%	41%
	- Prison job? *n=163*	34%	48%
	- Voluntary work outside of the prison? *n=155*	3%	5%
	- Paid work outside of the prison? *n=156*	4%	4%
16.2	In this prison, have you done the following activities:		
	- Education? *n=163*	80%	80%
	- Vocational or skills training? *n=156*	63%	69%
	- Prison job? *n=159*	82%	80%
	- Voluntary work outside of the prison? *n=150*	33%	33%
	- Paid work outside of the prison? *n=150*	34%	32%
	For those who have done the following activities, do you think they will help you on release:		
	- Education? *n=130*	66%	61%
	- Vocational or skills training? *n=98*	67%	66%
	- Prison job? *n=131*	41%	40%
	- Voluntary work outside of the prison? *n=50*	52%	53%
	- Paid work outside of the prison? *n=51*	59%	57%
16.3	Do staff encourage you to attend education, training or work? *n=165*	58%	60%
PLANNING AND PROGRESSION			
17.1	Do you have a custody plan? *n=169*	61%	58%
	For those who have a custody plan:		
17.2	Do you understand what you need to do to achieve your objectives or targets? *n=102*	89%	83%
17.3	Are staff helping you to achieve your objectives or targets? *n=98*	38%	44%
17.4	In this prison, have you done:		
	- Offending behaviour programmes? *n=94*	57%	48%
	- Other programmes? *n=89*	49%	42%
	- One to one work? *n=83*	36%	38%
	- Been on a specialist unit? *n=80*	20%	20%

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- ROTL - day or overnight release?	*n=80*	**9%**	**15%**
For those who have done the following, did they help you to achieve your objectives or targets:			
- Offending behaviour programmes?	*n=54*	**78%**	**70%**
- Other programmes?	*n=44*	**73%**	**65%**
- One to one work?	*n=30*	**60%**	**66%**
- Being on a specialist unit?	*n=16*	**63%**	**45%**
- ROTL - day or overnight release?	*n=7*	**43%**	**38%**

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PREPARATION FOR RELEASE				
18.1	Do you expect to be released in the next 3 months?	*n=167*	**19%**	**26%**
	For those who expect to be released in the next 3 months:			
18.2	Is this prison very / quite near to your home area or intended release address?	*n=29*	**41%**	**41%**
18.3	Is anybody helping you to prepare for your release?	*n=30*	**67%**	**58%**
18.4	Do you need help to sort out the following for when you are released:			
	- Finding accommodation?	*n=28*	**57%**	**63%**
	- Getting employment?	*n=28*	**54%**	**63%**
	- Setting up education or training?	*n=28*	**46%**	**48%**
	- Arranging benefits?	*n=28*	**68%**	**68%**
	- Sorting out finances?	*n=28*	**46%**	**58%**
	- Support for drug or alcohol problems?	*n=28*	**50%**	**43%**
	- Health / mental Health support?	*n=29*	**55%**	**49%**
	- Social care support?	*n=27*	**30%**	**36%**
	- Getting back in touch with family or friends?	*n=29*	**38%**	**39%**
18.4	Are you getting help to sort out the following for when you are released, if you need it:			
	- Finding accommodation?	*n=16*	**50%**	**37%**
	- Getting employment?	*n=15*	**13%**	**24%**
	- Setting up education or training?	*n=13*	**23%**	**25%**
	- Arranging benefits?	*n=19*	**47%**	**29%**
	- Sorting out finances?	*n=13*	**31%**	**25%**
	- Support for drug or alcohol problems?	*n=14*	**71%**	**49%**
	- Health / mental Health support?	*n=16*	**50%**	**30%**
	- Social care support?	*n=8*	**38%**	**24%**
	- Getting back in touch with family or friends?	*n=11*	**55%**	**31%**
FINAL QUESTION ABOUT THIS PRISON				
20.1	Do you think your experiences in this prison have made you less likely to offend in the future?	*n=166*	**43%**	**50%**

HMP Berwyn 2019

Comparison of survey responses between sub-populations of prisoners

In this table the following analyses are presented:
- responses of prisoners from black and minority ethnic groups are compared with those of white prisoners
Please note that these analyses are based on summary data from selected survey questions only.

Shading is used to indicate statistical significance*, as follows:

Green shading shows results that are significantly more positive than the comparator

Blue shading shows results that are significantly more negative than the comparator

Orange shading shows significant differences in demographics and background information

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Grey shading indicates that we have no valid data for this question

** less than 1% probability that the difference is due to chance*

		Black and minority ethnic	White
	Number of completed questionnaires returned	36	144
	DEMOGRAPHICS AND OTHER BACKGROUND INFORMATION		
1.2	Are you under 25 years of age?	17%	17%
	Are you 50 years of age or older?	6%	10%
1.3	Are you from a minority ethnic group?		
7.1	Are you Muslim?	52%	0%
11.3	Do you have any mental health problems?	34%	49%
12.1	Do you consider yourself to have a disability?	27%	39%
19.2	Are you a foreign national?	6%	4%
19.3	Are you from a traveller community? (e.g. Gypsy, Roma, Irish Traveller)	3%	2%
	ARRIVAL AND RECEPTION		
2.3	When you were searched in reception, was this done in a respectful way?	85%	79%
2.4	Overall, were you treated very / quite well in reception?	97%	88%
2.5	When you first arrived, did you have any problems?	75%	62%
	For those who had any problems when they first arrived:		
2.6	Did staff help you to deal with these problems?	24%	31%
	FIRST NIGHT AND INDUCTION		
3.3	Did you feel safe on your first night here?	89%	87%
3.5	Have you had an induction at this prison?	97%	99%
	For those who have had an induction:		
3.5	Did your induction cover everything you needed to know about this prison?	59%	60%
	ON THE WING		
4.2	Is your cell call bell normally answered within 5 minutes?	32%	39%
4.3	On the wing or houseblock you currently live on:		
	- Do you normally have enough clean, suitable clothes for the week?	86%	74%
	- Can you shower every day?	97%	98%
	- Do you have clean sheets every week?	89%	68%
	- Do you get cell cleaning materials every week?	40%	57%
	- Is it normally quiet enough for you to relax or sleep at night?	75%	71%
	- Can you get your stored property if you need it?	15%	21%

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** less than 1% probability that the difference is due to chance*

	Black and minority ethnic	White
Number of completed questionnaires returned	36	144

FOOD AND CANTEEN			
5.2	Do you get enough to eat at meal-times always / most of the time?	19%	31%
5.3	Does the shop / canteen sell the things that you need?	66%	66%
RELATIONSHIPS WITH STAFF			
6.1	Do most staff here treat you with respect?	63%	64%
6.2	Are there any staff here you could turn to if you had a problem?	57%	60%
6.3	In the last week, has any member of staff talked to you about how you are getting on?	29%	26%
6.6	Do you feel that you are treated as an individual in this prison?	32%	39%
FAITH			
	For those who have a religion:		
7.2	Are your religious beliefs respected here?	83%	68%
7.3	Are you able to speak to a chaplain of your faith in private, if you want to?	79%	61%
CONTACT WITH FAMILY AND FRIENDS			
8.1	Have staff here encouraged you to keep in touch with your family / friends?	18%	32%
8.2	Have you had any problems with sending or receiving mail (letters or parcels)?	73%	68%
8.3	Are you able to use a phone every day (if you have credit)?	100%	96%
	For those who get visits:		
8.7	Are your visitors usually treated respectfully by staff?	70%	74%
TIME OUT OF CELL			
9.2	Do you usually spend less than 2 hours out of your cell on a typical weekday?	15%	13%
	Do you usually spend 10 hours or more out of your cell on a typical weekday?	6%	6%
	For those who use the library:		
9.9	Does the library have a wide enough range of materials to meet your needs?	74%	69%
APPLICATIONS, COMPLAINTS AND LEGAL RIGHTS			
10.1	Is it easy for you to make an application?	82%	76%
	For those who have made an application:		
10.2	Are applications usually dealt with fairly?	33%	50%
10.3	Is it easy for you to make a complaint?	52%	67%
	For those who have made a complaint:		
10.4	Are complaints usually dealt with fairly?	5%	33%
10.5	Have you ever been prevented from making a complaint here when you wanted to?	31%	27%

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** less than 1% probability that the difference is due to chance*

	Black and minority ethnic	White
Number of completed questionnaires returned	36	144

HEALTH CARE			
11.1	Is it very / quite easy to see:		
	- Doctor?	**38%**	**40%**
	- Nurse?	**44%**	**50%**
	- Dentist?	**9%**	**14%**
	- Mental health workers?	**15%**	**19%**
	For those who have mental health problems:		
11.4	Have you been helped with your mental health problems in this prison?	**31%**	**35%**
11.5	Do you think the overall quality of the health services here is very / quite good?	**61%**	**44%**
OTHER SUPPORT NEEDS			
	For those who have a disability:		
12.2	Are you getting the support you need?	**22%**	**32%**
SAFETY			
14.1	Have you ever felt unsafe here?	**53%**	**43%**
14.2	Do you feel unsafe now?	**33%**	**21%**
14.3	Not experienced bullying / victimisation by other prisoners	**67%**	**56%**
14.4	If you were being bullied / victimised by other prisoners here, would you report it?	**41%**	**29%**
14.5	Not experienced bullying / victimisation by members of staff	**44%**	**53%**
14.6	If you were being bullied / victimised by staff here, would you report it?	**55%**	**49%**
BEHAVIOUR MANAGEMENT			
15.1	Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?	**33%**	**43%**
15.2	Do you feel you have been treated fairly in the behaviour management scheme (e.g. IEP) in this prison?	**32%**	**40%**
15.3	Have you been physically restrained by staff in this prison, in the last 6 months?	**12%**	**25%**
15.5	Have you spent one or more nights in the segregation unit in this prison in the last 6 months?	**3%**	**11%**
EDUCATION, SKILLS AND WORK			
16.3	Do staff encourage you to attend education, training or work?	**50%**	**61%**
PLANNING AND PROGRESSION			
17.1	Do you have a custody plan?	**74%**	**58%**
	For those who have a custody plan:		
17.3	Are staff helping you to achieve your objectives or targets?	**22%**	**43%**
PREPARATION FOR RELEASE			
	For those who expect to be released in the next 3 months.		
18.3	Is anybody helping you to prepare for your release?	**25%**	**73%**
FINAL QUESTION ABOUT THIS PRISON			
20.1	Do you think your experiences in this prison have made you less likely to offend in the future?	**38%**	**45%**

HMP Berwyn 2019

Comparison of survey responses between sub-populations of prisoners

In this table the following analyses are presented:
- responses of prisoners who reported that they had mental health problems compared with those who did not.
- responses of prisoners who reported that they had a disability compared with those who did not.
Please note that these analyses are based on summary data from selected survey questions only.

Shading is used to indicate statistical significance*, as follows:

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** less than 1% probability that the difference is due to chance*

		Mental health problems	No mental health problems	Have a disability	Do not have a disability
	Number of completed questionnaires returned	79	92	63	110
	DEMOGRAPHICS AND OTHER BACKGROUND INFORMATION				
1.2	Are you under 25 years of age?	14%	18%	10%	20%
	Are you 50 years of age or older?	9%	9%	15%	6%
1.3	Are you from a minority ethnic group?	14%	23%	14%	23%
7.1	Are you Muslim?	8%	11%	7%	11%
11.3	Do you have any mental health problems?			82%	25%
12.1	Do you consider yourself to have a disability?	65%	12%		
19.2	Are you a foreign national?	5%	3%	5%	4%
19.3	Are you from a traveller community? (e.g. Gypsy, Roma, Irish Traveller)	3%	1%	5%	1%
	ARRIVAL AND RECEPTION				
2.3	When you were searched in reception, was this done in a respectful way?	72%	88%	74%	85%
2.4	Overall, were you treated very / quite well in reception?	83%	96%	84%	94%
2.5	When you first arrived, did you have any problems?	82%	49%	84%	53%
	For those who had any problems when they first arrived:				
2.6	Did staff help you to deal with these problems?	23%	36%	25%	32%
	FIRST NIGHT AND INDUCTION				
3.3	Did you feel safe on your first night here?	84%	91%	82%	92%
3.5	Have you had an induction at this prison?	100%	98%	98%	99%
	For those who have had an induction:				
3.5	Did your induction cover everything you needed to know about this prison?	55%	64%	51%	66%
	ON THE WING				
4.2	Is your cell call bell normally answered within 5 minutes?	42%	34%	45%	33%
4.3	On the wing or houseblock you currently live on:				
	- Do you normally have enough clean, suitable clothes for the week?	72%	82%	67%	82%
	- Can you shower every day?	97%	99%	97%	99%
	- Do you have clean sheets every week?	67%	77%	59%	79%
	- Do you get cell cleaning materials every week?	53%	54%	53%	55%
	- Is it normally quiet enough for you to relax or sleep at night?	62%	83%	69%	74%
	- Can you get your stored property if you need it?	16%	23%	16%	23%

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** less than 1% probability that the difference is due to chance*

	Mental health problems	No mental health problems	Have a disability	Do not have a disability
Number of completed questionnaires returned	79	92	63	110
FOOD AND CANTEEN				
5.2 Do you get enough to eat at meal-times always / most of the time?	24%	31%	24%	32%
5.3 Does the shop / canteen sell the things that you need?	65%	67%	58%	71%
RELATIONSHIPS WITH STAFF				
6.1 Do most staff here treat you with respect?	53%	72%	52%	70%
6.2 Are there any staff here you could turn to if you had a problem?	53%	64%	47%	67%
6.3 In the last week, has any member of staff talked to you about how you are getting on?	30%	22%	23%	27%
6.6 Do you feel that you are treated as an individual in this prison?	33%	39%	33%	39%
FAITH				
For those who have a religion:				
7.2 Are your religious beliefs respected here?	68%	73%	64%	76%
7.3 Are you able to speak to a chaplain of your faith in private, if you want to?	57%	71%	54%	73%
CONTACT WITH FAMILY AND FRIENDS				
8.1 Have staff here encouraged you to keep in touch with your family / friends?	28%	31%	35%	27%
8.2 Have you had any problems with sending or receiving mail (letters or parcels)?	71%	69%	72%	68%
8.3 Are you able to use a phone every day (if you have credit)?	95%	98%	92%	99%
For those who get visits:				
8.7 Are your visitors usually treated respectfully by staff?	66%	77%	69%	75%
TIME OUT OF CELL				
9.2 Do you usually spend less than 2 hours out of your cell on a typical weekday?	16%	10%	23%	7%
Do you usually spend 10 hours or more out of your cell on a typical weekday?	4%	8%	3%	8%
For those who use the library:				
9.9 Does the library have a wide enough range of materials to meet your needs?	68%	73%	61%	76%
APPLICATIONS, COMPLAINTS AND LEGAL RIGHTS				
10.1 Is it easy for you to make an application?	74%	78%	72%	79%
For those who have made an application:				
10.2 Are applications usually dealt with fairly?	46%	44%	43%	48%
10.3 Is it easy for you to make a complaint?	65%	64%	59%	66%
For those who have made a complaint:				
10.4 Are complaints usually dealt with fairly?	21%	31%	21%	29%
10.5 Have you ever been prevented from making a complaint here when you wanted to?	34%	23%	37%	22%

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** less than 1% probability that the difference is due to chance*

	Mental health problems	No mental health problems	Have a disability	Do not have a disability
Number of completed questionnaires returned	79	92	63	110
HEALTH CARE				
11.1 Is it very / quite easy to see:				
- Doctor?	41%	39%	44%	36%
- Nurse?	53%	46%	54%	46%
- Dentist?	10%	14%	12%	13%
- Mental health workers?	21%	16%	20%	17%
For those who have mental health problems:				
11.4 Have you been helped with your mental health problems in this prison?	35%		35%	35%
11.5 Do you think the overall quality of the health services here is very / quite good?	40%	53%	45%	49%
OTHER SUPPORT NEEDS				
For those who have a disability:				
12.2 Are you getting the support you need?	28%	36%	31%	
SAFETY				
14.1 Have you ever felt unsafe here?	60%	33%	59%	37%
14.2 Do you feel unsafe now?	35%	13%	34%	17%
14.3 Not experienced bullying / victimisation by other prisoners	47%	67%	44%	66%
14.4 If you were being bullied / victimised by other prisoners here, would you report it?	37%	28%	46%	24%
14.5 Not experienced bullying / victimisation by members of staff	41%	60%	42%	58%
14.6 If you were being bullied / victimised by staff here, would you report it?	50%	49%	59%	46%
BEHAVIOUR MANAGEMENT				
15.1 Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?	32%	48%	30%	47%
15.2 Do you feel you have been treated fairly in the behaviour management scheme (e.g. IEP) in this prison?	26%	50%	26%	46%
15.3 Have you been physically restrained by staff in this prison, in the last 6 months?	33%	13%	37%	13%
15.5 Have you spent one or more nights in the segregation unit in this prison in the last 6 months?	14%	4%	16%	6%
EDUCATION, SKILLS AND WORK				
16.3 Do staff encourage you to attend education, training or work?	56%	58%	50%	63%
PLANNING AND PROGRESSION				
17.1 Do you have a custody plan?	58%	64%	48%	69%
For those who have a custody plan:				
17.3 Are staff helping you to achieve your objectives or targets?	44%	32%	29%	41%
PREPARATION FOR RELEASE				
For those who expect to be released in the next 3 months:				
18.3 Is anybody helping you to prepare for your release?	80%	54%	67%	65%
FINAL QUESTION ABOUT THIS PRISON				
20.1 Do you think your experiences in this prison have made you less likely to offend in the future?	37%	48%	36%	47%

HMP Berwyn 2019

Comparison of survey responses between sub-populations of prisoners

In this table the following analyses are presented:
- responses of prisoners aged 25 and under are compared with those of prisoners over 25
Please note that these analyses are based on summary data from selected survey questions only.

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** less than 1% probability that the difference is due to chance*

		25 and under	Over 25
	Number of completed questionnaires returned	30	148
DEMOGRAPHICS AND OTHER BACKGROUND INFORMATION			
1.2	Are you under 21 years of age?	3%	0%
	Are you 50 years of age or older?	0%	11%
1.3	Are you from a minority ethnic group?	20%	20%
7.1	Are you Muslim?	11%	10%
11.3	Do you have any mental health problems?	41%	48%
12.1	Do you consider yourself to have a disability?	21%	39%
19.2	Are you a foreign national?	7%	4%
19.3	Are you from a traveller community? (e.g. Gypsy, Roma, Irish Traveller)	4%	2%
ARRIVAL AND RECEPTION			
2.3	When you were searched in reception, was this done in a respectful way?	62%	85%
2.4	Overall, were you treated very / quite well in reception?	83%	92%
2.5	When you first arrived, did you have any problems?	53%	68%
	For those who had any problems when they first arrived:		
2.6	Did staff help you to deal with these problems?	7%	33%
FIRST NIGHT AND INDUCTION			
3.3	Did you feel safe on your first night here?	83%	88%
3.5	Have you had an induction at this prison?	97%	99%
	For those who have had an induction:		
3.5	Did your induction cover everything you needed to know about this prison?	48%	62%
ON THE WING			
4.2	Is your cell call bell normally answered within 5 minutes?	27%	40%
4.3	On the wing or houseblock you currently live on:		
	- Do you normally have enough clean, suitable clothes for the week?	72%	77%
	- Can you shower every day?	100%	97%
	- Do you have clean sheets every week?	80%	72%
	- Do you get cell cleaning materials every week?	38%	56%
	- Is it normally quiet enough for you to relax or sleep at night?	60%	75%
	- Can you get your stored property if you need it?	17%	20%

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** less than 1% probability that the difference is due to chance*

	25 and under	Over 25
Number of completed questionnaires returned	30	148

FOOD AND CANTEEN			
5.2	Do you get enough to eat at meal-times always / most of the time?	23%	29%
5.3	Does the shop / canteen sell the things that you need?	73%	65%
RELATIONSHIPS WITH STAFF			
6.1	Do most staff here treat you with respect?	45%	68%
6.2	Are there any staff here you could turn to if you had a problem?	32%	65%
6.3	In the last week, has any member of staff talked to you about how you are getting on?	11%	29%
6.6	Do you feel that you are treated as an individual in this prison?	36%	37%
FAITH			
	For those who have a religion:		
7.2	Are your religious beliefs respected here?	58%	74%
7.3	Are you able to speak to a chaplain of your faith in private, if you want to?	58%	67%
CONTACT WITH FAMILY AND FRIENDS			
8.1	Have staff here encouraged you to keep in touch with your family / friends?	7%	34%
8.2	Have you had any problems with sending or receiving mail (letters or parcels)?	76%	67%
8.3	Are you able to use a phone every day (if you have credit)?	90%	98%
	For those who get visits:		
8.7	Are your visitors usually treated respectfully by staff?	50%	77%
TIME OUT OF CELL			
9.2	Do you usually spend less than 2 hours out of your cell on a typical weekday?	14%	12%
	Do you usually spend 10 hours or more out of your cell on a typical weekday?	3%	7%
	For those who use the library:		
9.9	Does the library have a wide enough range of materials to meet your needs?	64%	72%
APPLICATIONS, COMPLAINTS AND LEGAL RIGHTS			
10.1	Is it easy for you to make an application?	66%	79%
	For those who have made an application:		
10.2	Are applications usually dealt with fairly?	32%	49%
10.3	Is it easy for you to make a complaint?	45%	69%
	For those who have made a complaint:		
10.4	Are complaints usually dealt with fairly?	19%	29%
10.5	Have you ever been prevented from making a complaint here when you wanted to?	38%	25%

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** less than 1% probability that the difference is due to chance*

	25 and under	Over 25
Number of completed questionnaires returned	30	148

HEALTH CARE			
11.1	Is it very / quite easy to see:		
	- Doctor?	17%	44%
	- Nurse?	30%	53%
	- Dentist?	19%	12%
	- Mental health workers?	14%	19%
	For those who have mental health problems:		
11.4	Have you been helped with your mental health problems in this prison?	25%	35%
11.5	Do you think the overall quality of the health services here is very / quite good?	25%	52%
OTHER SUPPORT NEEDS			
	For those who have a disability:		
12.2	Are you getting the support you need?	17%	33%
SAFETY			
14.1	Have you ever felt unsafe here?	39%	46%
14.2	Do you feel unsafe now?	14%	25%
14.3	Not experienced bullying / victimisation by other prisoners	61%	58%
14.4	If you were being bullied / victimised by other prisoners here, would you report it?	14%	36%
14.5	Not experienced bullying / victimisation by members of staff	48%	52%
14.6	If you were being bullied / victimised by staff here, would you report it?	37%	53%
BEHAVIOUR MANAGEMENT			
15.1	Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?	41%	41%
15.2	Do you feel you have been treated fairly in the behaviour management scheme (e.g. IEP) in this prison?	32%	40%
15.3	Have you been physically restrained by staff in this prison, in the last 6 months?	36%	19%
15.5	Have you spent one or more nights in the segregation unit in this prison in the last 6 months?	18%	8%
EDUCATION, SKILLS AND WORK			
16.3	Do staff encourage you to attend education, training or work?	40%	63%
PLANNING AND PROGRESSION			
17.1	Do you have a custody plan?	56%	62%
	For those who have a custody plan:		
17.3	Are staff helping you to achieve your objectives or targets?	20%	41%
PREPARATION FOR RELEASE			
	For those who expect to be released in the next 3 months.		
18.3	Is anybody helping you to prepare for your release?	60%	68%
FINAL QUESTION ABOUT THIS PRISON			
20.1	Do you think your experiences in this prison have made you less likely to offend in the future?	37%	45%

HM Prison & Probation Service

Action Plan: HMP Berwyn

Action Plan Submitted ----------

A Response to the HMIP Inspection 4 – 14 March 2019

Report Published 11 July 2019

INTRODUCTION

HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Probation for England and Wales are independent inspectorates which provide scrutiny of the conditions for, and treatment of prisoners and offenders. They report their findings for prisons, Young Offender Institutions and effectiveness of the work of probation, Community Rehabilitation Companies (CRCs) and youth offending services across England and Wales to Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS). In response to the report HMPPS / MoJ are required to draft a robust and timely action plan to address the recommendations. The action plan confirms whether recommendations are agreed, partly agreed or not agreed (see categorisations below). Where a recommendation is agreed or partly agreed, the action plans provides specific steps and actions to address these. Actions are clear, measurable, achievable and relevant with the owner and timescale of each step clearly identified. Action plans are sent to HMIP and published on the HMPPS web based Prison Finder. Progress against the implementation and delivery of the action plans will also be monitored and reported on.

Term	Definition	Additional comment
Agreed	All of the recommendation is agreed with, can be achieved and is affordable.	The response should clearly explain how the recommendation will be achieved along with timescales. Actions should be as SMART (Specific, Measureable, Achievable, Realistic and Time-bound) as possible. Actions should be specific enough to be tracked for progress.
Partly Agreed	Only part of the recommendation is agreed with, is achievable, affordable and will be implemented. This might be because we cannot implement the whole recommendation because of commissioning, policy, operational or affordability reasons.	The response must state clearly which part of the recommendation will be implemented along with SMART actions and tracked for progress. There **mus**t be an explanation of why we cannot fully agree the recommendation - this must state clearly whether this is due to commissioning, policy, operational or affordability reasons.
Not Agreed	The recommendation is not agreed and will not be implemented. This might be because of commissioning, policy, operational or affordability reasons.	The response must clearly state the reasons why we have chosen this option. There **must** be an explanation of why we cannot agree the recommendation - this must state clearly whether this is due to commissioning, policy, operational or affordability reasons.

ACTION PLAN: HMCIP REPORT

ESTABLISHMENT: HMP BERWYN

1. Rec No	2. Recommendation	3. Agreed/ Partly Agreed/ Not Agreed	4. Response Action Taken/Planned	5. Responsible Owner	6. Target Date
	Main recommendation				
	To HMPPS				
5.1	All prisoners released from Berwyn should receive support to review and address their resettlement needs. (S54)	Agreed	HMPPS (Her Majesty's Prison and Probation Service) acknowledge that the Through The Gate (TTG, a service helping people in prison get prepared for release) provision is not currently meeting the standards required. HMPPS are investing an additional £22m per annum over the remaining life of the Community Rehabilitation Company (CRC) contracts to ensure that they deliver an enhanced Through The Gate service to offenders leaving prison. This investment will support approximately 500 additional CRC staff to deliver TTG in prisons. This new specification includes the requirement that CRCs complete specific, tailored, tasks to help prisoners to secure and maintain settled accommodation, gain employment and manage debt and their financial affairs. The new specification has been fully operational at HMP Berwyn since 1 April 2019.	HMPPS Briefing & Correspondence	Completed
	Main recommendations				
	To the governor				
5.2	The prison should develop a strategy to reduce violence based on an analysis of the causes of violence, supported by	Agreed	The existing strategy has been revised and is informed by local trends and data. An updated Action Plan is in place that helps focus resources which will drive and monitor a reduction of violent incidents in the prison. The VR process will be Quality Assured (QA) by the Head of Custody.	Governor	Completed

	an action plan to drive and monitor a reduction in violent incidents. (S44)		The monthly Safer Communities Meeting (A strategic meeting attended by all Key Stakeholders and Partners) is now chaired by the Governing Governor to raise the profile and importance of the meeting. The meeting agenda has been revised to include an analysis of the incidents of violence, promotion of lessons learned and focusing on actions that will reduce violence in the prison.	Governor	Completed
			The prison has introduced CSIP (Challenge, Support, Intervention Plan, a case management model that supports perpetrators and victims of violence) in line with the national roll out of this programme.	Governor	Completed
			The response to Violent Incidents and the management of perpetrators will be further improved, with oversight from the Head of Safer Prisons, by actions that are designed to reduce violence including: • Full and prompt investigations with communicated actions to prevent recurrence and to improve overall safety • Full implementation of CSIP informed by an effective Violence Management Process that focuses on the improved management of the perpetrators of violence and supporting victims • Improved assurance around delivery of sanctions through Adjudications, Independent Adjudications and Police Referrals • The review and publication of the Incentive and Earned Privilege scheme which reinforces action to be taken following incidents of violence • The introduction of a proactive and monitored Peer Support Network • Mobilising a weekly Safety Improvement Meeting on each House chaired by the Head of House or Deputy within which all relevant incidents/persons of interest will be discussed • Effective communication of learning and outcomes from the violence reduction work.	Governor	September 2019

5.3	Prisoners who are self-isolating should have their basic needs for food, hygiene, social contact and fresh air are met. A plan to work towards ending their isolation should be agreed with them and regularly reviewed. (S45)	Agreed	A Self Isolation Policy has been implemented and includes a robust identification and management process that ensures that: • The reasons for isolation are known, documented and managed. • The individual is referred to and seen by Safety Support Officers as well as receiving support from their Community Staffing (house unit staff) and Keyworker (Keyworkers are being introduced as part of the Offender Management in Custody model (OMiC) to ensure that supportive professional relationships are formalised to assist prisoners in making changes in their behaviours and thinking) • Whilst isolating, all basic needs and requirements are met for the individual concerned and are monitored through an Individual Support Plan The identification and management process is Quality Assured by the Head of Custody The agenda for the Safer Communities Meeting has been revised to include oversight of Self Isolation in order to provide monthly assurances on progression and appropriate management and support for individual cases. The meeting provides accurate information of all those isolating in their areas, monitors progress and management of each case (including developing lessons learned and monitoring of trends of isolating practice). The process for managing incidents of Self-Isolation not associated with vulnerability (i.e. elective disengagement from the regime) has also formed part of the review of Incentives and Earned Privileges and will be consistently applied to support the re-engagement of prisoners into the regime.	Governor Governor Governor Governor	Completed Completed Completed Completed
5.4	The prison should continue its focus on drug supply and demand reduction, but should better coordinate and embed actions to reduce	Agreed	The existing Substance Misuse Strategy will be revised to cover the three key areas of restricting the supply of drugs, restricting the demand for drugs and building for recovery. An experienced Senior Manager has been newly appointed as the Drug Strategy Manager and is in place to oversee the development of the strategy across the Partnership.	Governor	Completed

	the availability and demand for drugs, and measure their impact. (S46)		The monthly Substance Misuse Strategy Meeting is chaired by the Head of Custody and completion of the Action Plan/Strategy Progress is managed and directed through this meeting to support progression. The quorum of this meeting has been revised to ensure appropriate representation and reporting from all areas responsible for establishing a whole prison approach to the Substance Misuse Strategy. The leadership responsibility for the Supply Reduction Strategy is undertaken by the Security Function and overseen by the Deputy Governor. They are responsible for identifying and reducing routes and the availability of drugs. This is monitored at the monthly Security Meeting and through targeted reductions in the number of prisoners testing positive through Random and Intelligence-led Testing drug programs. Demand Reduction Work continues to focus on promoting a culture that recognises the negative impact and consequences of drug use within the prison and the wider risks to prisoners, their future rehabilitation and their families, whilst offering opportunities to those in custody that give purpose and direction. HMP Berwyn's (substance misuse) recovery offer to meet the changing prison population will be agreed, mobilised and monitored through the established Substance Misuse Management Meeting and driven by the Head of Drug Strategy and Healthcare.	Governor Governor Governor Governor	Completed November 2019 November 2019 January 2020
5.5	Prisoners should be supported and managed effectively by a responsive and capable staff group. (S47)	Agreed	Staff capability will be underpinned by a learning offer that builds on the guidance provided through national training (Five Minute Interventions and Key Work training). Under the responsibility of HR Business Partner, the prison will refresh the Key Work guidance by the provision of a prison guide to areas of interest that will support prisoners and give staff tools to deal directly with a number of common issues they face.	Governor Governor Governor	October 2019 October 2019 October 2019

			Core policies will be refreshed to give greater consistency to 'whole prison' responses in relation to: • Reward and Responsibility – now Incentives and Earned Privileges • Complaints Processing • Mail Collection and Distribution • Activity Attendance and Allocation • Consultation Processes and Prisoner Forums • Equalities and Inclusion • Self-Isolation • Violence Management • ACCT (Assessment, Care in Custody, Teamwork, a document to record and manage self-harm) Management and Quality Assurance HMP Berwyn have launched a revised People Strategy that includes plans to build capability and resilience within their workforce. The outcome of this strategy will be to improve staffs ability to respond and provide necessary support to prisoners.	Governor	Completed
5.6	Senior leaders should promote the importance of equality work in the prison. There should be a robust strategy and oversight of equality work, informed by routine consultation, to identify and address the needs of prisoners in protected characteristics groups. (S48)	Agreed	The Governing Governor has taken personal leadership responsibility for Equalities and Inclusion, including realigning the designated Equalities lead reporting direct to the Governing Governor. The Equalities Strategy will be revised and an action plan formulated covering specific actions required to improve the establishments approach to Equalities, Diversity and Inclusion will be developed. The quorum for the monthly Equalities meeting has been revised and includes all Protected Characteristic Leads (nominated individuals from the Senior Management Team) identified for each core area and hard to reach groups. Protected Characteristic leads each have required actions as part of the prison Equalities Action Plan that are informed by local trend data and demographics. Success against the Action Plans will be monitored at the bi-monthly Equalities Meeting, through bi-monthly Resident Feedback (a prisoner forum) and through the thematic analysis of	Governor Governor Governor	Completed Completed September 2019

			DIRF's (Discrimination Incident Reporting Forms) in order to ensure positive change/identify issues across the population. The Resident Equality Mentor Role is being revised to ensure that opportunities for Peer Support and Resident Consultation are maximised. Necessary Governance and Supervision Processes will be agreed to ensure that any support based roles are monitored and managed appropriately to avoid any increased vulnerability.	Governor	October 2019
5.7	The balance and range of education, training and work places should reflect the needs of the population, keep prisoners occupied and be sufficiently challenging. (S49)	Agreed	The responsibility for the oversight of the Regime Offer has been provided by the Deputy Governor. The Interserve (a prison and probation facilities supplier) Activity Offer has been fully mobilised and the establishment is now able to offer permanent full activity at operational capacity. The Final Phase Project Team will provide an activity profile that reflects the forthcoming population increase plans and the needs of prisoners taking account of the prison learner needs assessment and workforce analysis data from the local community. The activity profile will be developed to match the need to keep prisoners occupied in meaningful ways, including the development of non-work activity time on communities when away from work.	Governor Governor Governor	Completed November 2019 December 2019
5.8	All eligible prisoners should be allocated to an education, training or work placement, and should be encouraged and expected to attend. (S50)	Agreed	The Establishment Allocation process has been revised to ensure that it is robust in identification and allocation and ensure that improvements are made to manage the volume of allocation to enable swift access to activity for all. The Resident Attendance Management, Sickness and Pay local policies have all been revised to dis-incentivise non – attendance/disengagement and the processes for management have been clarified for both Residential and Activity Areas to ensure improvement. The efficacy of these processes will be provided through monitoring incremental improvements relating to the :	Governor Governor Governor	Completed Completed September 2019

			• Numbers of prisoners allocated to work, education or training • Numbers of prisoners attending the above activities • Numbers of prisoners locked up during the core day as unemployed or non-attendees of activities Oversight by the Deputy Governor of these improvements will be provided through weekly review meetings chaired by the Head of Regimes which will be reported at the monthly Senior Leadership Team meeting. Prisoners will be encouraged and expected to attend activities. This will be applied through: • Compact agreement through the induction process • Correct use of the IEP (Incentives and earned Privileges) scheme • Improving staff awareness of what level of engagement is expected and the correct process to follow when prisoners choose to disengage • Key Work (work being introduced as part of the Offender Management in Custody model (OMiC) to ensure that supportive professional relationships will be formalised to assist prisoners in making changes in their behaviours and thinking).	Governor Governor	September 2019 September 2019
5.9	All eligible prisoners should have an up-to-date assessment that identifies their risks and needs. (S51)	Partly Agreed	This recommendation can only be Partly Agreed because the prison does not have control of the arrival of prisoners with incomplete reports that should have been completed by the sending establishment. The recent recruitment of Prison Offender Managers (POMs) has reduced the caseload to acceptable levels that better allow staff to complete assessments within the agreed timeframe for new cases and to focus on existing out of date assessments. The number of POMs will increase dynamically as the population increases. A business case will be developed to allow resources for the completion of OASys reports for when HMP Berwyn take on a remand prisoner population and for dealing with any other prisoner transferred to HMP Berwyn without a completed OASys	Governor Governor	September 2019 September 2019

5.10	Prison offender managers should have regular, good quality contact with prisoners, which drives their risk reduction and sentence progression. (S52)	Agreed	There is now a full POM staffing resource to maintain contact levels in line with current contact requirements. There are known training requirements surrounding OASys and Risk Management that will need to be addressed before full coverage can be achieved however these are progressing against an agreed plan. Offender Management Unit (OMU) Hubs have been established on each House (prisoner living accommodation) to provide space for interviews and assessments that will help maintain direct contact alongside telephone communications. Key work will also be developed to allow for the progression of risk and sentence plans will be monitored through these regular interactions with an escalation of concerns to Prison Offender Managers when needed. This work will be assured by the Head of Residential Services.	Governor Governor Governor	September 2019 Completed September 2019
5.11	Public protection procedures should be given urgent and sustained attention to ensure that prisoners' risks, both in custody and on release, are managed effectively. (S53)	Agreed	The Pin Phone Monitoring Processes, assured by the Deputy Governor has been revised in order to make compliance viable, to achieve the required protection for the public, and to identify and appropriately manage those in breach of their order or restrictions. This process: • Limits the time available to Individuals subject to monitoring to use Pin Phones to ensure that the amount of calls to be listened to is manageable within the profiled hours. • Provides a profiled resource that focusses on monitoring current calls to ensure live risk is managed. • Provides effective review processes so that cases not requiring monitoring are removed when the risk assessment does not justify continued monitoring. • Provides an additional needs led resource to address the backlog, starting with those released first as they pose the greatest real time risk. • Mandates that those staff conducting monitoring refer individuals identified to be breaching Restraining Orders directly to the Police and that those breaching other orders are managed through the Incentives and Earned Privileges and Adjudication Processes.	Governor Governor	Completed Completed

			A system compliant with PSI 49/2011 Prisoner Communication Services, is being developed for prisoner so found to be using the PIN system to breach orders will have their telephone access restricted where appropriate. An Assurance Process has been implemented to ensure that the existing Mail Monitoring Process is sufficiently robust in managing those on restrictions and reporting where breaches of restrictions are identified. The Identification, Review and Management (IRMM) Process has been revised to ensure that prisoners with contact restrictions are raised for discussion and risk is managed appropriately in preparation for release.	Governor Governor	Completed Completed
	Recommendations				
	Managing behaviour				
5.12	Challenge, support and intervention plans (CSIP) should be used effectively to address violent behaviour and support victims. (1.14)	Agreed	The existing Violence Reduction Strategy has been revised and is informed by local trends and data. Overseen by the Head of Custody, an Action Plan is in place and improvement will be monitored through the monthly Safer Communities Meeting and Establishment Assurance Process. This review incorporates the effective use of CSIP to address violent behaviour through a robust 4 stage approach which is supported by the thorough investigation of all violent incidents and an improved understanding of violence within the population. The Tool is now embedded within the prisons approach to Violence Management and individuals are monitored and managed to secure reduction in violence and the protection of victims. Support for victims of violence as a standalone issue will be revised as part of the overall strategy review and will be improved through: • The use of Peer Mentors to support Victims following incidents • The requirement for the investigation to encompass victim support and preventative actions	Governor Governor Governor	Completed Completed October 2019

			• The requirement for all victims to be seen by the Safety Support Officers post incident and a support package to be configured, if required, in conjunction with Residential Services.		
5.13	The rewards and responsibility scheme should incentivise prisoners to take responsibility and behave well, and provide effective and timely sanctions for poor behaviour. (1.15)	Agreed	A review of the local Reward and Responsibility Policy will be completed and a revised policy put in place. This policy will be called Incentives and Earned Privileges and mirrors the National IEP Framework. The revised policy will clearly define expected standards of behaviour and makes the requirement to engage with the regime and activity offer explicit to all prisoners. An Annual Review Process has been completed to provide assurance that those holding Enhanced Level remain eligible and the automatic allocation to Enhanced Level on Reception has been removed. The adoption of the National Policy Framework will improve staff understanding of effective and timely sanctions and will also enable greater possibilities to incentivise good behaviour. The revised policy will include an appendix covering the provision of specific Enhanced Communities on each House that are configured to offer greater privilege to those who maintain consistent standards of exceptional behaviour.	Governor Governor Governor	October 2019 Completed October 2019
5.14	There should be effective governance of the adjudications process to ensure it provides active challenge to poor behaviour. (1.20)	Agreed	A full review of the Adjudications Process has been commissioned with outcomes to be reported and validated through the Monthly Segregation Monitoring and Review Group (SMARG) and Adjudication Standardisation meetings. This review will address the: • Appropriateness of charging and use of minor sanctions (IEP) • Presence of Evidence and CCTV • Paperwork Standardisation • Annual Sanction Review including Tariff Range • Governance and Assurance The meeting frequency and programme has been reviewed to ensure monthly occurrence and the Head of Custody will complete Governance and Assurance Checks of the Adjudication Process,	Governor Governor	October 2019 October 2019

			complete quality assurance checks of concluded adjudications and take Senior Leadership Responsibility for Segregation.		
5.15	Full control and restraint and use of batons should be kept to a minimum through application of de-escalation techniques wherever possible. (1.24)	Agreed	The local Restraint Minimisation Strategy has been validated, agreed and implemented, with oversight from the Head of Custody. The efficacy of this Strategy will be monitored, reviewed and progressed through the established monthly Use of Force Governance meeting. The Use of Force Governance meeting will be enhanced by the review of incidents in the reporting period and the creation of a learning log where opportunities to provide lessons learned present themselves. On-Scene Managers will be directed to review incidents and provide feedback to those involved, including the use of de-escalation techniques wherever possible. A Use of Force Debrief process has been implemented to ensure that prisoners are interviewed after having force used on them to provide opportunities for learning from the individual post incident.	Governor Governor Governor	Completed September 2019 Completed
5.16	Segregated prisoners should have access to a regime appropriate to their risk and behaviour. (1.28)	Agreed	The regime of Segregated Prisoners has been revised to ensure that those who demonstrate compliance and those located on their own interest are able to access regime activities appropriate to their risk and behaviour. Compliance will be further reviewed against new standards of expected behaviour to provide assurance to the Head of Custody	Governor Governor	Completed September 2019
	Security				
5.17	The prison should ensure that, where practicable, all intelligence-led drug testing takes place. (1.37)	Agreed	Intelligence-Led Testing will be monitored and reported on through the Security Committee and the Substance Misuse Committee meetings to ensure resources are facilitating targeted activity where intelligence assessments provide evidence for this to be required.	Governor	October 2019
	Safeguarding				
5.18	The prison should record and analyse the causes of self-harm incidents,	Agreed	The strategic approach to Suicide, Self-Harm and ACCT Management has been revised and the reporting and recording	Governor	Completed

	and use this material to inform the strategic management of safeguarding and suicide and self-harm prevention. (1.44)		requirements surrounding incidents, causes and trends have been clarified. The Safer Communities meeting, now chaired by the Governing Governor, monitors and responds to submitted analysis surrounding incidences of self-harm in order to inform and improve the management of Vulnerability, and understanding of Suicide and Self-Harm Prevention and Safeguarding. Learning on issues relating to the strategic management of safeguarding and self-harm are escalated to the Senior Leadership Meeting by the Governor as required. The Safety Function have begun to complete Quick Learning Bulletins to support improvement among the Officer, Case Manager and Senior Leadership Groups and provide periodic training and workshops to drive improvement.	Governor Governor	Completed Completed
5.19	Assessment, care in custody and teamwork (ACCT) casework management documentation should be of a consistently good quality. Care maps for individual prisoners should identify objectives to address their risk of self-harm and ensure they receive the necessary care and support. (1.45)	Agreed	A Quality Assurance Framework for ACCT Casework Management has been implemented and is robustly monitored through Residential Services. This Framework requires all ACCT Documents to be Quality Assured on a weekly basis at 100% by an Independent Case Manager and sample checked at 10% by the House Manager (a senior manager grade). A report is required by the Safety Function to provide assurance that this has been completed with details around how issues have been addressed and rectified. The Safety Custodial Managers then complete a sample check and provide formal feedback to ACCT case managers. A report is submitted to the monthly Safer Communities Meeting for assurance with any repeat issues identified for address. The Governor has introduced weekly personal checks on ACCTs that, along with best practice and any other reported ACCT learning, is reported in the Berwyn Matters weekly staff briefing. The Safety Function have begun to complete Quick Learning Bulletins to support improvement among the Officer, Case Manager and Senior Leadership Groups and provide periodic training and workshops to drive improvement.	Governor Governor Governor Governor	Completed Completed Completed Completed

5.20	All staff should understand their adult safeguarding responsibilities. (1.47)	Agreed	The existing Adult Safeguarding Policy will be revised and launched. The policy will cover the reporting and referral process and what action staff should take when they are concerned about the safety of an adult or indeed a child. A named Senior Manager with responsibility for Adult Safeguarding has been added to the weekly Safety Improvement Meeting and Safer Communities agendas to raise the internal profile of adult safeguarding responsibilities. HMP Berwyn's Safeguarding responsibilities have been strengthened through multidisciplinary attendance at the Adult Safeguarding Board and this provides opportunity for the sharing of information and mutual support.	Governor Governor Governor	October 2019 Completed Completed
	Daily life				
5.21	There should be effective and consistent consultation with prisoners. (2.20)	Agreed	A full review of all Peer Support and Mentor Roles, by the Head of Residence, will take place to ensure that all have a specific function, are properly defined and are tasked accordingly. All those appointed to Peer Support/Mentor Roles will be specifically identified, appropriately trained and properly supervised through a robust governance and assurance process. Appointed Peer Support Workers and Mentors will attend Resident Consultation Forums through which issues can be raised, actions agreed and matters progressed. These Consultation Forums will be the responsibility of the designated function to whom the Peer Support Worker is attached and will cover, as a minimum, the following areas: • Equalities and Inclusion • Safety • Violence Reduction • Activities, Education and Employment • Health and Social Care • Progression and Release Planning • Daily Living The current Executive Council that meets with the Governing Governor will continue and takes place on a monthly basis. The	Governor Governor Governor	November 2019 November 2019 November 2019

			membership of this meeting will be revised to include the Peer Support Workers identified through the above process.		
5.22	Responses to complaints should be prompt. (2.21)	Agreed	HMP Berwyn will introduce a Key Worker guide that will help inform staff on how to deal with initial queries to reduce the reliance on complaints to get answers to basic queries. A Prisoner Information Desk (PID) will be developed on each house which will include peer led responses to complaints to help support timey resolution of low-level, non-confidential queries in order to reduce the number of issues needing to be dealt with via the complaint system. The complaints process has been revised to ensure that allocation is swifter and responses more easily tracked. The use of Interim Responses (a response made within 5 days of the complaint being raised) will be more closely monitored and the criteria permitting their use revised to ensure that Interim Responses are entered only when there exists a genuine reason, outside of time, as to why the complaint cannot be responded to within the requisite time frames mandated by Prison Service Instruction (PSI) 02/2012 Prisoner Complaints Trends on responding to complaints will be reviewed and monitored at the Senior Leadership Team meeting.	Governor Governor Governor Governor Governor	October 2019 December 2019 Completed November 2019 November 2019
	Equality, diversity and faith				
5.23	Personal emergency evacuation plans should always be fully completed and known to staff. (2.35)	Agreed	Guidance has been issued to the Residential Areas regarding the completion of Personal Emergency Evacuation Plans (PEEPs) and those in place are monitored by the Night Orderly Officer. This monitoring includes an ad-hoc assurance check of the staff knowledge. A quick reference guide will be compiled to attach to the front of each PEEP in order to provide a checklist to those completing and managing each one that everything has been fully completed and all priority needs are known.	Governor Governor	Completed September 2019

			The designated Protected Characteristic Lead (a Senior Manager) for Disability reports on the number of PEEPs within the establishment and provide the necessary assurance to the bi-monthly Equalities Meeting as part of their routine reporting.	Governor	Completed
5.24	Prisoner carers should be trained, have job descriptions and be supervised. (2.36)	Agreed	A Minimum Training Requirement for Prisoner Carers will be agreed between Healthcare and the establishment and a Job Description and Person Specification devised to ensure that only those qualified and suitable for the role are allowed to operate. A Supervision and Assurance process will be agreed by the Head of Safer Prisons to monitor and assess the appropriateness of the carer provision once a Resident Carer has been appointed in order to prevent the risk of exploitation or potential vulnerabilities. All existing arrangements have been reviewed and assessed for their ongoing suitability as an interim measure.	Governor Governor	October 2019 Completed
	Health, well-being and social care				
5.25	There should be a prison-wide strategy to support health promotion. (2.52)	Agreed	Betsi Cadwaladr University Health Board (BCUHB) have made links with Public Health Wales and are developing a secondment opportunity for a member of Public Health Wales to develop and lead on implementing a Health Promotion Strategy for the Prisoners at HMP Berwyn. This Healthy Prison Strategy will be managed and executed in the partnership between BCHUB and the establishment, its efficacy will be reviewed at the partnership board.	Governor / BCUHB	December 2019
5.26	Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs. (2.60)	Agreed	All patients who attend external hospital appointments are now added to the daily handover sheet. The Shift Co-ordinator is responsible for allocating a suitable Healthcare member of staff to review them on return to the establishment following their appointment. A Standard Operating Procedure has been developed to document/ formalise this process.	BCUHB BCUHB	Completed Completed
5.27	The prison should ensure that suitable occupational therapy equipment and adaptations are provided	Agreed	Occupational Therapy Staff identify Equipment and Adaptations that are required through an assessment of individual needs. Some of this Equipment can be provided by the Occupational Therapist through the Community Equipment Store and is	BCHUB	Completed

	and installed promptly. (2.66)		obtained within a timely manner. Once at site the Occupational Therapist fits the equipment as required. Other equipment may be required that is not available through the Community Equipment Store but may be considered under Reasonable Adjustments and Equalities. This is discussed with Social Services and the Prison to ascertain which areas are responsible for the provision of this equipment. Any equipment agreed to be provided by Social Services will be delivered and fitted by the Occupational Therapy Team. Other equipment that falls under Reasonable Adjustments will be provided by the Prison. Occupational Therapists will liaise with the Prison Equalities Team and Business Hub to identify appropriate equipment and arrange any fitting/delivery either through the Team or through the Facilities Management Services if required. The Prison are currently revising their Reasonable Adjustments Policy to provide additional clarity and Occupational Therapy Services are supporting this review in terms of defining Reasonable Adjustments and providing clarity on the various funding thresholds/likely demands for service/adjustment.	Adult Social Care Service Manager/ Amey Governor/BCHUB	September 2019 November 2019
5.28	The substance use services should have the necessary rooms to deliver therapeutic treatment. (2.79)	Not Agreed	There are funding implications to fulfilling against this recommendation due to the current limitations in infrastructure therefore this recommendation cannot be Agreed at this time. The lack of sufficient and suitable space in which to deliver group and one to one work has been identified and is on the HMP Berwyn Health, Wellbeing & Social Care Partnership Board Risk Register. A request for an Accommodation Review has been made through Partnership Board and a response is awaited.	Governor Governor	 Completed
5.29	There should be a formal and robust procedure to follow up patients who miss medicine doses. (2.87)	Agreed	A formal and robust procedure to follow up patients who miss medicine doses will be developed and will be communicated to all staff by the health provider.	BCHUB	September 2019
5.30	Pharmacists should carry out medicines use reviews with patients. (2.88)	Agreed	All patients now have the opportunity to request an appointment with a Pharmacist using the Uni-Link system and all on-site Pharmacists are fully involved in the Medicines Review Process.	BCHUB BCHUB	Completed September 2019

			Resident Information surrounding Medication Review and Pharmacy Provision is being revised and improvements will be made.		
5.31	Prisoners should have access to dental treatment within community-equivalent waiting times. (2.91)	Agreed	Dental Waiting Times have reduced since the inspection due to the resolution of recruitment issues. The Dental Function is being reviewed and developed to maximise patient facing time to levels equivalent to those in the local community, thus increasing the number of available appointments to meet demand. Additionally an Oral Health Promotion Programme is being delivered, since June 2019, by the on-site Dental Therapist to support preventative action by patients in an effort to reduce demand where appropriate.	Lead Dentist Lead Dentist	December 2019 Completed
	Time out of cell				
5.32	Prisoner attendance at the library and the gym should be analysed routinely to identify if any groups are excluded and to develop provision. (3.7)	Agreed	The Activity Attendance Monitoring Data Reporting is being fully reviewed across the Activity Profile in order to improve monitoring of all demographics and ensure that any emerging trends are identified, analysed and challenged wherever the need is apparent. This data is inclusive of the Library and the Gymnasium and will be reviewed and discussed within the bi-monthly Quality Improvement Group Meeting and monitored quarterly as part of the Functional Assurance Report.	Governor	November 2019
	Education, skills and work activities				
5.33	Work and training should take place in realistic work environments. (3.39)	Agreed	The mobilisation of the Interserve Offer (A directly commissioned industry provider) and the subsequent capacity to review the Activity Profile will ensure that the overall offer is more purposeful and realistic in terms of replicating what would be expected in an external workplace. The Head of Regimes will continue planned work across the Partnership to progress opportunities for Embedded Learning and Work Readiness in order to best prepare the Prisoners for internal progression and work on release. This work will also encompass the challenges presented by the Final Phase Ramp Up due to the new populations and the test of the Activity Profile at Operational Capacity.	Governor Governor	October 2019 January 2020

			The Head of Regimes will seek opportunities to mobilise Internal Quality Review Processes as the offer (from the training provider Interserve) progresses in order to ensure that quality of delivery and engagement is maintained as the offer grows with the population. These Internal Quality Review Processes will be brought to the Quality Improvement Group (QIG) Meetings for discussion with any recommendation for change presented to, and ratified within, the Strategic Senior Management Team Meeting.	Governor Governor	March 2020 March 2020
5.34	There should be a clear strategy to promote the Welsh language and the Welsh dimension in activities for prisoners that encourages all prisoners, especially Welsh speakers, to use and develop their Welsh language skills (3.40).	Agreed	HMP Berwyn's HR Business Partner will agree and publish a strategy which will take in to account the new demographics of the prison population (which includes a contingent from England) to help promote the Welsh language by encouraging Welsh speakers to develop their skills including during enrichment activities.	Governor	December 2020
	Children and families and contact with the outside world				
5.35	Prisoners should receive their incoming mail within 24 hours of its arrival at the prison. (4.6)	Agreed	The Mail Delivery and Collection Processes have been revised for incoming and outgoing mail and an assurance process has been implemented to demonstrate that mail is received, sorted, collected and distributed to the population within 24 hours of its arrival at the Prison. Residential Staff have been briefed of their responsibilities in collection and delivery and are required to report, formally to the Mailroom Functional Mailbox, any incidences where daily mail has not been collected and distributed.	Governor	Completed
	Reducing risk, rehabilitation and progression				
5.36	Prisoners who are suitable for home	Agreed	All those suitable for Home Detention Curfew are now identified in a timely manner and released in line with the national HDC Policy	Governor	Completed

	detention curfew should be released on time. (4.16)		Framework. Performance is monitored at the monthly Senior Leadership Meeting to ensure progress is being maintained and, where issues occur, they are tackled as a priority. An issue has been identified with sending establishments who transfer prisoners within the decision window without the process being commenced and this will be resolved by the Head of Offender Management Services.	Governor	October 2019
5.37	There should be adequate provision to address the unmet needs of prisoners on indeterminate sentence for public protection post tariff. (4.17)	Partly Agreed	The Recommendation can only be Partly Agreed as the Governor cannot influence the legacy of this sentence type in terms of actually aiding progression and release through the Parole Process. Equally the Governor may not be afforded the additional investment required to fund the submitted proposal and will therefore not be in a position to provide any opportunity greater than existing programmes (that may not be suitable for all unmet need), the generic support of a Custodial Setting and support to progress wherever possible. However, HMP Berwyn has taken steps to address these needs by: • Securing the provision of Accredited Programmes (including the forthcoming Kaisen General Violence Programme) to which Post Tariff Indeterminate Prisoners with unmet needs are prioritised accordingly. • Commissioning an Internal Lifer/IPP Offer that supports individuals prepare as readily as they can for release and enables access to Probation Services and Purposeful Activities that will support Risk Reduction when it comes to Parole Board Consideration. • Committing to a Progressive Transfer Approach for those who are suitable for, and accepted by, those establishments providing specialist support. • Providing a learning offer to support Key Workers of indeterminate sentenced prisoners with information on how the sentence management and parole board systems operate for this cohort of prisoners.	HMPPS Wales Executive Team /Governor Governor	October 2019
	Interventions				

5.38	There should be enough accredited offending behaviour programmes to meet the needs of the population. (4.33)	Partly Agreed	This recommendation is only Partly Agreed as the establishment is limited to the amount of programmes the prison is commissioned to provide and the accommodation/resources needed to provide these programmes. However, HMP Berwyn will ensure that: • Provision is informed by segmentation data, risk assessment and local information in order to ensure that places are offered to those presenting the greatest risk and in line with the published prioritisation criteria • The Delivery Programme is maximised according to need and frequency in order to make best use of available resources • Attrition is monitored and, where any difficulties arise, swiftly addressed ensuring that any potential for interruption to programme delivery is avoided as far as is possible • Prisoners with unmet needs are progressed through planned transfer as readily as they can be to facilitate programme completion elsewhere – with return capacity/transfers if necessary • Continually monitor the level of unmet need and work with the Population Management/Executive Team to re-configure population where considered necessary and where estate capacity allows As referenced; the Programmes Team commenced the delivery of Kaisen General Violence in July 2019 which will improve the current offer and better meet the needs of the existing population. The Delivery Programme will be reviewed annually in order to keep delivery as responsive as it can be within the existing resource.	HMPPS Wales Executive Team / Governor Governor Governor Governor	 March 2020 Completed March 2020

Recommendations	
Agreed	34
Partly Agreed	3
Not Agreed	1
Total – without missed Recommendation	**38**

Quality, Safety & Experience (QSE) Committee

24.9.19

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

To improve health and provide excellent care

Report Title:	Medicines Management Key Risks
Report Author:	Louise Howard-Baker, Assistant Director for Pharmacy & Medicines Management (Area East) Dr Berwyn Owen, Chief Pharmacist & Controlled Drugs Accountable Officer
Responsible Director:	Dr David Fearnley, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	The report is to highlight the Medicines Management Risks, the mitigation and actions to reduce the risks further.
Approval / Scrutiny Route Prior to Presentation:	Has not been scrutinised outside pharmacy, but is in response to a direct request to submit to QSE.
Governance issues / risks:	The paper contains medicines management risks which carry a risk for patient safety for the Health Board. It outlines the steps taken so far to mitigate the risks and further steps that need to be taken to achieve the target risk score.
Financial Implications:	There are financial implications and these are being addressed through divisional and BCUHB-wide planning routes and through workforce planning.
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 Leadership and Governance			
Equality Impact Assessment			

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

Introduction

The Pharmacy and Medicines Management Annual Report was submitted to the BCUHB Board Meeting on 2nd May 2019. The Board requested that a risk update be reported to QSE in September 2019.

Risks ≥20

Medicines Reconciliation

Supporting Evidence: NICE Guideline NG5; Welsh Government (WG) Patient Safety Notice PSN 028

Risk Description: There is a risk of harm to patients on admission to hospital from delayed and incorrectly written drug charts (Medicines Reconciliation).

Performance: In June 2019, of 635 patients audited in BCUHB, 57% had a record of medicines reconciliation, although this data includes wards without pharmacy cover and community hospitals. The standard is that the organisation has arrangements in place to ensure that medicines reconciliation takes place within 24 hours of a patient being admitted to an acute care setting.

Approximately 1/3rd of all pharmacy interventions are collected at the admission stage and the predominant reasons for the intervention are:

- Omitted drugs
- Allergy status
- Dose/strength
- Contraindicated drug
- Transcription error
- Unnecessary drug therapy

Existing Mitigation: Pharmacy undertake medicines reconciliation verification for newly admitted patients on admission areas including emergency departments during working hours although this may be limited in certain areas e.g. surgical admission wards. On general wards, newly admitted patients on are targeted by the ward pharmacy team. Some wards do not have pharmacy support, such as women and labour wards, theatres. This is historical as the funding for pharmacy services predominantly came from the service itself.

All Wales Medicines Strategy Group (AWMSG) Medicines Reconciliation Policy; BCUHB Enabling Policy.

The GP record (formerly IHR), which holds the patient's current prescription is available for all clinicians to view, although the quality of clerking remains variable and so requires pharmacy to validate the drug history taking.

There is ongoing work to encourage patients to bring in their own medicines. (Pre – operative assessment clinics; media advertisements, the green bags supplied to the Welsh Ambulance Service to bring patients' medicines into hospital)

Further action to achieve target risk score: There is a need to ensure recurrent funding for pharmacy in emergency departments (EDs) as patients are often held for long periods before being admitted directly into a receiving ward (therefore bypassing admission wards). The current funding for EDs across BCUHB is inconsistent. This is a problem on wards where there is no pharmacy support such

as women's wards where there may be patient outliers. A letter in September from the Chief Medical Officer (CMO) and Welsh Government (WG) has confirmed the need to pharmacy support in ED following a project undertaken in the spring 2019. A business case is being developed and WG are encouraging the Board to include within its Integrated Medium Term Plan (IMTP) going forward.

Medicines Shortages

Risk Description: There is a risk to patient safety, continuity of care and costs for the Health Board and HMP Berwyn due to existing and anticipated national shortages of prescription medicines. This is partly because of inherent manufacturing and supply issue and the situation is expected to worsen in the event of leaving the EU with no deal.

Performance: On 15th August 2019, 194 Out of Stock contracted medicine lines, were being actively managed by the acute medicines procurement staff. This is a 20% increase on the April 2019 position.

These medicines include:

- Opioid injections (diamorphine, fentanyl & morphine), which are critical for the ongoing management of our patients under care of the acute and palliative care settings.
- Anaesthetic agents continue to be in critical supply including ketamine and suxamethonium injections with alternative management plans put in place working with intensivist clinical colleagues
- Other specialist critical medicines in short supply include tuberculosis treatment (rifampicin, pyrazinamide & ethambutol) which has public health impact if alternative supply routes are not sourced and significant clinical engagement has been required to maintain communication with prescribers of available products.
- Chronic conditions medicines on GP repeat prescribing/dispensing systems.

Shortages are now clearly having an impact in Primary care and GPs are spending a lot of time changing treatments as supplies not available e.g. Hormone replacement therapy and phenelzine (antidepressant) have been particular issues of late. The acute procurement team have ring fenced some emergency stock of phenelzine for those community pharmacies unable to fill prescription supplies for their patients.

Existing Mitigation: There is a National All Wales Procurement Contract, which includes 73% of all medicines procured in secondary care and prioritises supplies for BCUHB hospitals. The Wales-wide management of national shortages involves a share allocation of those medicines on a weekly basis. Where there is a shortfall there is a requirement to ensure there is increased rigor around BCUHB acute hospital sourcing and procurement processes. This is coordinated by the regional lead procurement pharmacist(s) with a high level update via the NHS Wales Shared Services Partnership (NWSSP) Medicines (Acute) Sourcing team leader. It is the Health Board's responsibility to procure an alternative product where necessary.

Management measures include:

1. A risk assessment of the clinical significance of a medicine shortage and the urgency and impact of a suitable alternative.
2. The management of dwindling stock to ensure availability at the point of need and avoidance of stockpiling.

3. Engagement at a national level so Health Boards work together as NHS Wales on managing global shortages.

Briefing information for clinicians are provided by the Health Board's procurement teams, specialist pharmacist lead or local medicines information service. In the event of a significant national shortage, a clinical plan is required to mitigate risks to patient safety.

If a product line is unavailable from suppliers and required urgently, pharmacy procurement in secondary care is unable to view the stock holding at other Health Board hospital sites due to the limitations of the legacy pharmacy stock management system.

The Wales information circular cascade, which notifies healthcare professionals in primary and secondary care of medicines recalls is now being used to convey information on supply issues including any specialist advice, so a consistent message is given.

Community pharmacies continue to escalate shortage information or lack of supplies via their own reporting mechanisms.

The Chief Pharmacist has created a pharmacy logistics hub at Preswylfa to anticpate the significant involvement in the preparatory work for the EU-exit and planning around potential medicine shortages and this is being ramped up in expectation of the October 31st exit date.

Further action to achieve target risk score: An increased proportion of medicines on the national contract framework would provide more reliability in secondary care by prioritising supplies to Wales's hospitals.

A new all Wales pharmacy stock management system would enable users to view which hospitals hold stocks of medicines. The procurement of this system is in progress.

Withdrawal of cluster and PCTF funding may result in significant financial risk to area primary care Pharmacy and Medicines Management funding.

Risk Description: Cluster and Primary Care Transition Funds were utilised to support GP practices with pharmacist–led clinics. The short term funding is being withdrawn in March 2019, but an exit strategy was not formulated as there was an expectation that practices would self fund these clinics. Failure to do so will leave the Pharmacy & Medicines Management (P&MM) teams with staff for which there is funding and no establishment.

Existing Mitigation: Discussions are ongoing with GP practices to self fund the clinics. Discussions on going with clusters and Chief Financial Officer to agree long term core funding.

Further action to achieve target risk score: Investigate other funding streams e.g. any overage in Cash Releasing Efficiency Savings (CRES) achieved this year; General Medical Services (GMS) ring fence; secure core funding based on savings released over the last 3 years; Redeploy staff.

Risks 15-20

Pharmacy Support to Mental Health (currently scored ≥20 in the east)

Risk Description: There is a deficit in the number of funded pharmacy input into Mental Health and Learning Disabilities (MHLD) division in comparison to acute medical and surgery. For patients, this means that there is poor medicines reconciliation, a lack of regular medication review and overall medicines governance. For healthcare professionals, there is no education for doctors and limited education for nurses. This poses a risk for the safety of patients, because medication errors are unchecked. The increased MHLD specialist services being provided in primary care also have no dedicated pharmacy support.

The HASCAS report on the care provided in Tawel Fan highlighted the lack of pharmacy service provision to MHLD which has negatively impacted on service care and delivery.

Ongoing nursing and medical recruitment issues increase medicine-related risks and the increased number of patients with acute mental health illness needing crisis intervention also adds to the pressure on the hospital dispensaries, but no funding consideration is given to the additional capacity needed to meet this demand.

Annual leave cover for mental health wards is frequently difficult to cover due to the lack of funded capacity to do this.

Mitigation: There is a dedicated senior strategic lead pharmacist for MHLD across BCUHB supported by an operational lead in each area. A management tier has been established however there remain significant gaps in operational service provision. There is a P&MM Strategic Workforce Plan, but there remains a funding gap that MHLD are reluctant to commit to.

A business case has been submitted to the Medical Director to take to Executive Management Group (EMG).

To date there has been no agreement to fund core or support pharmacy services for the MHLD Division. Staff are increasingly stretched and stressed as a result of the unrecognised workload of MHLD because there has been no cover provided for staff sickness and reduction in staff working hours. This is impacting on service delivery including discharge turnaround times for acute beds and may lead to delays in medication supply for patients with acute mental illness and potential increased risk of error and patient harm.

Further action to achieve target risk score: Another business case is to be submitted to MHLD for consideration for transformation funding highlighting the recent Healthcare Inspectorate Wales (HIW) thematic report recommending dedicated pharmacy staffing. This has been supported by frontline clinicians.

Poor Medicines administration practice across BCUHB

Risk Description: There is a risk to patient safety due to poor medicines administration practice across BCUHB. This is caused by an organisational failure to develop processes, systems and environment for safe and effective medicines management and failure of all those required to administer medicines to comply with BCUHB medicines code, Nursing Medical Council (NMC) standards for medicines management and professional standards. This would lead to an impact on patient safety and the delivery of a safe and quality based service.

Mitigation: BCUHB Medicines Policy; Professional Standards: Medicines Management Standards have now been implemented to include administration of medicines. Updated competencies are near completion. Designated medicines

management competencies are now included in the BCUHB Mandatory Training Policy; A Medicines management Nursing Improvement Plan is being implemented across BCUHB; the MM Assurance Framework is being completed by all divisions to monitor & report performance against the standards and a schedule is in place for divisional and sites to report progress to the Strategic Safe Medication Steering Group. Terms of reference and membership have been revised for the Safe Medication Steering Group. All rapid reviews are discussed weekly at Putting Things Right meetings. Training and Assessment - Monthly back to basics sessions are held in all 3 regions. Incident Report themes are reviewed at the Safe Medication Practice Group meetings. Medicines Management Nurses are in place in all secondary care and community settings. The Medicines Safety Thermometer is on the Iris Ward Harms Dashboard is being developed to capture and drill down incident data. Medicines administration forms part of the Ward Accreditation process- with direct observation of medicines administration processes. There is a requirement that Medicines Management is a standing agenda item at local Quality & Safety meetings. Staff shortage contingency measures are in place; Prescribing risk assessment forms part if the annual Continuing Professional Development (CPD) declaration by all Non Medical prescribers; Bank and agency ward induction includes medicine management questions. The Medicines Management Nursing Collaborative meets monthly with attendance from all Divisions across BCU.

Further action to achieve target risk score: The recruitment of nurses into substantive posts would reduce a reliance on agency staff. Improving the environment where medicines are prepared and stored. Site specific risk assessments. Incident monitoring and review dashboard; Production of a training video to improve compliance with 2nd independent checking. Assurance that review of training records is undertaken at a local level needs to be more robust and uploaded onto ESR- currently working to address; Assurance that Bank/Agency staff are fully trained.

Risk of Dispensing Robot Failure - East

Risk Description: There is a risk to patient safety and patient flow as the Wrexham Maelor Hospital Pharmacy Dispensing Robot is no longer reliable. It is 11 years old and has reached the end of its life expectancy with replacement parts becoming more difficult to obtain. There are frequent failures requiring engineer call outs. On occasions all three cells have failed. New technology has improved design and functionality.

If the robot mechanically fails then the need to return to manual supply would require additional dispensary staff, dispensing and storage space. This may require taking staff off the wards, which impacts on clinical activities, such as medicines reconciliation, Take home medicines (TTOs) and dispensing and supply activities. There will be delays to administration or discharge as a result.

In the event of an IT failure, the pharmacy staff are unable to locate and dispense the drugs, meaning that there is no access to any medication stored in the robot..

The recently implemented Falsified Medicines Directive (FMD) is not able to be fully implemented with the old robot.

Mitigation: There are three cells that run independently, so if one fails the others take over. It is a priority on the east area medical device capital plan, but is expensive (approximately £650K). Business plans submitted to Welsh Government

for Pharmacy modernisation capital have been unsuccessful. Recent communication from WG is the Health Boards will need to fund from capital resources.

Further action to achieve target risk score:

Business plan to be submitted via the East Area Medical Devices Capital Plan for 2019-20

Prescribing Competency of New intake of FY1, FY2 and locum doctors

Risk Description: There is a risk to patient safety due to limited assurance of the prescribing competency of new intake of FY1, FY2 and locum doctors. Clinical interventions collected by ward pharmacists and incident reports indicate problems with all medication including high risk insulin, anticoagulants, opiates and antimicrobials. This could lead to a death or harm to a large number of patients and subsequent litigation, damage to HB reputation.

Mitigations: BCUHB has Service Increment for Teaching **(**SIFT) funded pharmacists on each acute site who are involved in the teaching of undergraduates from Cardiff University. All three regions have introduced prescribing assessments for the FY1 intake with subsequent mentoring for those not achieving the required standard. Most pharmacists have ward pharmacists, who review prescriptions and correct where appropriate or contact the prescriber, where necessary to clarify. There are pharmacists in the emergency departments and pharmacists and pharmacy technicians in admission areas to ensure that all patients' medications have been correctly prescribed on admission. Clinical interventions and Datix incidents are recorded and reviewed for trends to attempt to identify and mitigate risk. Audits are undertaken and the results feedback to grand round +/- clinical teams to improve prescribing. There is a BCUHB Enabling Policy that allows Pharmacists amend drug charts at admission. Prescribing training is being introduced as part of the curriculum for doctors outside Wales now.

Further action to achieve target risk score: The use of name stamps, or collection of FY, FY and locum doctor signatures on induction would ensure that prescribers can be easily identified (currently interventions data shows that in approximately 1/3rd of cases, the prescriber is unidentifiable). Steps are being taken to standardise the induction covering prescribing for FY1/FY2 doctors. Pursue mandatory prescribing e-learning for all new prescribers at any level coming into the organisation, including locums. Improve access to up to date clinical resources including treatment pathways and guidelines. Electronic-prescribing on all hospital sites. Engage with medical supervisors on how prescribing errors are fed back. A funded postgraduate medical education pharmacist post. Extended pharmacy hours including pharmacist and technician cover for all ward areas including escalated areas (which would require additional funding)

Lack of Pharmacy Capacity to Support Community Hospitals & rehabilitation wards (east & central)

Risk Description: The current funded pharmacy support for the east and central area community hospitals and rehabilitation wards excluding Llandudno and Denbigh only allows for a once weekly visit from a pharmacist and technician respectively. This means that patients may wait for up to 7 days for a medicines reconciliation to be undertaken, which does not meet the standard of 24 hours set by NICE. This can lead to significant harm to patients who may have critical medicines omitted from the

prescription chart. Currently patients of higher acuity are being transferred to community hospitals to release beds on the acute sites. This also increases the risk of medicines-related harm to patients. Evidence demonstrates that through medicines optimisation, pharmacy can reduce the length of stay, so savings are also possible. If staff were available daily in the community, it would be possible to dispense take home medicines on site and not have to wait for them to be delivered from Wrexham. One of the pharmacists is currently on long term sick leave, which puts further pressure on the support for the community hospitals and the rehabilitation wards. This risk has also been highlighted by the Assistant Medical Director for Area Specialties.

Mitigation: The current provision is for a once weekly visit to the community hospitals and rehabilitation wards by a pharmacists and a pharmacy technician.

Scanners were purchased so charts can be viewed in the acute hospital dispensary for clinical checks prior to dispensing take home prescriptions. This has overcome the extremely poor quality photocopied and faxed prescriptions.

Further action to achieve target risk score: Investment and recruitment of pharmacists, pharmacy technician and label printers would allow medicines reconciliation, medicines optimisation and earlier discharge of patients, thereby promoting patient safety and savings from medicines and earlier discharge.

A business case is being developed to be considered within the IMTP for 2020/21.

Prescription Charts in Pharmacy & Not on Wards

Risk Description: There is a risk that patients will not receive critical or emergency medication or consultant review due to prescription charts being sent to pharmacy for a clinical check. This is because Pharmacy needs to undertake the clinical check for all newly prescribed drugs to ensure that there are no interactions with co-prescribed medicines and that the dose, and route are correct. The risk of a chart not receiving a clinical pharmacy check could increase the risk of patient harm due to a prescribing error. If this coincides with a consultant ward round it could result in the chart not being available for review, so medicines could be continued inappropriately, or new medicines not started. If it coincides with a medicines round it may result in omission of critical medicines e.g. insulin, anti-epileptics, Parkinson's drugs.

Existing Mitigation: The majority of newly prescribed medicines take place on admission wards. These have extended pharmacy team cover. Most other wards receive a daily pharmacist visit plus daily technician support. Charts checked during this time do not leave the ward. Other mitigation includes:

- Pharmacy technicians are trained in transcription.
- POD system minimises the time the chart needs to be in dispensary.
- Photocopy charts when possible, and if work cannot be prioritised.
- Restructuring of the ward pharmacy technician service provides greater cover and reduces the necessity to remove prescription charts from the ward.
- Scanning of charts directly to pharmacy team A is now in place for remote wards e.g. mental health; community hospitals
- A new electronic ordering form has been developed in the east, which will reduce the need to send charts down to pharmacy.
- MTeD has got the facility to make direct ordering to the dispensary.

- Review of stock lists and stock held, so that wards don't need to order so much.

An audit in December 2017 has shown that only 5% of the total daily inpatient workload required prescription charts to come to pharmacy.

Further action to achieve target risk score: Electronic prescribing will means there are no paper charts and clinical checks will be done electronically. Increased ward cover by pharmacy technicians will reduce the need for charts to leave the wards. The number of bleeps in pharmacy needs s to be increased so that pharmacy staff can be contacted directly by wards when new medicines are prescribed.

Controlled Drugs

The Controlled Drugs Local Intelligence Network (CD LIN) undertakes and provides oversight, scrutiny and a governance function in relation to the safe management of Controlled Drugs across North Wales. The annual report summarises the key work undertaken during 2018/19 and highlights the following national risks associated with CD use for BCU, namely:

- Opioid medicine procurement shortages (see above) and opioid dependency as recently highlighted in the media by NHS England.
- Prescription governance - A risk has been identified which is particularly pertinent, but not exclusive to managed practices where locum doctors are employed and there are difficulties identifying who has signed controlled drug prescriptions. This has been raised with Welsh Government as national action is needed to allow tracking of individual CD prescribers.
- Community pharmacy closures, due to pharmacist shortages, which impacts on essential services, such as the dispensing of opiates and substance misuse services.

As part of the surveillance work undertaken by the CD LIN, an increase in oxycodone prescribing has been identified as a new risk for the Health Board. The CD LIN will continue to monitor this trend in 2019/20 and will progress with actions to mitigate future inappropriate prescribing once this review is complete.

Temporary Closures of Community Pharmacy

Risk Description: There is a risk that patients are unable to obtain their medications when required due to temporary closures of community pharmacies. In some areas this occurs on a regular basis affecting therefore often affects patients.

Clinical Governance is monitoring the closures monthly and reporting Medicines Management

Concerns over Pharmacy A staffing levels and offsite dispensing

Risk Description: There is a risk that patients will be unable to access their medication in a timely fashion. This is due to staffing levels being low and shops getting into backlog. This is the case specifically for concerns highlighted in two branches in the west area. There is also a concern that they have rolled out Offsite Dispensing without appropriate risk assessment in branches that are already in difficulty. There has also been poor engagement with GP practices in relation to this new system.

Further action to achieve target risk score: A meeting was held with Pharmacy A in August 2019 to discuss concerns and an action and collaborations agreed to improve communication with GP patients and patients, joint visits to community pharmacies, share recruitment plans and specific contractor sites where discussed. Pharmacy A have been escalated to the General Pharmaceutical Council as a concern and continue to be monitored by the Chief Pharmacist escalation process.

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Royal College of Obstetricians / Royal College of Medicine (RCOG/RCM) Review of Maternity Services at Cwm Taf Health Board (15-17 January 2019) : Report Published by Welsh Government on 30th April 2019 : Q 2 Update
Report Author:	Ms Fiona Giraud, Director of Midwifery and Women's Services
Responsible Director:	Miss Teresa Owen, Executive Director Public Health
Public or In Committee	Public
Purpose of Report:	**BACKGROUND** In light of the ongoing focus on Maternity Services within Wales and in the areas bordering Wales, the Women's Directorate would like to provide the Committee with the following update. Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of maternity services within Cwm Taf University Health Board in October 2018. The inspection was in response to a number of concerns highlighted regarding the provision of safe care, staffing issues, incident reporting and sustainability of the service. As part of the inspection HIW explored how the service met the Health and Care Standards in Wales (2015). In summary of the Inspection the team raised concerns about the sustainability, resilience and ability of the service to provide care and treatment in a safe and effective way. In relation to the concerns HIW issued an immediate assurance letter requiring the Health Board to take immediate remedial actions and escalated their concerns to Welsh Government. In response the Royal College of Obstetricians and Gynaecologists (RCOG) was commissioned by Welsh Government to undertake an external review to investigate the care provided by the maternity services at Cwm Taf University Health Board. The review took place on 15-17 January 2019. The assessors visited both the Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) sites and met with many staff. In addition to this, a number of teleconference calls were made to allow people from other sites to speak to the assessors. The assessors found a service working under extreme pressure and under sub-optimal clinical and managerial leadership. The identification by the Health Board of the under–reporting of Serious Incidents (SIs) had resulted in increased internal and external scrutiny, highlighting that basic governance processes were not yet

	properly in place. The service was also expected to imminently merge two separate consultant led units onto one site with a freestanding midwifery led unit on the other site, with no evidence that clinical teams were engaged and supportive of this decision and process. This was compounded by a shortfall in the midwifery establishment, sub-optimal senior clinical leadership, a significant use of locum medical staff at both junior and consultant level and a lack of established standards of practice. The service was also seen to be operating under a high level of public and media scrutiny. As part of the RCOG review, a patient and public engagement event was held as a public meeting. In addition to this, an online survey was developed (hosted by the RCOG). This remained open for six weeks and one to one telephone interviews were conducted. Families which had used maternity services and families affected by events leading to this review were invited to participate using all methods of engagement. A full report of the findings from the public engagement is presented in a separate report entitled Listening to Women and Families about Maternity Care in Cwm Taf. (The findings of which have been included in the local benchmarking exercise as detailed in the Local Response to the Report section within this briefing to the Committee.) An earlier report, prompted by the identification of the unreported SIs, was submitted to the Health Board in September 2018. This review was undertaken by a Consultant Midwife. The report provided an in depth review of the shortfalls of the service and produced very similar findings to the RCOG report. The existence of this 2018 report was only discovered and made available to the assessors when on site. The significance attached to this report by the Executive Team and what actions had been initiated remains unclear. The immediate concerns regarding the safety of the maternity service were escalated by the assessors at 13:00 on 16 January to Welsh Government and the RCOG. **Overall Findings of the Report and WG Reponses** The RCOG/RCM Report raised a number of significant issues and makes a series of recommendations. On publication of the report on the 30th April 2019, the Minister of Health and Social Services placed the service in Cwm Taf in special measures. In response Welsh Government wrote to all the Health Boards in Wales asking them to consider their own service in the context of the recommendations of the report and to provide assurances on the safety of maternity services within their Health Board. **Local Response to the Report** The Women's Directorate in Betsi Cadwaladr University Health Board (BCUHB) can confirm that the RCOG/RCM Report on their review of maternity services at the former Cwm Taf University Health Board has been formally received, the findings considered and the learning has been shared with all staff within the Directorate and with all stakeholders.

	In response, the Directorate has benchmarked its local service provision against the relevant recommendations made in the report as requested by Welsh Government. This comprehensive review of local services was submitted to Welsh Government on 14th May 2019. Of the 70 recommendations made in the report, the local exercise identified 6 amber rated areas for local improvement. These areas are detailed under the governance issues/ risk section in this Committee Cover Sheet. A further update was provided to Welsh Government on 24th July 2019 (Appendix 1) following an All Wales Leads meeting on 5th June 2019. This meeting led by Welsh Government, HIW and Welsh Risk Pool gave an opportunity to discuss Health Boards' interpretation of the recommendations made in the RCOG's Report, offered Service Leads an opportunity to review their initial submission and invited updated re-submissions as deemed necessary. Having had this opportunity to discuss certain specific queries with professional bodies, colleagues across Wales and locally the Directorate has updated its initial submission and revised a further four recommendations into an amber rating. This is in addition to the original 6 highlighted for further improvement locally. Please note all 10 are detailed under the governance issues/ risk section of the paper for the committee's information and the required actions are captured on the revised assurance/benchmarking template included with Appendix 1. **Health Inspectorate Wales (HIW) National Review of Maternity Services** On the 3rd June 2019, Health Inspectorate Wales wrote to all Health Boards in Wales confirming that they would be undertaking a national review of maternity services across Wales, as outlined within their 2019-2020 Operational Plan. Their decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the issues identified during HIW's inspection of maternity services in the Royal Glamorgan Hospital in the former Cwm Taf University Health Board in October 2018. *http://hiw.org.uk/docs/hiw/inspectionreports/210119royalglamorganmaternityen.pdf* HIW's national maternity review will provide a national picture of the quality and safety of NHS maternity services across Wales. This work will provide public assurances and help improve services for women and their families The national review will explore: • The experience of women, their partners and families It will also explore the extent to which Health Boards across Wales: • Provide safe and effective maternity services • Understand the strengths and areas for improvement within their maternity services The national review will collect evidence in a number of ways over the next year.

	Phase 1 (June to December 2019) will consider the evidence and any themes that emerge from a programme of unannounced inspections of maternity units across Wales. The focus will be on the care provided in the maternity units up to the point of discharge plus some aspects of antenatal care provided in the community. In the Autumn 2019, HIW will launch a national maternity survey, developed with input from the Community Health Council (CHC). The survey will gather the experience of maternity services from a broad range of women, their partners and families across Wales. The survey will be published on HIW's website. A separate national survey will be launched to capture the views of multi-disciplinary staff working in maternity services. This will also be published on HIW's website and shared within each Health Board in Wales for dissemination to staff. Phase II (January to March 2020) will be informed by the work undertaken during Phase I. This will involve interviews with key personnel within each Health Board regarding the quality, safety and governance of maternity services. As part of their scoping for the review HIW will liaise with other organisations who have recently conducted or plan to conduct work in relation to maternity services, including CHC and third sector organisations. To support the review process, HIW has established a maternity stakeholder panel and a separate advisory panel who will provide additional support and advice their internal project board on the day to day implementation of the review. A report will be produced following each inspection and, in line with process, any urgent concerns will be raised immediately within the individual Health Board and the Welsh Government. The review will conclude with the publication of a national service report in Summer 2020. Health Boards' benchmarking templates and assurance standards on the safety of their maternity services, which were provided to Welsh Government in context of the RCOG Report on Maternity Services at the former Cwm Taf Health Board, will also inform their review. In addition to the responses provided to Welsh Government, HIW requested each Health Board to completed a self-assessment template (Appendix 2), and provide the following information: • A governance structure/map of maternity services within the Health Board. • A map which shows the flow of patients across maternity units within the Health Board g flow from Midwifery led units in Obstetrics led units. • The 2017 and 2018 MBRRACE reports. • The latest Each Baby Counts report/data (anonymised) • The latest risk register/log for Maternity Services. • The latest risk register/log for each maternity unit/site.

	The completed self-assessment template and additional information was submitted to HIW as requested on 17th June 2019. A further request from HIW for additional information was received on the 19th August 2019. This request included copies of; • The 2017 and 2018 MBRRACE Reports • A list of the Maternity Ward/Site to support the flow of patients across Maternity Units within the Health Board. The response with the requested information and explanation as to when the 2017 and 2018 MBRRACE Reports are due to be published and be available to Health Boards and Maternity providers, is enclosed in Appendix 4 **Community Health Council (CHC)** In response to the RCOG Review of Maternity Services in Cwm Taf the Community Health Council in North Wales undertook a review of their concerns caseload specifically in relation to Maternity Services within the last 12 months. The identified cases were highlighted to the Health Board In response the Women's Directorate undertook a thematic review of the cases (please see enclosed report – Appendix 3) and formally met with CHC on the 30st July 2019 to review the findings in context of the issues that women and their families raised during the review of services in Cwm Taf. The review and a presentation of the Directorate's User Engagement Strategy which included Women's feedback were positively received. The CHC, as a result of their caseload review, will be stepping up both their patient and visiting activities and are open to working with the Health Board in the interest of women and their families in North Wales. **Maternity Care in Wales – A Five Year Vision for the Future (2019-2024)** The strategy was launched by the Minister of Health and Social Services on the 3rd July 2019. The report sets out a vision for achieving high quality maternity services in Wales and includes the learning from the RCOG's Review of Maternity Services in the former Cwm Taf University Health Board. The aim of the strategy is to put the family at the centre of decisions, so that all women, babies and their families receive the highest quality of care which meets their needs. The strategy is themed around 5 core principles; • Family centred care • Safe effective care • Continuity of carer • Skilled multi-professional team • Sustainable quality services Under each core principle there are clear commitments that require National and Health Board actions. Progress against Health Board actions will be assessed at the WG Annual Maternity Performance Board meetings that all Health Boards are required to attend. These are scheduled in Quarter 3 of 2019/20.

	Implementation of the new maternity strategy is one of the Directorate's priorities as detailed in the Service's three year plan. An inaugural meeting of the local implementation group, which includes service users and all stakeholders, was scheduled in Quarter 2 and progress on this year's plan will be monitored quarterly.
Approval / Scrutiny Route Prior to Presentation:	The Directorate's submissions to Welsh Government and HIW have been reviewed by Executives colleagues and approved by the Chief Executive of the Health Board. This paper has not been scrutinized by any other Board Committee.
Governance issues/ risks:	Please refer to the enclosed and updated Assurance/Benchmarking template (Appendix 1) for all updates on the actions submitted and note where a recommendation is not relevant to BCUHB it has been blacked out. As previously noted the initial benchmarking exercise against the 70 recommendations made by the RCOG highlighted six amber rated areas for ongoing improvement locally with the rest in green. The amber areas were and remain as;: • 7.7 **Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care – (**Update – A Task and Finish Group has been set up, led by the Directorate's North Wales Clinical Lead, to look at early pregnancy and re-current miscarriage services and the environments of care in North Wales. This group includes services users. Whilst the Health Board has a dedicated Early Pregnancy Unit in Ysbyty Glan Clwyd, the Directorate is working with colleagues at Ysbyty Gwynedd to secure a more appropriate environment for this service in the West Health Economy and hope to repeat the exercise with the East Hospital Management Team when they meet on the 10th June 2019.) • **7.30 Ensuring the most unwell women are seen initially by a Consultant and all women are seen by a Consultant within 12 hours (NCEPOD recommendation, National standard for all specialties) – (**Update – The Directorate's North Wales Clinical Lead has approached the Royal College of Obstetricians and Gynaecologists and Welsh Government regarding this recommendation and its local translation as it seems to contradict other Workforce Governance Standards produced by the College. This informed discussion at the All Wales Leads meeting on the 5th June 2019, led by Welsh Government (WG), to look at Maternity Service Provision in Wales in context of the Cwm Taf Report. The North Wales Clinical Lead raised this standard at the Women's National Specialist Advisory Group (NSAG) on 15th August 2019. The decision of NSAG was to formally write to Welsh Government to ask for clarification of standards required by Women's services in Wales. • **7.55 Consider implementing the National Bereavement Care Pathway that has been developed by SANDS in collaboration with stakeholder including women and their families, RCOG and RCM -** (Update – *The*

	bereavement services within the Women's Directorates has subsequently been benchmarked against the SANDS standards and the service is now fully compliant. This action is now assessed as green.) • **7.57 Continue with efforts to recruit and retain permanent staff** – *(Update – The Directorate has 2wte Midwifery vacancies currently. Following adverts, 30 candidates were interviewed over a 2 day period beginning of August 2019. All Medical Vacancies, on all 3 Tiers of the rotas are being progressed through the recruitment process.)* • **7.63 Independent Board members must challenge the quality of the data, which inform the reports they receive and rely upon for assurance** - (Update – This issue was last *discussed at QSE Committee on 21/5/19.* • **7.64 Independent Board members should receive training in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety pf the services that the Board provides -** (Update – *Again discussed at QSE Committee on 21/5/19 and training was provided on 1/8/19)* The first four areas for local improvement with plans will inform the Women's Service Plan for 2019/20. The last two areas for action require the Committee's support and monitoring. A further four amber areas for ongoing improvement and monitoring have been identified following national, professional and reflective local discussions. The additional amber rated areas with commentary are as follows; • **7.1 Urgently review the systems in place for data collection** – A section of this recommendation is now Amber to reflect that the Myrddin Maternity System has not been 'rolled out' onto the Ysbyty Gwynedd this site to date. Of note and for assurance all relevant data is captured by an e-form on all of our three sites and collection is not dependant on the maternity module in Myrddin. • **7.6 O & G Consultant Staff must deliver a standard induction programme** – The Directorate acknowledges that further improvement is required locally around this recommendation to ensure that locum induction is consistently delivered by Consultant staff on all 3 sites. • **7.32 Ensure Obstetric Consultant cover is achieved in all clinical areas when required** - Clarification has been sought on whether this refers to 12 hour resident consultant cover. The North Wales clinical lead is liaising with Welsh Government and the RCOG on the basis of this recommendation. The recommendation is not aligned to the current RCOG's workforce plan which is based on the 2016 RCOG's Workforce Report: Providing Quality Care for Women – Obstetrics and Gynaecology Workforce. "In light of the current available evidence, fixed levels for consultant labour ward presence for different sizes of units cannot be justified. However, it is strongly recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday, with the aim of extending this to every day of the week to provide the same quality of service over seven days, in line with the aims of NHS England's seven day service standards". The All Wales Head of School ,

	Associate Dean for Obstetrics and Gynaecology and RCOG Fellows Representative for Wales has responded by stating the above 2016 Workforce guidance should be followed. There is therefore no current RCOG recommendation for 12 hour resident consultant cover. This was further discussed at the National Speciality Advisory Group (NSAG) who will be formally writing to Welsh Government to seek clarity on this recommendation. • **7.38 Ensure the Consultant on-call for the Labour Ward has ownership of all patients in the maternity Unit for the period of call. This must involve the antenatal ward round being performed by the consultant**. – While we have assurances that the consultant on call has ownership for all maternity patients, we do not have systems currently in place for every patient on the antenatal ward round to be seen by the on call consultant. This recommendation is 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 These standards also refer to the use of Board rounds and appropriate delegation. The North Wales Clinical Lead has shared with all consultants the need for consultant-led Board rounds on every acute inpatient ward every day, and every patient should have a highly visible care plan. At the Board round the consultant decides which patients' reviews that day can be delegated to another competent clinician. This will be based on considerations such as 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 and likelihood of imminent discharge. Where a daily review is delegated the reviewer should feedback promptly to the consultant any concerns they have about a patient. The directorate recognises that local services need to undertake further work on this recommendation to be fully compliant, which will require a review of all Consultant Job Plans in Quarter 2/3. All related plans as detailed in the enclosed assurance/benchmarking template (Appendix 1) will be presented and monitored locally within the Women's Directorate Committee & Assurance Framework on a monthly basis, and updates provided to Secondary Care QSE and the Quality and Safety Group of the Heath Board in addition to these quarterly reports to the Committee. *Note - some appendices contain reference to embedded items which are available to members on request*
Financial Implications:	Any financial implications will have to be assessed as part of the improvement plans and incorporated into the Service's three year plan (2020/23).
Recommendation:	The Committee is asked to note the assurances provided by the Directorate and support the identified areas for improvements.

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
The Service was de-escalated from Special Measures in January 2018.
Please be assured that the Women's Directorate, supported by Executive Colleagues and Service User Representatives, continue to closely scrutinise service provision as part of the local post Special Measures de-escalation monitoring arrangements and take the learning from Cwm Taf to support ongoing improvements.

Equality Impact Assessment

An EqIA will be completed as required for any improvement plans when a change of policy or direction is envisaged or required.

APPENDIX 1

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

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Gofynnwch am / Ask for: Dawn Lees
E-bost / Email: Dawn.Lees@wales.nhs.uk
Dyddiad / Date: 24th July 2019

Dear Andrew

RE: Report on Maternity Services in the former Cwm Taf Health Board

Further to the Health Board's benchmarking exercise against the 70 recommendations in the Report submitted on the 14th May 2019 and an opportunity to discuss other Health Boards' interpretation of the recommendations at an All Wales Leads meeting on the 5th June 2019, the Women's Directorate has taken the opportunity as offered to review our initial submission.

Having had the opportunity to discuss with colleagues across Wales and locally the Directorate has updated their initial submission and revised a further four recommendations into an 'Amber' rating. This is in addition to the original 6 as previously noted. The additional amber rated areas are:

- **7.1 urgently review the systems in place for data collection** – A section of this recommendations is now Amber to reflect that the Myrddin Maternity System has not been 'rolled out' onto the Ysbyty Gwynedd site to date. Of note and for assurance all relevant data is captured by an e-form on all of our three sites and collection is not dependant on the maternity module in Myrddin.

- **7.6 O & G Consultant Staff must deliver a standard induction programme** – The Directorate acknowledges that further improvement is required locally around this recommendation to ensure that locum induction is consistently delivered by Consultant staff on all 3 sites.

- **7.32 Ensure Obstetric Consultant cover is achieved in all clinical areas when required** – Clarification is required on whether this refers to 12 hour resident consultant cover. The recommendation is not aligned to the current RCOG's workforce plan, which is based on the 2016 RCOG's Workforce Report: Providing Quality Care for Women's - Obstetrics and Gynaecology Workforce. We have liaised with the All Wales Head of School, Associate Dean for O&G and RCOG Fellows Representative for Wales who has stated the 2016 Workforce guidance should be followed. There is therefore no current RCOG recommendation for 12 hour resident consultant cover. The Directorate

acknowledges that further work is required in order to comply fully with the guidance locally.

- **7.38 ensure the Consultant on-call for the Labour Ward has ownership of all patient in the maternity Unit for the period of call** – following national discussion the Directorate recognises that local services need to undertake further work on this recommendation to be fully compliant, which will require a review of all Consultant Job Plans.

I enclose a copy of the revised benchmarking exercise document for your information. We've welcomed this opportunity to review and re-submit our findings following national discussion and hope the exercise re-affirms our commitment as a Board to keep the learning from the original review alive and a driver for ongoing improvement within Maternity Services in North Wales.

Yours sincerely

Gary Doherty
Prif Weithredwr
Chief Executive

cc Karen Jewell, Nursing Officer for Maternity and Early Years
Teresa Owen, Executive Director of Public Health
Fiona Giraud, Director of Midwifery and Women's Services
Mr Hemant Maraj, North Wales Speciality Clinical Lead for Women's Directorate

Independent Review of Maternity Services at Cwm Taf Health Board – Assurance Framework

Health Board: BCUHB

Date of update: 12 Sept 2019

Terms of Reference from review	Recommendations	Where we are (July 2019) Examples of assurance evidence	Areas for Targeted Intervention or Improvement	RAG Green – compliance Amber – improvement required Red – Immediate action
1. To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.	7.1 Urgently review the systems in place for: • Clinical validation • Checking the accuracy of data used to monitor clinical practice and outcomes • What information is supplied to national audits	The Women's Directorate have Inpatient, Outpatient and Workforce dashboards based upon the RCOG recommended templates. The dashboards are reviewed at monthly accountability meetings and Women's Quality, Safety and Experience subgroup and if any issues of significance are determined they would be raised via BCU Quality Safety Group and Secondary Care Quality Committee. In order to provide a consistent dataset for all sites within BCU, maternity data has been collected using electronic forms since August 2017. Prior to this, digital pens were used. The transfer to e-forms provided opportunity for improved data quality and a more comprehensive dataset in line with DSCN 2016/02. Details of initial assessment and indicators relating to labour and delivery are collected after delivery with information taken from the woman's hand held case notes. This information, as well as being part of a monthly submission to NWIS for national analysis, is used to populate various dashboards and performance reports shared with the Directorate Leadership Team. The Women's Directorate has worked with the Information department to develop a dashboard, published via IRIS, the Health Boards Information Reporting Intelligence System. This provides a comprehensive summary of quality, safety and performance indicators with various degrees of granularity to various staff groups within the service and across the organisation. This work is in the final stages of development, the dashboard has been made available to the team to test and provide feedback for further developments. In addition to local performance, this dashboard also includes information from English Trusts that provide commissioned services for BCU women. The Health Board supplies performance and serious incident data to Welsh Government and also supply information to the following national audits: • MBRRACE (Stillbirths, NND, maternal deaths) • Each Baby Counts (babies requiring active cooling) • NMPA (maternity statistics) • Baby Friendly accreditation • Bliss Baby Charter accreditation Maternity Dashboard - invite t	An All Wales Maternity Dashboard will be developed to support organisations with learning and sharing best practice. This will collect a nationally agreed set of measures that reflect quality, safety and patient reported outcomes including those in the Maternity Information Dataset (MIDS).	

		Most of the data in the new dashboard comes from Datix, this could potentially be developed further to provide a report that shows the number and nature of incidents logged in a period to support usage/monitoring. Women's Services participates in all of the *National Clinical Audit and Outcome Review Plan* (NCAORP) projects, which the Welsh Government has listed as a priority for Welsh Health Boards. This includes data collection, submission and response to the recommendations of the National reports when launched. Each project has a lead allocated from within the Directorate who liaises with the relevant Clinical Audit and Effectiveness Facilitator to ensure that participation requirements are fulfilled. Reporting to Welsh Government in order to provide assurance of the Health Board's response to the National recommendations takes the form of a 'Part A' and a 'Part B' pro-forma that are returned to the Clinical Audit & Effectiveness Department at one month and three months (respectively) from the report launch date. These outline those actions that need to be taken by the Health Board in response to the project findings and provide detail of the plans to deliver these locally. Within Women's Services these projects are discussed within the relevant Governance forums and led by agreed Directorate staff.		
	• Data collection	The Maternity Myrddin Module has not yet been implemented in West and the site are developing a local plan to capture all the data required. All relevant data is captured by an e-form on all of our three sites and collection is not dependant on the maternity module in Myrddin.	Myrddin Module being rolled out across North Wales	
	7.2 Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines: • Are up to date and regularly reviewed • Are readily available to all staff, including locum staff and midwifery staff • Have a multi-disciplinary approach • Are adhered to in practice	The Women's Directorate have a Written Control Document (WCD) Group that has a designated senior midwife and three consultants as part of the group. All current WCDs are applied across North Wales and are reviewed on a monthly basis. Appropriate clinicians are contacted by the Group to update specific WCD as they near renewal dates.  WCD Terms of Reference 2017.doc All draft WCDs are circulated widely to the multi-disciplinary team and comments collected via an electronic system by the admin support staff member for the Group. The Women's Directorate forums are also used to review the draft WCD as expert panels of professionals; • Intrapartum forum • Antenatal forum • Gynae forum A database is maintained detailing all WCD, renewal dates, allocated authors and progress of allocated WCD. On completion of the draft WCD, it is forwarded to the Women's Directorate Quality, Safety & Experience Subgroup for	The WCD Group are working toward indexing the WCD on the intranet alphabetically	

		agreement and then progresses to Women's Board for final ratification. The WCD is then uploaded onto the Women's Directorate WCD page, which is on the BCUHB intranet and is accessible in all clinical areas by all staff inclusive of locums. Short cut icons to Women's policies/WCD have been added to the homepage of all computers in clinical areas to support accessibility. Adherence to policy is monitored as part of the review of all clinical incidents.		
	7.3 Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.	The Women's Directorate have an overarching North Wales audit lead and individual consultant leads at each hospital site. The anaesthetic department also hold audit days and midwifery/obstetric staff attend when maternity cases are on the agenda for discussion. There is an audit programme that is held by the overarching lead, who measures performance and outcomes against guidelines.  Audit programme Women's 2019.xlsx Local audit meetings are held on a monthly/bi monthly on each North Wales Audit days are held bi-annually to ensure shared learning for service improvement. Women's Services participates in all of the *National Clinical Audit and Outcome Review Plan* (NCAORP) projects, which the Welsh Government has listed as a priority for Welsh Health Boards. This includes data collection, submission and response to the recommendations of the National reports when launched. Each project has a lead allocated from within the Directorate who liaises with the relevant Clinical Audit and Effectiveness Facilitator to ensure that participation requirements are fulfilled. Reporting to Welsh Government In order to provide assurance of the Health Board's response to the National recommendations takes the form of a 'Part A' and a 'Part B' pro-forma that are returned to the Clinical Audit & Effectiveness Department at one month and three months (respectively) from the report launch date. These outline those actions that need to be taken by the Health Board in response to the project findings and provide detail of the plans to deliver these locally. Within Women's Services these projects are discussed within the relevant Governance forums and led by agreed Directorate staff.		
	7.4 Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery: • To ensure compliance with guidelines • To ensure competency and consistency of performance is included in annual appraisal.	All serious incidents are subject to a rapid review facilitated by the Clinical Risk & Governance Team on notification by Datix. An impartial multi-professional panel inclusive of a Clinical Supervisor for Midwives review the incident and take immediate action to review compliance with guidelines and to determine if there are any clinical practice issues that need to be addressed. This would trigger escalation to the Director of Midwifery and Clinical Lead for North Wales. Should the incident require further investigation an external panel from another site will be utilised		

		to ensure unbiased conclusions and recommendations are made. Governance processes April 19.d All serious incident reports are agreed and finalised at the Women's Directorate Quality, Safety & Experience Subgroup, ensuring the Director of Midwifery and Clinical Director are kept informed of all outcomes. All staff have an annual appraisal and the compliance rate for 2018 was as follows: • Midwifery: 94.67% • MSW/HCSW: 98.54% • Medical staff: 99% All midwifery and obstetric staff discuss their performance over the previous 12 months (inclusive of CHKs data for doctors) and future training needs. Staff appraisers will support and facilitate any personal development required. Any involvement with complaints and serious incidents will be discussed and associated learning will be reflected upon.		
	7.5 Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.	The Directorate commenced the implementation of the national Fetal Surveillance Standards in April 2019. There is a Task & Finish Group working in collaboration with Welsh Risk Pool to ensure full compliance is developed and maintained. The Director of Midwifery & Women's Services requested a competency-based assessment be part of the Fetal Surveillance Standards, but this was not considered essential by the Maternity Network, Welsh Risk Pool and the Bristol PROMPT Team. One of the national obstetric leads for the Standards is a BCU consultant and his expertise plays an integral part in the Task & Finish Group. There is a risk log which is updated following each meeting to ensure a smooth transition of the implementation of the Fetal Surveillance Standards. Agenda 3-5-2019.doc The Task & Finish Group disseminate all relevant training compliance requirements via posters which are electronically circulated and then printed and displayed in all clinical areas for staff to read. Staff have also been issued a passport on which they can record their evidence of the mandatory six hours of face to face CTG training.	Following publication of the Independent Review of maternity Services at Cwm Taf by the RCOG, discussions are being held at a national level with regards to the requirement for competency based assessments. A national standardised teaching approach for the CTG component of PROMPT, to include physiology is also required.	

		CTG Poster.docx CTG Passport.docx Mandatory CTG training compliance is reviewed monthly at Women's Board and the current rates are as follows: Midwifery compliance CTG training: 100% Medical staff compliance CTG training: 75% A CTG Masterclass was held on the 9th March 2019 in YGC: 32 Obstetricians attended and 47 midwives. Two further Masterclasses have been organised for this financial year to support 100% compliance with the Fetal Surveillance Standards.		
	7.6 O & G consultant staff must deliver: • A standard induction programme for all new junior medical staff • A standard induction programme for all locum doctors	There is an induction programme for all new medical staff which is inclusive of a description of their role and responsibilities. An induction pack is also given to each new starter and covers all essential information. DEPARTMENTAL INDUCTION PROGR/ Induction programme for Juni 2019 April New doctor induction.dc INDUCTION PACK BCUHB EAST-Final -: All midwives also receive an Induction Pack; Induction of Midwives to the Cor All middle grade and consultant medical locum staff are required to complete a clinical competency check list prior to appointment. This is to openly inform the Health Board of their capabilities and clinical supervision requirements. An induction pack is also given to each locum and they receive a local induction to the clinical areas. Locum Agency Clinical Competency	The Directorate acknowledges that further improvement is required locally around this recommendation to ensure that locum induction is consistently delivered by Consultant staff on all 3 sites	
	7.7 Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care.	The Women's Directorate are currently reviewing their Miscarriage Pathway and this forms part of the three year plan this financial year. 13 12 18 Women's Governance Structu P2 - Gynaecology 01 03 2019 V1.7.xlsx Response to Mr Jonathan Williams - The Directorate are also reviewing the environment utilised to deliver this care provision in light of the Miscarriage in Wales document 2019 and NICE guidance.	The Maternity Strategy is being finalised following the launch of the national Strategy in July 2019	

		The Directorate are in the process of planning the development of a recurrent miscarriage clinic in North Wales to improve services available to these women. The Women's Directorate are working with the Fair Treatment for Women in Wales (FTWW) Group to ensure women's views are considered as part of any service development. A Task and Finish Group has been set up, led by the Directorate's North Wales Clinical Lead, to look at early pregnancy and re-current miscarriage services and the environments of care in North Wales. This group includes services users. Whilst the Health Board has a dedicated Early Pregnancy Unit in Ysbyty Glan Clwyd, the Directorate is working with colleagues at Ysbyty Gwynedd to secure a more appropriate environment for this service in the West Health Economy and hope to repeat the exercise with the East Hospital Management Team when they meet on the 10th June 2019.		
2. Assess the prevalence and effectiveness of a patient safety culture within maternity services including: o **The understanding of staff of their roles and responsibilities for delivery of that culture.** o **Identifying any concerns that may prevent staff raising patient safety concerns within the Trust.** o **Assessing that services are well led and the culture supports learning and improvement following incidents.**	7.8 Ensure external expert facilitation to allow a full review of working practice to ensure: • Patient safety is considered at all stages of service delivery. • A full review of roles and responsibilities within the obstetric team. • The development and implementation of guidelines. • An appropriately trained and supported system for clinical leadership. • A long-term plan and strategy for the service. • There is a programme of cultural development to allow true multi-disciplinary working.	Governance processes are well embedded into Women's Services and there is a defined North Wales team that manage clinical risk and Governance, ensuring patient safety at all stages of service delivery. CR Team v6.docx All staff are issued with a job description detailing their roles and responsibilities. All locum and new medical staff receive an induction pack which also details their roles and responsibilities and that of other grades of medical staff ensuring clarity of role. Guidelines are developed via the Written Control Documents Group as detailed under section 7.2. The Women's Directorate have developed an action plan in response to the Staff Survey to inform improvement in culture across North Wales. The Directorate has initiated several proactive forums to improve workplace behaviour. A 'Respectful Workplace forum' has been initiated to help promote and foster a culture of civility and respectful behaviour in the Obstetrics & Gynaecology department in the East. This has representation from all grades of doctors, midwives, nurses, theatre, administrative and management staff. An external organisation, Deloittes, was commissioned to work with the Women's Directorate as part of the cultural and leadership action plan whilst in special measures. Deloittes are supporting the training and development of the Senior Leadership Team, Site Teams and Clinical Directors and their services have been extended for a further 12 months. The BCU Workforce and OD department are also committed to supporting this ongoing work. Deloittes work has included clarity of roles, 360 degree reviews and Business Chemistry assessments for all individuals and		

		whole teams. They also support cultural work, ensuring women are at the centre of care provision, hence further promoting safety. Deloittes also support cultural development within the Directorate and are working with all teams to promote multi-disciplinary working The Directorate have supported the development of clinical leadership, supporting staff to access courses such as: • RCM Leadership Programme • Masters programmes in Leadership • Clinical Supervisor for Midwives undertake a leadership module on appointment set at Masters level The Women's Directorate have a three year plan (7.7) and have developed a draft maternity strategy. The Women's Directorate have also implemented PROMPT training to promote multi-disciplinary working. The training encompasses human factors training such as clinical leadership, situational awareness and team working. The national midwifery lead for PROMPT is the professional lead midwife for BCUHB and therefore the training is well embedded in Women's Services.		
	7.9 Develop a trigger list for situations which require consultant presence on the labour ward which much be: • Agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives • Audited and reported on the maternity dashboard.	Currently the RCOG role of the consultant guidance is used as guidance for reviewing unwell women. goodpractice8responsibilityconsultant Compliance has been achieved and is recorded on the inpatient dashboard and monitored monthly at Women's Quality, Safety and Experience subgroup and Women's Board.		
	7.10 Introduce regular risk management meetings which must be: • Open to all staff • Conducted in an open and transparent way • Held at a time and place to allow for maximum attendance	Risk meetings are held an all three sites and all staff are welcome and encouraged to attend. Most meetings are held at lunchtime/early afternoon to ensure maximum attendance and are open and transparent as per Duty of Candour. All matrons review Datix each morning following handler allocation by the midwifery Clinical Risk & Governance Team. Datix meetings are also held on each site on a weekly basis and significant issues are discussed by a multi-disciplinary team. All staff are welcome to attend these meetings including students to facilitate learning. Staff are invited to submit statements and attend serious incident reviews that they have been involved with. This ensures participation and transparency in all discussions held and immediate learning for those involved with the incident. All the evidence from these discussions is then deliberated by an independent panel who conclude the findings and make recommendations for improvement and shared learning.	Multi-disciplinary attendance is continuously monitored as an area for ongoing improvement.	

		There is a clear escalation pathway for clinical risk and Governance issues via the Women's Directorate and Health Board Committee structures. Womens committee structure amended I		
	7.11 Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at: • Governance meetings • Audit meetings • Perinatal mortality meetings	Governance meetings are held on each site on a monthly basis as are Perinatal mortality meetings. Audit meetings are held quarterly and there are bi-annual North Wales audit meeting. Elective clinical activity is modified to allow medical staff attendance All meetings have an attendance register to ensure attendance can be monitored and evidenced at appraisal.	Multi-disciplinary attendance is continuously monitored as an area for ongoing improvement. The Governance Lead is currently discussing the potential to hold a North Wales Governance meeting within the annual Audit day to share lessons learned on a wider scale, ensuring the incident loop is closed.	
	7.12 Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	Following any significant incident, the site team discuss debriefing with staff and organise sessions as required, often with the support of a team leader for mental wellbeing and counselling from Occupational Health department.		
	7.13 Identify a clinical lead for governance from within the consultant body. This individual must: • Be accountable for good governance • Attend governance meetings to ensure leadership and engagement	There are appointed consultant governance leads on all three sites who work in collaboration with the midwifery Clinical Risk & Governance Team. CR Team v6.docx		
	7.14 Consultant meetings should • Be regular in frequency • Be joint meetings with anaesthetic and paediatric colleagues • Have a standing agenda item on governance	Regular consultant meetings are scheduled and held on all three sites. The Clinical Directors also hold bi-monthly meetings. There are many multidisciplinary forums attended by consultant obstetricians, anaesthetists and paediatricians inclusive of the following: • Site meetings • Risk meetings • Perinatal mortality meetings • Audit meetings • Antenatal forum • Gynae forum/early pregnancy • Intrapartum forums locally and North Wales • Women's Board Womens committee structure amended I Governance is a standing agenda item.		
	7.15 Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at:	There is training on the Datix system for all new starters included as part of the Health Board induction programme. Health Board. Local induction is also inclusive of an update re Datix		

	• Junior doctor induction • Locum staff induction • Midwifery staff induction • Annual mandatory training			
	7.16 Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	All consultants are immediately available and resident on call can be undertaken as required.		
	7.17 Ensure training is provided for all SAS staff to ensure that they are: • Up to date with clinical competencies. • Skilled in covering high-risk antenatal clinics and outpatient sessions.	All SAS staff are required to maintain the RCOG continuing professional development portfolio and present evidence of this at appraisal. They also include shared learning from clinical incidents and risk meetings. The SAS staff always have access to the consultant on call if there is no consultant in clinic and they are aware of the role of the consultant on call as it is detailed in the RCOG good practice guide used in the Directorate and also in the new staff induction pack.		
	7.18 Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	N/A		
3. **Review the RCA investigation process, how SIs are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.** Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.	7.19 Ensure that a system for the identification, grading and investigation of SI's is embedded in practice through: • Appropriate training to key staff members • Making investigations multidisciplinary and including external assessors.	All members of the midwifery Clinical Risk & Governance Team have had a minimum of Health Board training in risk management, incident management and risk register training. The Women's Lead for Clinical Risk & Governance has also completed the Welsh Risk Pool Pilot Certificate in Healthcare Risk Management and Legal Services in 2018. The Governance Team ensure external panels are utilised for incident reviews by holding them on a different site to that which the incident occurred. Where panels external to the Health Board are required, the Corporate Team approach appropriate experts to review the incident in question. Incidents are reviewed weekly via teleconference chaired by the Women's Lead for Clinical Risk & Governance and are attended by all matrons, the Head of Inpatient/Outpatient Services, the General Manager and the Lead Neonatal Nurse for North Wales. This ensures the outcome of any rapid reviews held are discussed to share learning and that incidents can be escalated/de-escalated as appropriate. All Stillbirths, Neonatal deaths and maternal deaths (direct and indirect) are subject to individual investigation and reported to Welsh Government. The national Perinatal Mortality Review Tool is used to review all Stillbirths and NND. The Women's Lead for Clinical Risk & Governance also attends a weekly performance meeting with the Corporate Concerns Team to discuss the following: • Incident management (working to real time), • Catastrophic and major incidents and the progress made in reviewing them (one open, an indirect maternal death being reviewed on 13th May) • Open Welsh Government reportable incidents (two open and not overdue, the indirect maternal death and one	The Directorate is working towards the development of an annual North Wales Governance meeting.	

		incident in commissioned services-Countess of Chester Hospital).  Women's Directorate Datix Prc		
	7.20 Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Sis.	The incident review process is well embedded and staff now feel that with the implementation of the new Clinical Supervision for Midwives role, they are supported through the incident management process.		
	7.21 Improve incident reporting by: • Delivering training on the use of the Datix system for all staff • Encouraging the use of the Datix system to record clinical incidents • Monitor the usage of the incident reporting system	There is training on the Datix system for all new starters included as part of the Health Board induction programme. Health Board. Local induction is also inclusive of an update re Datix Incidents are monitored weekly in the Putting Things Right weekly teleconferences and at the weekly meetings with the Corporate Concerns Team. A weekly update is sent to all staff with regards to the number of incidents open on each site. The number of incidents is reviewed and has not changed significantly over the past 12 months. The Women's Directorate have significantly improved their process of incident management and are now working in real time. The Directorate have been commended by the Corporate Concerns Team for the work undertaken.		
	7.22 Actively discuss the outcomes of Sis which individual consultants were involved in their appraisal.	As detailed in 7.4, involvement in serious incidents forms part of the appraisal discussion for all medical staff including consultants. Any learning identified informs change in local policy and/or care provision.		
	7.23 Improve learning from incidents by sharing the outcomes from Sis on a regular basis and in appropriate, regular and accessible format.	Learning is shared from clinical incidents to all staff via a lessons learned template and memo if required.  what happned 44 LIR feedback NOT C(All staff clinically involved in an incident will receive an executive summary of the incident report and groups of staff can also meet with the Women's Lead, Clinical Risk & Governance and the site matron if preferred. There is capacity to request feedback when a staff member submits a Datix and a screen shot of directions on how to do this has been widely circulated.  Datix feedback.pdf	Women's Services need to continue to review and improve local processes and how lessons learnt are disseminated. A Safe & Effective Care Group has been established to review shared learning and the review process. The Directorate is working towards the development of an annual North Wales Governance meeting.	

		Incident outcomes and lessons learned are also discussed at risk meetings, audit meetings and perinatal mortality/morbidity meetings. Appropriate elements of learning are also escalated to BCU Board via the Governance committee structures (7.14). Learning is also shared nationally through various forums.		
	7.24 Identify a clinical lead from senior medical staff within the Directorate to support the midwifery Governance lead	North Wales Clinical Lead identified.		
4. **Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.**	7.25 Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: • That clinical audits are multidisciplinary • That there is a clinically validated system for data collection • That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset • Sharing of the outcomes of clinical audits and the performance against national standards.	There is an appointed Audit lead on each site and an overarching North Wales Audit Lead. There is a north Wales Audit Programme as detailed in 7.3. Audit forms part of medical staff appraisal as detailed in 7.4. Local and North Wales Audit days are held as detailed in 7.3. There is an Improvement Midwife within the midwifery Clinical Risk and Governance Team, who will be requested to take on specific areas of concern that require improvement and development. Women's Services participates in all of the *National Clinical Audit and Outcome Review Plan* (NCAORP) projects, which the Welsh Government has listed as a priority for Welsh Health Boards. This includes data collection, submission and response to the recommendations of the National reports when launched. Each project has a lead allocated from within the Directorate who liaises with the relevant Clinical Audit and Effectiveness Facilitator to ensure that participation requirements are fulfilled. Reporting to Welsh Government in order to provide assurance of the Health Board's response to the National recommendations takes the form of a 'Part A' and a 'Part B' pro-forma that are returned to the Clinical Audit & Effectiveness Department at one month and three months (respectively) from the report launch date. These outline those actions that need to be taken by the Health Board in response to the project findings and provide detail of the plans to deliver these locally. Within Women's Services these projects are discussed within the relevant Governance forums and led by agreed Directorate staff. The Directorate have an Improvement Midwife in post as part of the overall Governance Team.		
	7.26 Agree jointly owned neonatal and maternity services audits of neonatal service data including: • Neonatal outcome data • Perinatal deaths • Transfer of term babies to SCBU • Babies sent for cooling • Each Baby Counts reporting • MBRRACE reporting • Breast feeding rates • Skin to skin care after birth • Neonatal infection • Baby Friendly accreditation • Bliss Baby Charter accreditation	The Neonatal Lead and Neonatal Nurse Lead are part of Women's Board and therefore all national audit data is jointly shared and discussed. There is a jointly owned action plan to reduce the number of Term Admissions to SCBU.  Worksheet in Compliance Return There are joint reviews of all NND, Perinatal deaths, Intrapartum Stillbirths, and cooling incidents. These reviews inform both MBRRACE and EBC national audits.	National Strategic Breastfeeding Action Plan awaited.	

		The national Maternity and Neonatal Network are requested to have a work-plan aligned with the commitments in the Strategic vision to prioritise the development of work-streams that support the reduction of perinatal morbidity and mortality and reduced variation in maternity care and outcomes across Wales. There are audits undertaken with parents that discuss how soon after birth skin to skin was initiated and how long it continued for. Breast feeding rates in maternity services are collected along with the expressing breast milk/initiation of lactation numbers for babies on the neonatal units. The maternity units in the Women's Directorate are BFI accredited and neonatal services are applying for Stage 1 accreditation this year. There has been joint Women's and Children's training to effectively implement the sepsis risk calculator for babies. Transitional care is part of the standards within the Bliss Baby Charter and compliance with the standards is audited. There is a North Wales Strategic Breast Feeding Action Plan and the national Action Plan is awaited.		
	7.27 Consider extra resource to the Maternity Governance and Risk team to ensure: • Workload is manageable • That Datix are reviewed, graded and actioned in an appropriate and timely manner	Additional hours have been added to the midwifery Clinical Risk & Governance Team and additional roles to further support Governance processes within the Women's Directorate.		
	7.28 Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should: • Have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved • Understand and facilitate improvement in the reporting of safety issues and clinical risk • Provide a single point of reference for liaison with external agencies • Ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.	There is an identified Exec Lead for the Women's Directorate who provides direct progress reports to the Exec Board. The Director of Midwifery and Women's Services has direct access to the Exec Lead for Maternity Services, the Director of Nursing and also to the Board as per the job specification for the role. The Exec Lead receives monthly reports from the Director of Midwifery and Women's Services to ensure knowledge of performance and Governance concerns. All reports from external agencies are signposted to the Exec Lead and Director of Midwifery and Women's Services once received by the Health Board.		
5. **Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.**	7.29 Closely monitor bank hours undertaken by midwives employed [redacted], to ensure: • The total number of hours is not excessive • The Health Board complies with the European Working Time Directive • These do not compromise safety	Midwifery bank staff usage is monitored monthly during site Accountability, Workforce & OD and Finance & Performance meetings. The Health Board complies with the European Working Time Directive. Daily status report also circulated every 24hours detailing bank/locum staff establishment.		
an	7.30 Ensure the Medical Director has effective oversight and management of the consultant body by:	The Medical Director has one to one sessions with the North Wales Clinical Lead on a regular basis.		

	• Making sure they are available and responsive to the needs of the service • Urgently reviewing and agreeing job plans to ensure the service needs are met • Clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers)	The Clinical Lead ensures that the CDs are regularly reviewing job plans to ensure service needs are met. The Clinical Lead will agree what will be covered in SPA activity and will disseminate to the Clinical Directors who in turn will disseminate to the consultant body on each site. Currently the RCOG Responsibility of Consultant On Call Good Practice document is used as guidance for reviewing unwell women. goodpractice8responsibilityconsultant Rotas are scrutinised daily and a Status Report is issued, ensuring safety in all clinical areas and appropriate skill mix to inform all staff and the hospital site teams. The use of locum medical staff has also been reduced from 55% to 11%. Maternity Gynaecology Status		
	Ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation (national standard)	Currently the service is working to 24 hours and improvement is required with resident consultant cover to meet 12 hour NCEPOD recommendation. SBAR on 12 hour consultant review.d The North Wales Clinical Lead has discussed this with the All Wales Head of School, Associate Dean for O&G and RCOG Fellows Representative for Wales who agrees that a trigger list for consultant presence and local standard of 24 hour consultant review ensures high quality standard of care. 12-hour consultant review is ideal but not feasible throughout Principality with current resources. This will be discussed further with the RCOG via the RCOG representatives for Wales and at NSAG via the North Wales Clinical Lead. The Directorate's North Wales Clinical Lead has approached the Royal College of Obstetricians and Gynaecologists and Welsh Government regarding this recommendation and its local translation as it seems to contradict other Workforce Governance Standards produced by the College. This informed discussion at the All Wales Leads meeting on the 5th June 2019, led by WG, to look at Maternity Service Provision in Wales in context of the Cwm Taf Report. The North Wales Clinical Lead raised this standard at the Women's National Specialist Advisory Group (NSAG) on 15th August 2019. The decision of NSAG was to formally write to Welsh Government to ask for clarification of standards required by Women's services in Wales.	This standard will require 24/7 consultant cover which is not achievable in how the service is currently configured. Discussions will be held nationally and with the RCOG to understand if and how this standard is achieved elsewhere in the UK and the findings will inform our service, 3-year plan and options for compliance presented to Board.	
	7.31 Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken	Anticipated birth projections inform planning and **future** service design reviews.		

	• Ensure involvement of paediatric staff for all future service design reviews and actions.	The Neonatal Lead sits on Women's Board and is aware of the Women's Directorate three year plan. There is also a three year joint priorities plan for Women's and Children's Services.		
	7.32 Ensure obstetric consultant cover is achieved in all clinical areas when required by: • Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved • Undertake a series of visits to units where extended consultant labour ward presence has been implemented • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other • Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	Clarification is required on whether this refers to 12 hour RESIDENT consultant cover. The North Wales clinical lead is liaising with Welsh Government and the RCOG on the basis of this recommendation. The recommendation is not aligned to the current RCOG's workforce plan, which is based on the 2016 RCOG's WORKFORCE REPORT: *PROVIDING QUALITY CARE FOR WOMEN - OBSTETRICS AND GYNAECOLOGY WORKFORCE.* "In light of the current available evidence, fixed levels for consultant labour ward presence for different sizes of units cannot be justified. However, it is strongly recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday, with the aim of extending this to every day of the week to provide the same quality of service over seven days, in line with the aims of NHS England's seven day service standards. This level of consultant presence is felt necessary for service development, multidisciplinary training and clinical governance throughout the working day, seven days a week. The focus, however, should change from meeting arbitrary levels of consultant presence to ensuring there are appropriate numbers of staff, with the appropriate competencies, available at all times." The All Wales Head of School, Associate Dean for O&G and RCOG Fellows Representative for Wales has responded by stating the above 2016 Workforce guidance should be followed. There is therefore no current RCOG recommendation for 12 hour resident consultant cover. This will be further discussed with NSAG. Clarification has been sought on whether this refers to 12 hour resident consultant cover. The North Wales clinical lead is liaising with Welsh Government and the RCOG on the basis of this recommendation. The recommendation is not aligned to the current RCOG's workforce plan, which is based on the 2016 RCOG's WORKFORCE REPORT: PROVIDING QUALITY CARE FOR WOMEN - OBSTETRICS AND GYNAECOLOGY WORKFORCE. "In light of the current available evidence, fixed levels for consultant labour ward presence for different sizes of units cannot be justified. However, it is strongly recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday, with the aim of extending this to every day of the week to provide the same quality of service over seven days, in line with the aims of NHS England's seven day service standards". The All Wales Head of School , Associate Dean for O&G and RCOG Fellows Representative for Wales has responded by stating the above 2016 Workforce guidance should be followed. There is therefore no current RCOG recommendation for 12 hour resident consultant cover. This was further discussed at NSAG. NSAG will be formally writing to Welsh Government to seek clarity on this recommendation.	Clarification required to deliver improvements required.	

	7.33 Actively share the findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to: • Reassess the quality of induction, training and supervision in obstetrics • Seek assurance on the suitability of this service for trainees . • Appoint a named RCOG College tutor to provide support for the trainees currently on the RGH site with adequate time and resource to fulfil this function	N/A It can be noted that on the two training sites an RCOG college tutor is in place and a consultant in the third unit is preparing to undertake this role in the further. Feedback from trainees is collated from GMC trainee survey and from the end of placement trainee reports. The Deanery report is reviewed and considered by Women's Board to inform areas for improvement. 2060 Alex Howells - HEIW 13 05 19 CE1 GMC O&G feedback 2019 YG.pd GMC feedback for BCU Womens.pdf GMC O&G feedback 2019 WMH		
	7.34 Allocate all trainees currently in post a clinical and educational supervisor • The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education • The competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor	All trainees have a clinical and educational supervisor and a database of names is held on each site. All clinical supervisors and educational supervisors sign contracts which detail their role and responsibilities. ES Contract.pdf		
	7.35 Undertake a training needs assessment for all staff to identify skills gaps and target additional training	The Training Needs Analysis has been updated and will be agreed at Women's Quality, Safety & Experience subgroup and ratified at Women's Board. TNA 2019 MD.docx		
	7.36 Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors.	Consultant on call available as per RCOG guidance (7.30) Clinical supervisors available for trainees as discussed in 7.34 and for specialist midwives as detailed in 7.40.		
	7.37 Develop an effective department wide multi-disciplinary teaching programme. • This must be adequately resources and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • Attendance must be monitored and reviewed at appraisal.	PROMPT has been embedded into Women's Services for the past 18 months. Certificates of attendance are issued for evidence at appraisals and sign in registers are also in place. An annual review was undertaken following the first 12 months of implementation and the current stats for compliance to date are detailed in 7.5.		
	7.38 Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. • This must involve the antenatal ward round being performed by the consultant.	Detailed in job description, roles, and responsibilities in new staff induction pack. 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	Improvement is required to ensure full compliance with the recommendation and will require review of consultant job plans and possible allocation of two	

		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. INDUCTION PACK BCUHB EAST-Final -; seven-day-service-cl inical-standards-sep 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 obstetric and gynaecology 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.	consultants on call on mornings – one for obstetrics and one for gynaecology.	

	7.39 Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. • A risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.			
	7.40 Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: • Their scope of practice is clearly defined • The Health Board and the individuals are protected against litigation risk for their extended roles.	There is currently one midwife in Advanced Clinical Practice employed in Wrexham and three Midwives employed in Bangor. All of the midwives are operationally and clinically supervised by and responsible to the Labour Ward lead Consultant Obstetrician on the two sites where they are employed and their line manager is the site matron. The Womens Directorate are in the process of identifying the future requirements for workforce planning to support medical staff at Tier 1. A paper is to be presented to the Board in June 2019, to inform the three year plan. Advanced Clinical Practice Framework Advanced Practice Framework.pdf		
6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.	7.41 Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.			
	7.42 In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. • Staff must be held to account for poor behaviours and understand how this impacts upon women's safety and outcomes.	Addressed by Deloittes, work ongoing as detailed in 7.8. Also training provision from Clinical Supervisors of Midwives as detailed in 7.51. The Royal College of Midwives Representatives have provided STOP sessions throughout the Directorate as a joint initiative with the Health Board and the sessions are reactivated should a need be identified. The Directorate has initiated several proactive forums to improve workplace behaviour. A 'Respectful Workplace forum' has been initiated to help promote and foster a culture of civility and respectful behaviour in the Obstetrics & Gynaecology department in the East. This has representation from all grades of doctors, midwives, nurses, theatre, administrative and management staff. All staff are encouraged to undertake the RCOG Improving Workplace Behaviour online resource, which enables them to recognise potential factors which may contribute to an unpleasant and ineffective working environment and help avert such situations. Staff are encouraged to read the BCUHB Dignity at Work Policy, which outlines the steps an individual who feels that they have		

		been harassed or bullied should follow and the process that will be followed by the leadership team.		
7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.	7.43 Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services. • This can determine the structures and competencies of clinical leadership and governance that will support the service.			
	7.44 Support training in clinical leadership • The Health Board must allow adequate time and support for clinical leadership to function.	Addressed by Deloittes, work ongoing as detailed in 7.8.		
	7.45 Provide mentorship and support to the Clinical Director • Define the responsibilities of this role • Ensure there are measurable performance indicators • Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service • Consider buddying with a Clinical Director from a neighbouring Health Board.	Addressed by Deloittes, work ongoing as detailed in 7.8. The CDs also attend the annual Clinical Directors workshops held annually by the RCOG. The North Wales Clinical Lead has mentoring and coaching sessions with the Secondary Care Medical Director and as a member of the Women's NSAG, has a network of colleagues for further support. All CDs attend monthly Accountability meetings to discuss the performance of the site teams and the North Wales Clinical Lead monitors individual performance.		
	7.46 Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to include an individual response for each of the following: • Governance and clinical quality to include guideline updating. • Data quality • Medical staff education and training • Multi-disciplinary training • Audit • Risk management • Incident review • Complaints handling	All CDs appointed and have clear job descriptions. Clarity of roles and responsibilities undertaken with Deloittes. All staff aware of who to approach for each role. Objectives set for each lead in annual appraisal.		
8. Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.	7.47 Develop and strengthen the role and capacity or the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care: • Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources • Support lay members to engage with women using services in the FMU and RGH and at PCH to assess satisfaction and to identify issues relating to choices. • Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.	In 2017 BCU reviewed the function of its existing Maternity Services Liaison Committee (MSLC) and a new forum Maternity Voices was established. It has a lay chair and the majority are lay members. Numbers of lay members fluctuate and new members are actively encouraged through social media, BCU website and through attending local engagement and listening event in communities across north Wales. Maternity Voices are always looking at new ways of engaging with service users and all feedback from users is collated and presented to Maternal Voices so that any patterns for concern are noted and acted upon.	Ways of encouraging participation and engagement from users are reviewed annually and new ideas introduced to ensure that users can get involved on both an ad hoc basis or as a committee member. Improved use of social media is in development and the BCU maternity web page is under constant review.	

		A member of Maternity Voices has a seat on BCU Woman's Board where quarterly reports are presented.		
	7.48 Utilising the role and strengths of the Community Health Council: • Ensure appropriate resources to act effectively as an independent advocate • Ensure that information is available to families regarding its role and contact details • Explore provision of CHC to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support • Involve the CHC in the early implementation of the new maternity facilities at PCH and the FMU at RGH so they can be assured regarding the impact on access and satisfaction with maternity services.	The CHC are aware of Maternity Voices, as they are members of BCU Board. Women's Services work with the CHC to raise concerns and find appropriate solutions. Similarly, the ombudsman also supports families seeking complaint resolution. Contact details for the CHC are made available to women during the formal complaints process.	Improvement required to strengthen relationship with the CHC. The CHC will be provided with an update of the work of Maternity Voices in 2019 and this will include information on how to contact the group and how to join the group.	
	7.49 Develop the range and scope of engagement with women and families: • Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback. • As a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure • Feedback the outcomes of all engagement to women and families • Explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques.	Each woman is provided with a copy of a BCU Birth Place Decisions, which provides information for women and their partners on planning where to give birth inclusive of commissioned services. Women are also provided with details of clinical outcomes for all available outcomes. BCU use a range of opportunities to seek feedback:- Real Time Feedback System (Viewpoint) Maternity Voices User Forum Afterthoughts Clinic (debriefing after birth) Complaints and serious incidents Listening Groups are organised across north Wales through the year. Maternity Voices attend local events such as Family Fun Days and pregnancy groups to seek feedback on services. 19.04 Report Family Fun Day Abergele.d Draft poster MV.doc	Maternity Voices is in the process of collating some women's stories that will be posted on our maternity web page. Maternity Voices are in the process of visiting each maternity unit to review the environment of care.	
	7.50 Continue to work with and build on the community based engagement approaches being suggested by the MSLC • Explore working with external partners, including the CHC and community based organisations.	Maternity Voices engage with local pregnancy and birth organisations IE Positive Birth Movement, local home birth groups,	Improvement is required to strengthen our relationship with the CHC	
	7.51 Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families. • Review the process of investigation of concerns, handling 'on the spot' issues and ensure that all responses and discussions are	Listening skills form part of midwives annual mandatory training in 2019, as part of enhanced communication skills training delivered by the Clinical Supervisors for Midwives. Introduction to Advanced Communi	Improvement is required to strengthen the training by ensuring it is multi-disciplinary. Women's Services need to continue to review and improve local processes and how lessons learnt are disseminated.	

	informed by comprehensive investigations and accurate notes • Priorities the key issues that women and families have highlighted to improve the response • Ensure that promises of sharing notes and providing reports to families are delivered • Clarify the process regarding the triangulation of the range of information sources on patient experience, Sis, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues • Review the learning from the Sis in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.	Positive and negative feedback from women who attend Birth Afterthought clinics are given to maternity staff and areas for improvement discussed through group supervision for midwives. All women and their families are informed that a review of their care is being undertaken and following the investigation a feedback meeting is offered to go through the investigation report findings. A copy of the report is given to the woman and her family to keep. Thematic reviews are undertaken where themes and trends or local concerns are raised. The Corporate Concerns team and BCU legal services, for an external expert opinion, review any investigation report that identifies a breach in duty of care and associated liability. All learning is shared as detailed in 7.23.		
	7.52 Learn from the experience of women and families affected by events: • Respond and work with families in the way they require. • Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care.	Women and their families are involved in the incident investigation process and are asked to document any questions that they would like to be considered by the external panel. During feedback meetings following discussion around conclusions and recommendations made by the panel, women and their families are asked whether they are happy with the actions taken or if they feel anything else could be done. Feedback from families both positive and negative is fed back to the staff involved in the incident, with the woman's agreement. Feedback from women is used to inform service improvement.	Women and their husband/partner's presence during incident reviews will be commenced later this year once support processes have been established.	
	7.53 Review the communications, support and engagement approach and strategy. • Ensure that the focus is not solely on management of key messages • Demonstrate openness, honesty and transparency, admission of fault and learning from this.	Monthly staff 'drop in' sessions are undertaken across North Wales by the Senior Leadership Team. This ensures staff engagement and involvement in plans for development, strategy updates and that key messages are openly discussed.  STAFF DROP IN SESSIONS - Poster 2 The Duty of Candour is embedded into the Women's Directorate and all reports are honest and admit where breach of duty and associated liability have occurred.		
	7.54 Prioritise an engagement programme with families at its heart. • Women and families affected by events should be part of the improvement, co-design and culture change of the new service.	A service user is part of Women's Board and on various Directorate forums contributing to strategy and improvement in service design. Stakeholder engagement is always employed during service change and Maternity Voices are asked for their opinion on services issues.		

	7.55 Review the level and effectiveness of the bereavement service • Ensure that appropriate support and counselling is available for all families as required	The bereavement service has been benchmarked against SANDS standards and is compliant with them. A Bereavement Pathway has been implemented. A full time Bereavement Midwife is in post providing named support for bereaved women and postnatal follow up. The Bereavement Pathways in use in the Directorate reflect the All Wales Stillbirth Clinical and Psychological Standards for Practice (Maternity Network, 2018) and also with the SANDS standards. The Directorate have expressed an expression of interest with the National Bereavement Pathway organisation, but the scope of the pathway guidance available on the www.nbcpathway.org.uk website is currently limited for use in England NHS trusts so will not be able to proceed for the moment with being an NBCP adopter site. The Bereavement Midwife will maintain communication to ensure shared learning where possible.	The Bereavement Midwife has commenced a foundation counselling course, and will continue to develop her skills in this area. The Directorate continue to work towards improving support services for women who experience miscarriage.	
	• Consider implementing the National Bereavement Care Pathway that has been developed by SANDS in collaboration with stakeholders including women and their families, RCOG and RCM.	The bereavement services within the Women's Directorate has subsequently been benchmarked against the SANDS standards and the service is now fully compliant.		
	7.56 Provide training for staff in communication skills, in particular on: • Empathy, compassion and kindness	Provided by Clinical Supervisors for Midwives as detailed in 7.51.	Improvement is required to strengthen the training by ensuring it is multi-disciplinary.	
9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board	7.57 Continue with efforts to recruit and retain permanent staff.	The Womens Directorate are currently able to retain and recruit staff from within North Wales, other areas across Wales and from England. Current reliance on locum agency = 8%. **Midwifery** 2wte Equivalent vacancies **Medical staff**: Tier 1 – 1 Junior Fellow (east) advert closed 30.08.19, 2 SHO (Centre) interviews 04.08.19 Tier 2 – 3 SAS posts and 1 Reg post offered (East) awaiting clearance, 2.5wte in Centre, 1 post offered following interviews (23.08) Tier 3 – 2 vacancies (West) 1 post on Trac, and one being progressed by CD; 1 vacancy (Centre) being progressed by CD.		
	7.58 Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working.	The Women's Directorate have a three year plan and draft Strategy but are awaiting the national Maternity Strategy to inform the final version.	The Maternity Strategy is being finalised following the launch of the national Strategy launched earlier this month.	
	7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including: • Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.			

	7.60 Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service. 7.61 Develop a plan to increase inpatient capacity if that is seen to be required. 7.62 Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018. • Independent Board members must challenge the executive over the contents of this report • Independent Board members must ensure they are fully informed on the monitoring of planned improvements.			
	7.63 **Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.**	The Health Board continues to work to mature its arrangements to support Board and committee effectiveness. Wales Audit Office structured assessment 2018, reported that the Health Board showed signs of strengthened scrutiny and is working to develop a strong focus on fewer but key priorities. The quality of board level scrutiny is becoming more focused and challenging across the Board and its committees. It is continuing to improve, calling in those responsible for delivery, and calling senior officers back in where they have not been provided with the necessary assurance, driving hard to strengthen accountability for improvement. This is underpinned by an ongoing programme of board development sessions and Board workshops to further develop the individual and collective skills of Board members to confidently contribute, question and challenge . In addition, board members participate in walkabouts and ward visits providing a further opportunity to triangulate information by listening first hand to staff, observing services and understanding the pressures and consider the quality of services. This issue was last discussed at *QSE Sub Committee* on 21/5/19.		
	7.64 Independent Board members should receive training in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services that the Board provides.	A future training session for the Board covering Health and Safety and the implications of the Corporate Manslaughter and Corporate Homicide Act 2007. This issue was last discussed *at QSE Sub Committee* on 21/5/19.	The training will take place later in the summer or early Autumn of this year, following the latest Board refresh. Tentative date of 9/10/19 given.	
10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms	7.65 Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.			
	7.66 Update the risk register and review regularly at Board level.	The Women's Risk Register is updated on a quarterly basis or sooner if required. The Register is also discussed at Women's Quality, Safety & Experience subgroup and Women's Board following quarterly review. Secondary Care Quality Committee review all Risk Registers on a quarterly basis.		

		All governance reports detailing concerns have associated Risk Register entry references detailed, so they can be linked for further detail as required.		
	7.67 Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care.	The Women's Directorate have a three year plan and draft Strategy.	The Maternity Strategy is being finalised following the launch of the national Strategy earlier this month.	
	7.68 Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding: • Methods of service delivery • Consultant delivered labour ward care • The role of and function of a resident consultant • Achieving a balance between obstetrics and gynaecology commitments • Reducing the use of SAS doctors for out of hours service delivery and developing their in hours role	Benchmarking with other maternity services has been undertaken to review service delivery and creative ways of working. The last review in 2016 resulted in the implementation of the resident on call consultant role.	Improvement is required with resident consultant cover to meet 12hour NCEPOD recommendation	
	7.69 Identify and nurture the local leadership talent	Potential future leaders are nurtured when identified.		
	7.70 Ensure that any future service change for the development process of the maternity service as a whole is inclusive of all staff and service users. • Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision • Consider an externally facilitated and supported process for review • Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provision	Any service review would involve the CHC, strategic planning colleagues and all stakeholders. Maternity Services are compliant with Birth Rate Plus and a three year review will be undertaken in the autumn of this year to re-assess. The medical rotas on the three hospital sites are also compliant.		

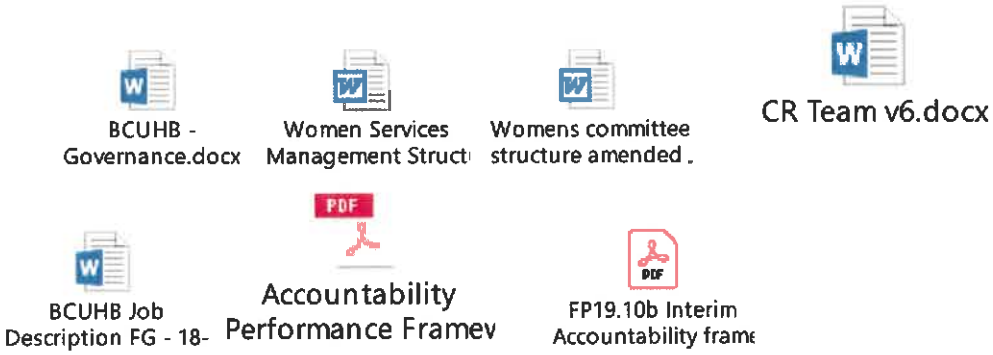
APPENDIX 2

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

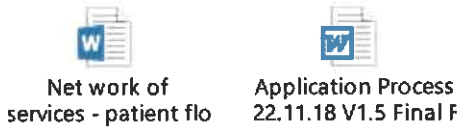
BCU Response: Healthcare Inspectorate Wales (HIW) National Maternity Review June 2019

In response to the HIW letter received on 3 June 2019, the Women's Directorate have collated the documents requested as follows:

1) **A Governance structure/map of maternity services within the health board.**



2) **A map which shows the flow of patients across maternity units within the health board e.g. flow from midwifery led units to obstetric led units.**
The Network of services and patient flow is detailed in the attachment below. Women resident in North Wales contact their local health centre to organise pregnancy booking and an appointment is arranged with a community midwife. For all women opting to give birth in a location outside North Wales, community midwives explain the application process, as per the attachment below.



3) **2017 & 2018 MBRRACE Reports.**
The BCH perinatal reports and latest maternal report have been attached for information. The Women's Directorate have benchmarked itself against the MBRRACE and other reports and have detailed the actions taken for improvement. Quarterly meetings are held by the Directorate to review the action plan and an agenda has been attached to evidence this, as has a thematic review of Stillbirths within BCUHB for 2018, demonstrating additional work undertaken as recommended by MBRRACE.


MBRRACE 2015.pdf


MBRRACE 2016.pdf


MBRRACE-UK Maternal Report 20'


Combined action plan updated May 2


Thematic SB review 2018.doc


MBRRACE meeting agenda May 19.doc

4) **The latest EBC report.**
The latest Each Bay Counts Report is attached and the benchmarking performed against this report has also been included. The recommendations from EBC has been incorporated into the above combined action plan.

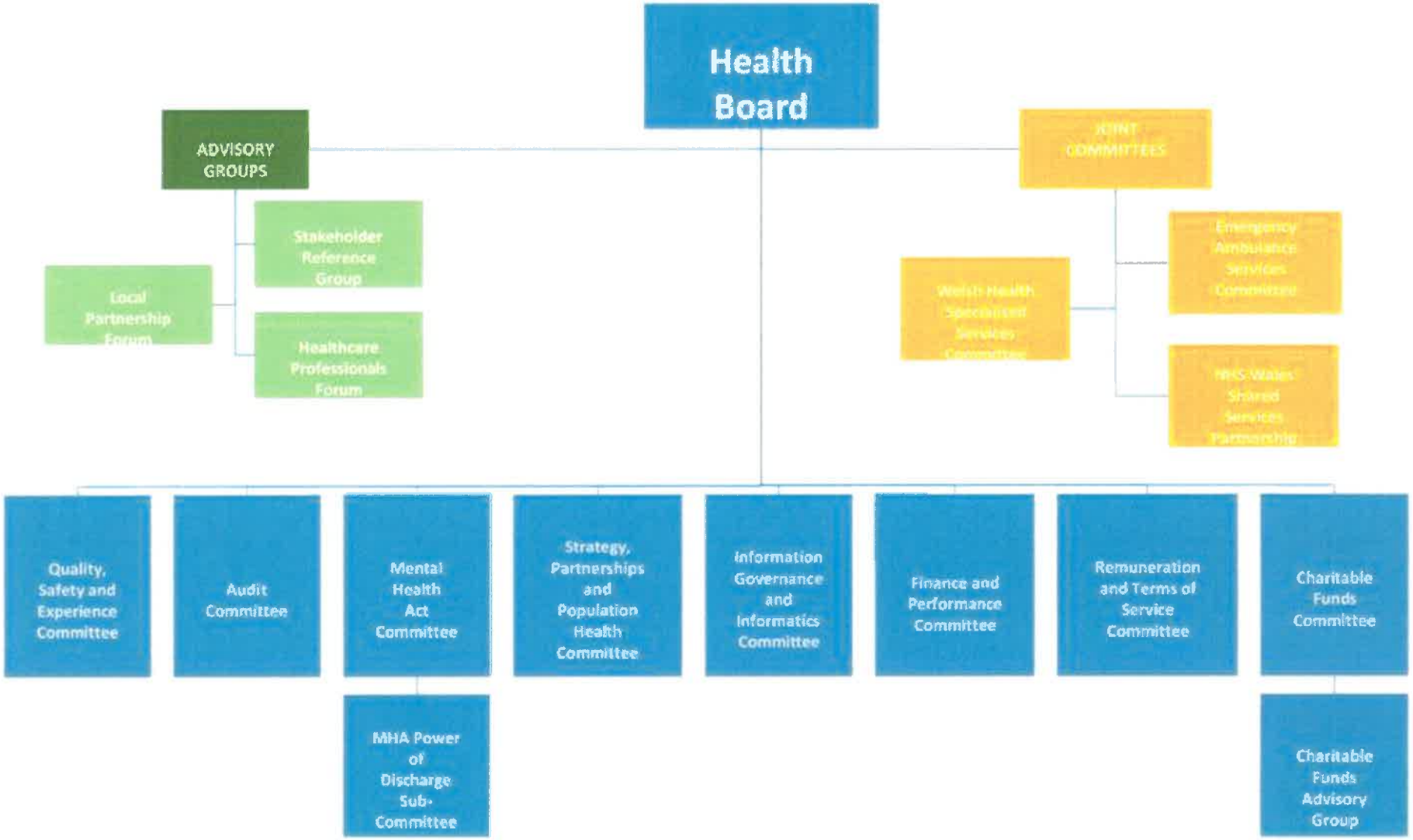

Each Baby Counts reprot - January 201


each-baby-counts-report-2018-11-12.pc

5) **The latest Risk Register for maternity services inclusive of the risks for each site.**
The Women's Services Risk Register has been attached detailing all open risks inclusive of those aligned to the Health Board Executive Team, Secondary Care, Maternity Services as a whole and site specific.


Risk Register June 19.xlsx

BCUHB GOVERNANCE REPORTING STRUCTURE



Women's Directorate
Management and Leadership Structure – July 2019

North Wales Speciality Clinical Lead for Women's Directorate
Mr Hemant Maraj

Director of Midwifery and Women's Directorate
Ms Fiona Giraud

Clinical Directors
Miss Maggie Armstrong - Central
Mrs Kalpana Upadhyay- East
Dr Zainab Ilyas– West

Head of Women's Services
(North Wales)
Mrs Heledd Jones

Consultant Midwife
Mrs Polly Ferguson

General Manager and Business Lead
Lesley Brown

West
Maternity Matron
Mr Dave Farmer
(Interim)

- **Labour Ward Leads**
  Miss Pitts/Eleri Pritchard
- **Maternity Ward Manager**
  Emma Rhodes
- **Gynaecology Ward /OPD Manager**
  Christine Plant/Janet Smith (Interim)
- **MOAU/ANC Lead**
  Natasha Lewis-Davies
- **AMU Lead**
  Karen Jones

Clinical Leads Table - (West) June 2019.d

Central
Maternity Matron
Mrs Lorraine Gardner

- **Labour Ward Leads**
  Mr Niladri Sengupta/Nadine Hunt
- **Maternity Ward Manager**
  Alyson Hatton
- **Gynaecology Ward /OPD Manager**
  Lesley Goodwin
- **MOAU Lead**
  Kizzy Williams
- **AMU Lead**
  Meinir Clayton-Evans

Clinical Leads Table - Central 2019.docx

East
Maternity Matron
Karen Roberts
(Professional Development Matron)

- **Labour Ward Leads**
  Dr Lynda Verghese/ Bethan Evans
- **Maternity Ward Manager**
  Jane Jones
- **Gynaecology Ward OPD Manager**
  Melissa Hewlett
- **MOAU Lead and ANC**
  Linda Cadman-Jones
- **AMU Lead**
  Karen Hookes Jones

Clinical Leads Table (East) - June 2019.dc

Outpatient Maternity Matron
Mrs Julie Reeve
(Interim)

Locality Leads

- **Gwynedd/ Môn**
  Maria Russell
- **Denbighshire/Conwy** –Mary Bell Coverino
- **Flintshire** – Pauline Goring
- **Wrexham** - Liz Jones

Antenatal Screening/ Fetal Medicine Service
Jacqueline Stockton/Mr B Kumar/Sue Heath

Infant Feeding Co-ordinator
Sharon Breward

Women's Lead for Governance and Risk
Maureen Wolfe

Risk Team
(please see attached structure)

CR&G Team v6.docx

Lead Manager (West)
Llio Johnson

- **Service Manager**
  Nerys Jones
  - **Admin Team**
  - **Medical Secretaries**
  - **Ward Clerks**

Lead Manager (Central)
Dino Tedaldi

- **Service Manager**
  Lindsey Roberts
  - **Admin Team**
  - **Medical Secretaries**
  - **Ward Clerks**

Lead Manager (East)
Jill Harrison

- **Service Manager**
  Vincenza Safina
  - **Admin Team**
  - **Medical Secretaries**
  - **Ward Clerks**
  - **Risk Team Admin**

NB Please also refer to the Obstetrics/Gynaecology Specialist Leads List (Available per site)

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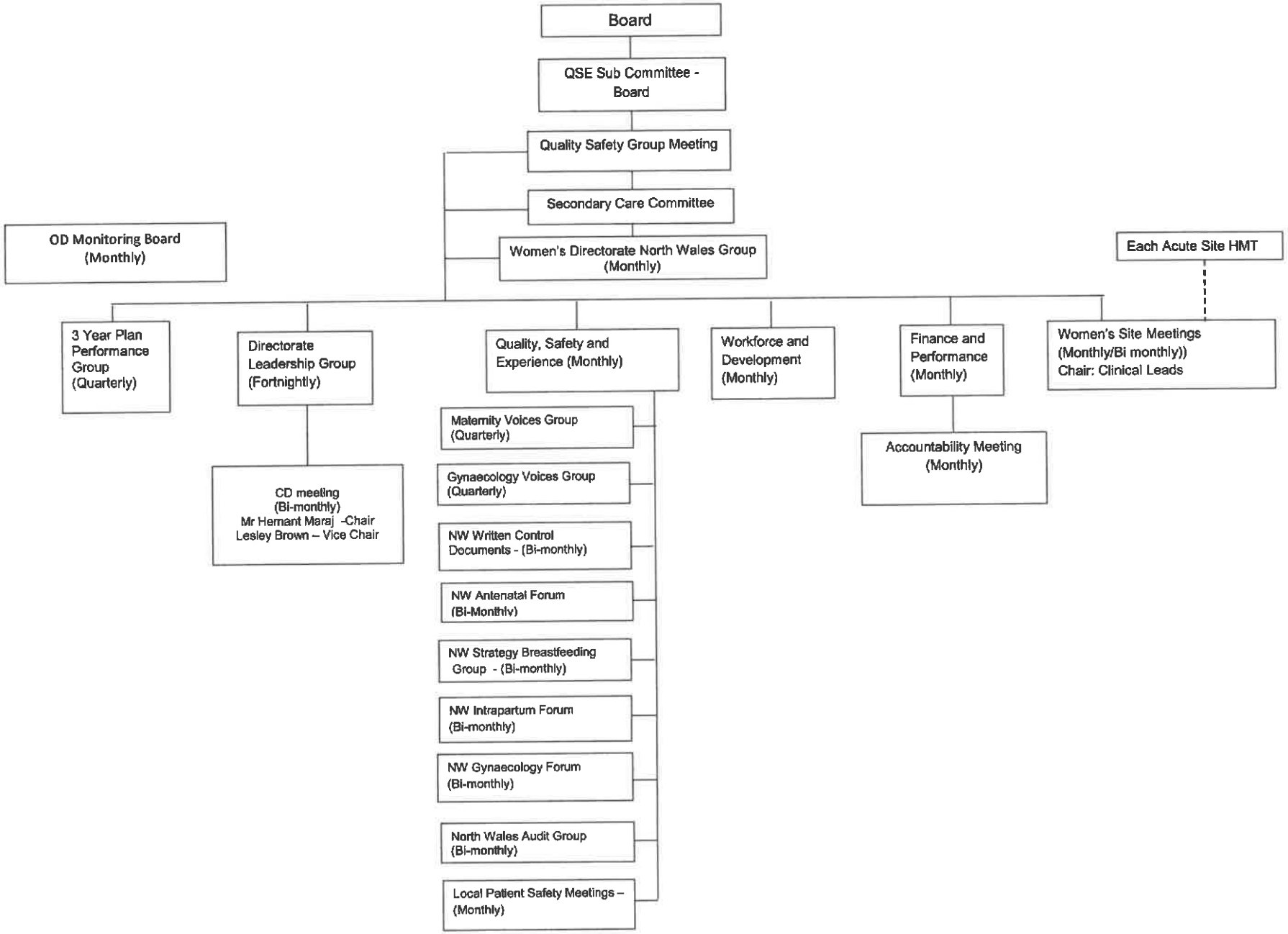
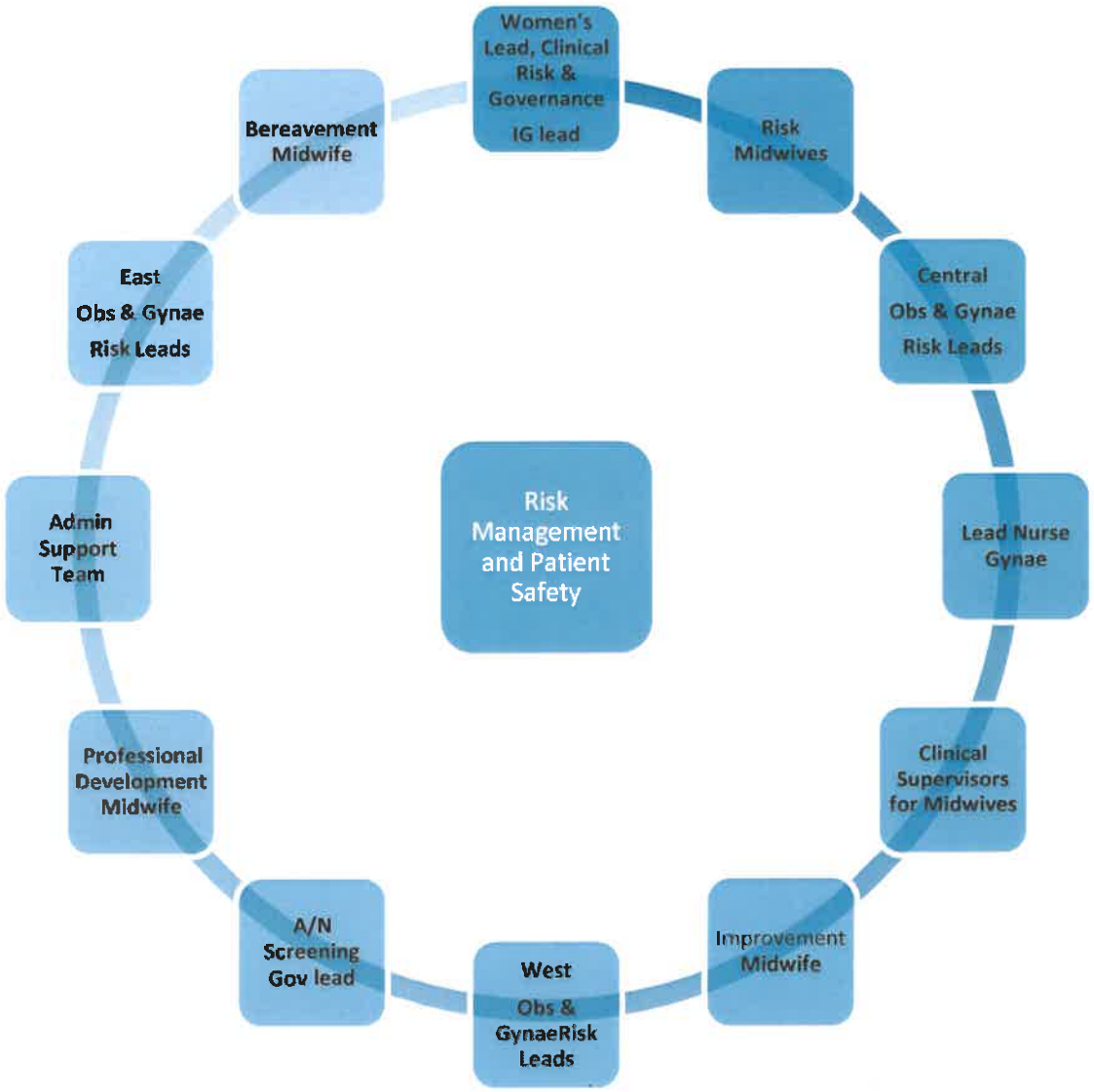
Women's Services Directorate Committee Structure



July 2019

Women's Directorate Clinical Risk Team



Women's Directorate Clinical Risk Team

East Obs & Gynae Risk Leads: Obstetric risk lead Miss Guru, Intrapartum risk lead (mainly PPH) Ms Verghese, Antenatal and Fetal Medicine risk lead and Gynae risk lead, Mrs Upadhyay

Central Obs & Gynae Risk Leads: Obstetric risk lead, Mr Sengupta and Gynae risk lead, Mr Clerk

West Obs & Gynae Risk Leads: Labour ward risk lead, Miss Pitts, Antenatal risk lead, Dr Ramesh, Gynae risk lead Dr Rieck and Gynae Oncology risk lead Mr Peevor

Womens Lead Clinical Risk & Governance/Information Government: Moe Wolfe (All sites)

Strategic role across North Wales with the aim of co-ordinating the midwifery team, ensuring all aspects of risk and governance are identified and managed effectively. The Women's Lead also coordinates the Risk Register for the Women's Directorate. Represents the Women's Directorate at designated health board meetings and is the Information Governance lead for Women's services

Risk Midwives: Gaynor Lloyd (West & Central) and Gill Murnane (East)

Review and allocation of Datix. Co-ordinate and lead on 72 hour, concise and comprehensive reviews of clinical incidents and feeding back lessons learned. Represent the Risk Team at Directorate meetings

Lead Nurse Gynae: Gail Pettifor-Jones (All sites)

Leading on service improvement and governance in Gynae services

Women's Directorate Clinical Risk Team

Clinical Supervisors for Midwives: Catherine Pritchard (West), Rebecca Ferneyhough & Wendy Roberts (East/Central)

Provision of fresh eyes in all clinical areas. Supporting midwives to support women with their birth choices and leading on Maternity Voices sessions to gain user feedback to improve the quality of Women's services. Feeding back actions from lessons learned have been implemented in all clinical areas, therefore closing the loop on reviews held.

Improvement Midwife: Jan Quarmby (All sites)

Where themes are identified within clinical risk across North Wales, leads on quality improvement to resolve the issue by implementing required steps to address problem identified.

Antenatal Screening Governance Lead: Out to recruitment (All sites and community areas)

Leading on service improvement and governance in antenatal screening

Professional Development Midwife: Sarah Hookes/Julie Reeve (All sites)

Leads on the delivery of mandatory training to ensure safe, quality care provision and lead for implementation of multidisciplinary PROMPT training across North Wales. Also maintains midwifery register of compliance at the four annual mandatory training days.

Admin Support Team: Linda Maurice, Sam Knight and Lynn Jones

Women's Directorate Clinical Risk Team

Provide admin support to risk team. Coordinate all activities/meetings for the risk team. Link with service users and coordination of Governance, Risk and Perinatal meetings on East site

Bereavement Midwife: Lucy Dobbins (All sites)

Leading on improving support for bereaved families, training and support for staff, policy development and communication with relevant stakeholders to take the service forward.

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Betsi Cadwaladr
University Health Board

CAJE REF:

JOB DESCRIPTION TEMPLATE

JOB DETAILS:

Job Title	**Director of Midwifery and Women's Services**
Pay Band	
Hours of Work and Nature of Contract	**37.5 wte**
Division/Directorate	**Women's Directorate (A Directorate of the Secondary Care Division)**
Department	**Women's and Maternal Health**
Base	To be completed on recruitment

ORGANISATIONAL ARRANGEMENTS:

Managerially Accountable to:	**Operational accountability through Secondary Care Director to Chief Operating Officer**
Reports to: Name Line Manager	**Director of Secondary Care**
Professional Accountability	To Executive Director of Nursing and Midwifery to LHB Chief Executive and Board for professional and regulatory issues for Nurses, Midwives and non-registered staff within those professions

Key Relationships:

Internal	External
Executive Director of Nursing & Midwifery and Chief Operating Officer.	Nursing/Medical/Therapy Professions & Professional Groups
Secondary Care Director and Secondary Care Medical Director	Public Health Wales
Area Directors	Other NHS organisations
Area Medical and Nursing Directors	Local Authorities
Director of Quality Assurance/Deputy Director of Nursing	Local & national voluntary organisations
Secondary Care Finance Director and HR Lead	Staff representatives and trade unions
Hospital Medical Directors/Hospital Nurse Directors	Professional bodies and associations
Senior clinicians and clinicians across all sectors, divisions and management teams	Patients/service users and their relatives/carers
LHB Chief Executive, Directors and Independent Members	Community Health Councils (CHCs) and local patient/carer advocacy services
Head of Operational Estates	Local partnerships

Senior Nurses (Matrons, Ward Sisters, Nurse Specialists, Nurse Practitioners and Team Leaders)	Independent Contractors
Clinical Site Managers and the Bed Management Team	
Clinical Directors for Therapies, Health Sciences and Medicines Management (Chief Pharmacist)	Chief Nursing Officer and Nursing Officers at WAG
Associate Directors for Safeguarding, Professional Regulation and Education, Infection Prevention.	Directors and representatives of external agencies such as HIW, HSE, WRP, NPHS, WAST

Job Summary/Job Purpose:

The post holder has the lead accountability for the strategic service planning, including financial and workforce planning as well as for the overall operational delivery of Women's services across all 3 acute sites and 3 Areas across North Wales. The post holder will provide and take overall responsibility to drive forward service transformation for the Women's Directorate and be responsible for implementing the Quality Improvement Strategy, promoting a culture of Prudent and Compassionate Health Care. The post is the expert for midwifery and gynaecological nursing in the Health Board.

The post holder will be a core member of the Senior Management Team for the Health Board and a key member of the Secondary Care Senior Leadership Team.

The Head of Midwifery element of the post is a statutory requirement. The post holder will advise the Health Board, working closely with the Executive Director of Nursing and Midwifery on both professional Midwifery matters and maternity and women's service delivery.

The post holder will provide strategic leadership to all staff groups in the directorate, including Medical and Administration/Operational teams to deliver shared aims and values which engage users in order to consistently develop high quality, efficient and cost effective services for women and their families across North Wales.

The post holder is the professional leader to all Midwives within the Health Board and is the line manager for the Directorate Clinical Medical Lead, Clinical Directors, General Manager, Consultant Midwife and the Nursing and Midwifery Heads of Services.

The post holder will represent Midwifery & Gynaecology Nursing , Maternity and Women's Services at a Local, Regional, National and UK level influencing the practice and policy agenda working in partnership with key stakeholders; Governments, Regulators, Professional colleagues/ forums and educational institutes and commissioned providers.

This post will maintain a clinical workload and responsibility for direct patient care, which should be at least 10% of the working week.

This post holder will be required to participate in the Silver on-call.

Particular Key responsibilities will be to:

- To lead the directorate in creating an environment in which excellence, research and development and public protection and safety can flourish to meet the demands of a 21st century services.
- Ensure that the Executive Board is aware of any situation that may compromise professional midwifery registration.

- To Advise the Board and lead the continuing transformation of Women's Clinical Services across all sites and into Community Areas, reflecting the prudent principles for healthcare, evidence based professional and service specific requirements.
- Lead on the overall strategic planning of the Women's Services on behalf of the Health Board.
- Lead on the quality Improvement agenda and Infection Prevention Control Strategy for the Directorate identifying and implementing quality changes in services, providing expert service monitoring of the quality impact.
- Lead on the Clinical and Workforce Governance Assurance Framework for the Directorate and the required statutory monitoring arrangements, influencing the standard of care provided to women and their families.
- Lead on the specific health improvement plan for the Directorate and contribute to the Health Board's overall strategy to reduce health inequalities.
- Lead on service evaluation and patient/service user/community perspective in providing high quality patient/service user care for women and their families.
- Assume overall responsibility for the financial management and performance target set by Welsh Government for Services, setting budgets, leading on the financial governance and all PMO and CIP projects for the Directorate.
- Directly managing multiple budgets over several sites with budget responsibility for many teams and impacting on numerous clinical areas.
- Be directly involved in the commissioning process, influencing at an appropriate level to improve services, acting as an advocate for women to make sure the commissioning cycle reflects their needs.
- Develops and shapes policies and strategies for developing clinical practice throughout the Directorate and ebyon in order to ensure high quality, safe health care services for women and their families in an effective and cost effective way.
- Lead on the introduction, ongoing development and evaluation of the Clinical Supervisors for Midwives for the Health Board as per CNOs/NMC requirements.
- Set the direction for Midwifery and Gynaecology Nursing and the development, implementation and monitoring of risk, promoting health and wellbeing.
- Develop partnerships with further education and Universities to meet the requirements of the Health Board.
- Advice on the development of the Nursing and Midwifery Educational programmes locally and nationally, influencing the outcome requirements for services.
- Work with all areas of secondary care services to deliver the strategy with special attention to cross-working issues and work flows with the Area Directors and Area Nurse and Medical Directors.

- To be an 'Ambassador for Midwifery and Women's Services' within the Health Board, Regionally, Nationally and across the UK, influencing policy and service development.
- As one of the cache of Senior Midwifery Leaders in Wales, contribute to the wider health and organisational agenda of the NHS in Wales, WG and professional bodies nationally an on an UK basis.
- Responsible for the delivery of the operational, financial, performance and activity targets and most importantly focuses on improving patient, carer and staff experience for Women's Services.
- Provides inspirational, dynamic professional, visual management, leadership, supervision and an overseeing role to the clinical professions within the portfolio to develop and facilitate the delivery of excellent practice and clinical outcomes for patients that is evidence based and measurable (metrics).
- Develops and shapes policies & strategies for developing clinical practice throughout the Women's Services in order to ensure high quality, safe health care services for our patients in an effective and cost effective way.

DUTIES/RESPONSIBILITIES:

1.0 Strategic & Professional Leadership

1.1 To provide overall leadership management and direction to all staff working within the Womens Directorate ensuring learning across the region and Wales with the development of sustainable/coherent nationally credible programmes of Leadership Innovation.

1.2 Responsible for initiating and for the development of Research and Development programmes within Maternity and Women's services to support national, regional and local priorities and identify research and development priorities that will enhance and pull together initiatives required to advance Leadership and Innovation.

1.3 Provide expert, visible and strategic professional leadership to the clinical and non clinical workforce in delivering local and national strategy to enable the Health Board to achieve its' strategic agenda.

1.4 Devise and deliver a management structure for the Directorate that provides leadership and management accountability and reflects the changing nature of patient/service user care and expectations of services.

1.5 Lead on the strategic vision for the management of Maternity and Women's Services for North Wales.

1.6 Provides professional management, leadership and supervision in budgetary management, workforce redesign, training and development, and ensures compliance with the All Wales and Health Board policies.

1.7 Directly line manage the Clinical Lead for North Wales, Clinical Directors, Site, Consultant Midwife and Heads of Services and for Nursing and Midwifery.

1.8 Provides active and transformational leadership to the Directorate's Senior Management Team and the delivery and realisation of their professional service and corporate objectives.

1.9 Providing expert professional advice, support, challenge, scrutiny and decision-making as required or where necessary to nurses, midwives and other directors, senior managers and staff across the Local Health Board.

1.10 As an ambassador of the Local Health Board ensure that self and others represent and practice to the highest professional standards at all times.

1.11 Develop and manage relationships with all key external stakeholders and voluntary groups who contribute to service planning and developments

1.12 Ensure that the clinical professions make a full contribution to the Organisation's financial viability, avoiding waste and exercising proper stewardship and accountability over public monies and resources.

1.13 To lead staff to support services in delivery of agreed operational and financial efficiencies and cost improvements through modernisation, service improvement and service/workforce redesign to ensure full utilisation of resources and skill mix.

1.14 Set and monitor performance standards for the clinical professionals, registered and non-registered within the Directorate.

1.15 Accountable for the work to ensure the safety and well-being of patients, service users and colleagues, taking any necessary corrective action as appropriate to prevent any deterioration in service standards, or to the safety and welfare of patients and staff.

1.16 Overall accountability for the delivery of all targets and standards as they pertain to Women's services. The post holder is responsible for highlighting any factors which put the achievement of targets, patient care, safety or professional regulation at risk, and for proposing and taking remedial actions.

1.17 Overall management responsibility for the delivery of strategies for Maternity and Women's Services to drive and measure quality service change.

1.18 Overall responsibility for developing, implementing, monitoring and managing monthly key performance indicators against core BCUHB/ Welsh Government deliverables and areas for service improvement. Provide quantitative and qualitative evidence that clinical services is responding and improving to a high standard, and takes immediate and decisive action where standards are

unacceptable.

1.19 Responsible for the development, implementation and monitoring of a range of Health Board policies relating to their area of responsibility.

1.20 Responsible for reviewing and implementing recommendations from external statutory and professional inspections as they relate to Nursing and Midwifery, including Internal and External Audit bodies, Welsh Health Estates, the Health & Safety Executive, Local Supervising Authority and Health Care Inspectorate Wales.

1.21 Overall responsibility for the implementation of Quality Development Plans and improve whole system clinical governance to ensure that effective clinical governance is in place across the entirety of the patient journey, including the interface between primary and secondary care and in all related commissioned services.

1.22 Ensure that the Safeguarding People at Risk of Harm Governance and legislative Reporting Framework, Quality Outcomes Framework and statutory agenda is fully implemented with guidance and in collaboration with the Associate Director of Safeguarding.

1.23 Ensure that all staff understand and comply with Safeguarding procedures and policies.

1.24 Ensure each department or specialist service has an identified Safeguarding lead to support the delivery and engagement with the Safeguarding People at Risk of Harm agenda on behalf of the Associate Director of Safeguarding

1.25 Through coordination of safer patient groups ensure there is sufficient "spread" of learnt lessons from concerns, complaints, Safety Incident reporting (DATIX), Serious Incident Reviews, Root Cause Analysis and Coroners cases

1.26 Plan, secure funding and deliver services to achieve the rationalisation of existing services in consultation and in conjunction with internal stakeholders and external organisations. Develop strategies to achieve and maintain high standards of clinical care in the best physical environment and standards of environmental cleanliness, nutrition and all the fundamentals of care.

1.27 Develop positive working relationships with other clinicians and managers to ensure that the organisation is at the forefront of best professional practice and service delivery.

1.28 Ensure that complex formal and informal complaints are resolved satisfactorily, with the post holder being well versed in the Local Health Board's complaint procedures, and ensuring that learning from complaints is evidenced by improvement.

1.29 Direct the resolution of complex problems that directly impact upon the operational practice/services, and be a resource as both a mediator and expert for difficult, complex and sensitive problems.

1.30 Ensure that all staff within the Directorate comply with Safeguarding people at risk of harm, infection prevention, decontamination, prevention and management of pressure ulcers and other procedures and policies.

1.31 Overall responsibility for the management of physical assets of services.

1.32 In the event of a major incident/major outbreak the post holder will be required to perform a senior leadership role within the major incident policy and will be required to undertake training for this role.

1.33 Accountable and responsible for supporting staff when there is a need to provide statements for the Police, courts and when staff attend court, outside of the professional safeguarding arena

1.34 Manage and lead the programme of work to ensure the outcomes from these services and those gained via other service user experience feedback activities; contribute to service improvement and enhanced service user and service user experience.

1.35 Develop the management skills of the line managers, with areas for development identified at each manager's annual performance development review.

1.36 Set and monitor the objectives of line managers.

1.37 Overall responsibility for the management and delivery of operational, financial, performance and activity targets.

1.38 Direct and motivate staff to work within across and beyond nursing and midwifery services to address difficult and conflicting priorities.

1.39 Regularly advise and provide assurance to the Board and Executive Director of Nursing and Midwifery on all professional issues relating to Midwifery.

1.40 Provide specialist clinical advice and decision making relating to the workforce e.g. in relation to Birth Rate Plus compliance for Midwifery and on safe nurse staffing establishment and deployment of nursing for the Health Board.

1.41 Develop and deliver strategies that incorporate all the Fundamentals of Care for Nursing and Midwifery including Tissue Viability, Continence Management, Infection Prevention and nutrition to enhance the safeguarding of patients and high quality for service users, ensuring the delivery of targets as set locally and by Welsh Government.

1.42 Responsible for reviewing and implementing recommendations from external statutory and professional inspections as they relate to Nursing, including Internal and External Audit bodies, Welsh Health Estates, the Health & Safety Executive, and Health Care Inspectorate Wales.

1.43 Ensure a system of clinical supervision for the Directorate on behalf of the Health Board.

1.44 Impart complex, sensitive and contentious information, both to individual staff members, as well as to groups of staff, and other agencies using a range of communication tools to achieve this.

1.45 Challenge and find strategies to overcome organisational barriers to excellence in clinical services.

1.46 Be a source of expertise using highly complex analytical and judgemental skills when representing the Health Board at committees, implement highly complex emergency strategies, review outcomes and supervise HB employees in same.

1.47 Maintain own self development and keep abreast of developments within the service areas and profession.

2.0 Communication and Relationships

2.1 The post holder is required to have the highest level of communication skills for dealing with both patients and staff. Required to communicate straightforward messages as well as communicating highly complex messages to a variety of stakeholders within and outside of the Health Board.

2.2 The post holder is required to be empathetic and able to communicate difficult and sensitive messages ensuring that the patient or staff member understands and accepts the message.

2.3 Provide visible leadership and by example become the model for putting patients, users and carers at the centre of services.

2.4 Develop, implement and evaluate systems that ensure that all staff groups learn from complaints, Independent Reviews and Serious Incident Reviews.

Lead and direct the investigation of serious incidents and ensure that lessons are learned throughout the organisation, taking further action if indicated.

2.5 Act and ensure that complex formal and informal complaints are resolved satisfactorily with the post holder being well versed in the Local Health Board's complaint procedures, and ensuring that learning from complaints is evidenced by improvement.

2.6 Required to respond to the media in high profile clinical cases.

2.7 Represent the Executive Director of Nursing and Midwifery at specific events, including strategic Health Board meetings with external agencies and organisations and nationally representing CNO's office.

2.8 To provide leadership and direction across situations where high complex ideas or concepts need to be conveyed and implemented across the organisation in easily understood language, clearly articulating processes where acceptance and resistance to change exist.

2.9 Communicate directly with the Executive Director of Nursing, and Midwifery to brief her on contentious issues and potential media coverage and professional issues of concern ensuring direct engagement with specialist Associates.

2.10 Co-ordinate and/or chair professional single agency and multi agency meetings in relation to highly complex issues within secondary care in relation to professional concerns/vulnerable adults outside of the safeguarding arena

2.11 Establish, maintain and develop client/patient/carer stakeholder relationships in the best interests of patient services and the Local Health Board, and monitor public confidence in relation to Nursing and Midwifery.

2.12 Support the development of a culture of public involvement that is open and transparent, ensuring that users, carers and the general public's views are effectively represented and appropriately incorporated into decision making across the Local Health Board

2.13 Develop positive working relationships with other clinicians and managers to ensure that the organisation is at the forefront of best professional practice and service delivery.

2.14 Represent the Director of Nursing and Midwifery in partnership working with other statutory and voluntary agencies, working locally and across Wales, in relation to patient services, the needs of carers and service users.

2.15 Build relationships with local government, the independent and voluntary

sectors and other partners. To represent the programmes of work nationally to regional stakeholders/external bodies, partners organisations including local universities.

2.16 Plans and facilities discussions and debates with professional colleagues at al levels to address professional and service challenges and problems internally and externally.

2.17 Engage with and promote co-operation and collaboration with other organisations, to develop strategic partnerships and alliances to improve the health of local communities and ensure effective partnership working.

2.18 Lead, Coordinate and/or chair professional single agency and multi-agency meetings in relation to highly complex issues across the Health Board in relation to professional concerns/clinical issues/improving patient experience.

2.19 Actively support the development of effective strategic links between health service planning and delivery and the Public Health function

2.20 Provide leadership and management to deal with the most complex cases within Women's Directorate in relation to Nursing and Midwifery and developing strategies to manage clinical departments and teams in difficulty and requiring support

2.21 The post holder will be required to communicate highly complex, sensitive or contentious information at individual and group level and will be expected to be comprehensive in verbal, written and presentation skills on a variety of subjects.

2.22 The post holder will be expected to be competent in the provision of high quality written communication including reports for the wider use including the Board and associated sub committees to present highly complex information to influence and negotiate on the delivery and achievement of services. This information will at times be contentious and sensitive.

2.23 Develop effective relationships with the Community Health Councils, Professional Forum and Stakeholder Reference Groups to ensure strategic plans are developed with full cognisance of their views.

2.24 Ensure full engagement with Safeguarding multi-agency and single agency Investigations, Enquiries and Reviews as guided by the Associate Director of Safeguarding

3.0 Financial and Performance Management

3.1 Accountable for the overall management of multiple complex budgets across

differing Clinical Services for the Directorate, with associated capital assets, with due regard to complying with the Health Board Standing Financial Instructions and with European tendering legislation.

3.2 Overall accountability for the allocation of budgets within the Women's Directorate to drive forward the strategy for service redesign. Overall responsibility for setting and agreeing the annual budget for clinical services, taking account of forecasting of known cost pressures and anticipated service developments/rationalisations in other parts of the Health Board.

3.3 Overall financial authority as authorised signatory for all pay and non-pay budgets for the Directorate including commissioned services.

3.4 Overall responsibilities for developing and maintaining robust systems of financial control, for all budgets within the Directorate, including monthly review and monitoring of the financial performance ensuring that corrective actions are taken to deliver the financial targets.

3.5 Examine and appraise the value for money obtained by the use and deployment of all staff and resources and identify areas for improvement of efficiency.

3.6 Lead the implementation of strategies to maximise staffing resources: Skill mix Reviews; Workforce re-design; E-Rostering.

3.7 Works under the broader financial framework of the LHB identify and making relevant cost savings where required.

3.8 Examine and appraise the value for money obtained by the use and deployment of staff and resources within clinical services and identify areas for improvement of efficiency.

3.9 Lead the implementation of strategies to maximise staffing resources: Skill mix reviews; Workforce re-design; provision of training and education for clinical professions within the scope of the responsibilities.

3.10 Ensure systems in place for scrutiny and performance management of rosters, providing assurance of cost effective deployment of staff, minimising the use of bank and agency and improving the quality, safety and efficiency of services

3.11 Scrutinises, secures and monitors allocation of funds to remain within the total budget and to keep abreast of future developments that may affect the budget.

3.12 Overall responsibility for identifying, negotiating and implementing income generation and commercial opportunities as the officer accountable for the management of complex budgets across different clinical teams with due regard to complying with the Standing Financial Instructions of the Local Health Board and with European tendering legislation.

3.13 Responsible for the budget of any externally funded posts.

3.14 Identifies, leads and monitors cost improvement programmes and efficiency measures for all budgets within the Directorate.

3.15 Develop and agree contracts and service level agreements for new and/ or existing services in liaison with the Health Board's finance department and within the Local Health Board's Standing Financial Instructions.

3.16 Develop a long term strategic plan for Women's Directorate. Ensure that all strategic plans are aligned with Betsi Cadwaladr university Health Board's objectives.

3.17 Implement and monitor compliance with local and national policies and ensure that the Director of Nursing, of Midwifery is kept briefed of these and other international developments that may lead to further improvement in midwifery quality and leadership across the Health Board and within the independent sector.

3.18 Lead and produce an annual operational plan for the Directorate which details how national and local policies and priorities will be delivered to meet national and local standards/targets and in particular how improvement will be demonstrated in the Healthcare Standards submission.

3.19 Ensure that systems are in place to monitor and measure progress in achieving the Healthcare Standards, other standards/targets and service developments/ rationalisations contained in the annual plan.

3.20 Accountable for the delivery of all targets and standards as they pertain to care metrics, fundamentals of care within the Directorate. The post holder is responsible for highlighting any factors which put the achievement of targets and patient care or safety at risk and for proposing and taking remedial actions.

3.21 Overall responsibility for researching, prioritising and developing business cases for capital and revenue funding in line with the Health Board internal policies, tendering processes and with Capital Investment Manual procedures, to support operational and strategic service changes/ developments in accordance with national and local guidance.

3.22 Overall responsibility for recognising where business cases/ plans impact on safe services, ensuring other agencies and partners are involved accordingly to promote service user safety and excellence in standards.

3.23 Responsibility for benchmarking the full range of clinical services activities to inform service changes and identify areas of best practice for adoption.

3.24 Overall responsibility for ensuring policies and procedures are developed with partner agencies beyond the organisation, with a system for implementation, audit and review.

3.26 Overall responsibility for compiling and managing the Women's Division Risk Register ensuring the contribution to the Local Health Board's risk register is produced, reviewed and updated as required.

4.0 Business Development Commissioning and Planning

4.1 Work with the Shared Service teams to make decision based on clinical judgement developing shared services approach, secure benefits of regional and national procurement for maternity services and apply innovative management techniques to improve the effectiveness and efficiency of services for patients.

4.3 Introduce and lead on service transformation for the Directorate, delivering pathways of care aligned to the three year plan, applying the highest standards of customer service as a concept, latest international evidence to improve services he/she is responsible for.

4.4 Direct and deliver strategies and manage services to ensure that care to patients is of a consistently high standard across the Directorate and that the Fundamentals of Care is applied, taking immediate action where care falls below standards enabling the Local Health Board's strategic objectives to be met.

4.5 Develop strategies to support all departments within the Directorate in achieving and maintaining high standards of midwifery, nursing and clinical care in the best physical environment.

4.6 Secure funding for new services and / or to achieve the rationalisation of existing services in consultation and in conjunction with internal and external stakeholders.

4.7 Direct the development of systems and processes for the identification, management and handling of patient/service user feedback through a variety of communication mechanisms and report to the Local Health Board, trends and issues of significance that directly impact on the quality and safety of care and actions taken to correct them.

4.8 Direct development of systems for ensuring that professionals understand and learn from the experience of others, reflect and adopt their practice to account for the views of patients, service users and carers where necessary.

4.9 Develop, implement and evaluate systems that ensure the Women's Directorate learn from complaints, Independent Reviews and Serious Incident Reviews

4.10 Responsible for researching, prioritising and developing business cases for capital and revenue funding in line with Health Board internal policies, tendering processes and with Capital Investment Manual procedures, to support operational and strategic service changes/developments in accordance with national and local guidance.

4.11 Overall responsibility for recognising where business cases/plans impact on safe services, ensuring other agencies and partners are involved accordingly to promote service user safety and excellence in standards.

4.12 Produce an annual operational plan which details how national and local policies and priorities will be delivered to meet national and local standards/targets, and in particular how improvement in midwifery nursing and clinical services will be evidenced within the Directorate.

4.13 Amend the Annual Plan to respond to local and national imperatives, ensuring the delivery of the corporate objectives and improvement in Healthcare Standards assessment.

4.14 Overall responsibility for ensuring the use and development of a range of performance management monitoring tools to ensure that systems are in place to continually assess and review secondary care services achievement of local and national targets.

4.15 Direct the development and delivery of a system of audit, improvement and assurance for nursing and midwifery in the Division to provide assurance that the Health Board is achieving its' strategic objectives of 'Making it safe; Making it better'.

5.0 Healthcare Standards, Performance Improvement and Management, Planning, Policy and Service Development

5.1 Implement the Local Health Board's strategic objectives as these relate to Maternity and Women's services i.e Up Stream Preventative Measures, Fundamentals of Care, Secondary Care, Community Care, Care Metrics and specific National Performance Indicators and Outcome Measures for Maternity Services and in particular improve performance in the Healthcare Standards as they relate to midwifery, nursing, patients and safe, quality patient care.

5.2 Responsible for long term strategic planning of more than a year in advance whilst working in a climate of change and financial pressures for example operalisation of the service users strategy, infection prevention strategy building on the corporate objectives and strategic direction, fundamentals of care strategy and community midwifery strategy.

5.3 Responsible for the development of operational and strategic plans to deliver all clinical services within the Directorate, integrating national strategies which impacts across nursing, midwifery and other health professionals within BCUHB

5.3 Encourage, support and influence a positive commitment to service improvement and transformation across all staff groups and services within the Directorate.

5.4 Lead and direct the investigation of serious incidents and ensure that in

conjunction with Area Directors and Director of Quality Assurance that lessons are learned, taking further action if indicated.

5.5 Ensure that systems are in place within the Directorate to monitor and measure progress in achieving the Healthcare Standards, other standards/targets and service developments/ rationalisations contained in the three year plan.

5.7 Overall Accountability for the delivery of all National targets and standards as they pertain to the Women's Directorate. The post holder is responsible for highlighting any factors which put the achievement of targets, patient care, safety or professional regulation at risk and for proposing and taking remedial actions.

5.8 Responsible for recognising where business cases/plans impact on the Women's Directorate in collaboration with colleagues ensuring other agencies and partners are involved accordingly to remote patient safety and excellence in standards.

5.9 Ensure that there are robust systems in place to provide assurance regarding Professional Registration and Regulation of clinical staff, including revalidation, working in conjunction with the Associate Directors for managing complex and sensitive issues relating to fitness to practise of the professions.

5.10 Chair the Directorate's monthly Board, Quality, Safety and Experience Group and other relevant groups locally and nationally.

6.0 Clinical Care

6.1 Overall accountability for the work to ensure the safety and well-being of patients, service users and colleagues, taking any necessary corrective action as appropriate to prevent any deterioration in service standards, or to the safety and welfare of patients and staff.

6.2 Utilise highly complex clinical skills in making decisions at both clinical and at strategic organisational level on a daily basis. This includes very senior clinical decision making of patient safety especially at times of Infection outbreaks or during bed escalation advising and instructing Silver on call and Hospital Sites and Divisions.

6.3 Co-ordinate all operational services within the Directorate, providing advice and support to acute hospital sites and other clinical divisions as appropriate.

6.4 Maintains a clinical workload and responsibility for direct patient care, which should be at least 10% of the working week.

7.0 Policy

7.0 Interprets national guidance, legislation and policy and advises the Local Health Board on compliance/assurance for Midwifery and Women's Clinical Services.

7.1 Overall responsibility for the development, implementation and monitoring of a range of Health Board policies relating to Women's Services

7.2 Provides a Midwifery and overall service response for the interpretation, development, implementation and monitoring of local and national policy/strategy in order to establish service goals and standards for Maternity Services and for the Health Board.

7.3 Overall lead and directly contribute to the Midwifery, Women's and Maternal Health strategic direction and objectives of the Health Board, ensuring that strategies are operationalised to meet those objectives.

7.4 Overall responsibility for implementing for/and monitor compliance with local and national policies, and for ensuring that the Director of Nursing, Midwifery is kept briefed of these and other international developments that may lead to further improvement in midwifery and related patient services across the Local Health Board.

7.5 Take overall responsibility for ensuring Policies and Procedures are developed with partner agencies beyond the organisation, with a system for implementation, audit and review.

7.6 Develops and advises corporate policy and strategy for the delivery of Maternity and Women's service reconfiguration across North Wales.

8.0 Research and Development

8.1 Overall responsibility for initiating the development of Research and Development (R&D) programmes to support national, regional and local priorities and identify R&D priorities that will enhance and pull together initiatives required to advance innovation in the Maternity and in Women's Health.

8.2 Carry out research inclusive of audit and investigations to aid the development of high quality care and services across the Women's Directorate which are evidenced based and support the delivery of the Health Board objectives.

8.3 Use of research and audit findings to inform own knowledge and that of services to complete professional overview reports with the identification of recommendations, which must be implemented within area of responsibility and will impact across the Health Board, with the inclusion of audit activity.

8.4 Interpret and implement professional initiated Quality Reports to ensure the

risk of litigation against the Health Board or individual practitioners is reduced by the implementation of key guidance.

8.5 Promote initiate, commission and co-ordinate research to aid the development and utilisation of evidence based practice. Reflects on research based care in conjunction with teams in Primary Community and Secondary Care to develop new practices, new roles and redesign services.

8.6 In line with Research and Development strategies collaborate with Universities and associate directors to develop and deliver research proposals for Maternity and Women's Services to contribute to the body of knowledge working closely with partners in Academic establishments.

8.7 Co-ordination and implementation of non-medical staff research and development programmes, working with the Medical and Nurse Directors, Medical Consultants and Midwife and Heads of Services and other members of the Corporate Nursing Team to contribute to the research and development strategy for the clinical professions.

8.8 Interpret and implement national and local policy relevant to clinical audit and Research & Development and communicate as necessary to teams and individuals.

8.9 Develop and deliver an annual programme of audit activity within the Directorate, focussed on clinical service delivery, and produce an annual audit plan with systems in place to act on results.

8.10 Contribute to the development of a distinctive and innovative relationship with Higher Education Institutes

9.0 Freedom to Act

9.1 The post holder will have the freedom to act, as outlined within the scope of the role and responsibilities and within a delegated scheme of authority, as agreed by the Secondary Care Director on behalf of the Chief Operating Officer and the Director of Nursing & Midwifery.

9.2 Report directly to the Secondary Care Director via the Chief Operating Officer's Structure (operationally) and Director of Nursing and Midwifery (professionally) to assure the Health Board on performance in relation to Midwifery/Maternity and Women's Services, providing strategic direction to all staff groups.

9.3 This post holder is a very senior manager across the organisation and is expected to use their own initiative and act independently within minimal guidelines setting goals and standards for self and others.

9.4 The post holder has the freedom to act autonomously to ensure that Women's Directorate achieves its objectives through the core areas of strategic planning; general management; financial management; performance management; planning, policy and service development, including modernisation; service quality; workforce management; and Information Management.

9.5 Works independently, informed by an individual performance development review undertaken by the Secondary Care Director/Director of Nursing and Midwifery and attends regular catch up sessions.

9.6 Required to interpret Health Service Policy and Strategy with a requirement to act within policies, guidelines and strategy of the Board and to set goals and standards for self and others.

9.7 The post holder will take decisions on behalf of the Health Board where he/she represents the Health Board in their capacity as the strategic lead for Midwifery and Women's Directorate within and outside of the Organisation.

10.0 Human Resources Management

10.1 Directly influence, via line reports and the directorate structure a complex network of staff within the Women's Directorate across several departments to deliver agreed operational and financial efficiencies and cost improvements through modernisation, service improvement and service/workforce redesign to ensure full utilisation of resources and skill mix.

10.2 The post holder has professional management accountability for the staff within the Directorate who manage recruitment, development, absence management, grievance and disciplinary matters ensuring all job descriptions and performance appraisal reviews include record and monitor roles and responsibilities for Safeguarding People at Risk of Harm.

10.3 Sets and monitor the objectives of the Senior Management/Leadership Team that the post holder has direct line management responsibilities.

10.4 Develop the management skills of the teams with areas for development identified at each manager's annual performance development review, to allow support succession planning.

10.5 Lead the setting and monitoring of performance standards for the registered and non-registered workforce and those to whom registrants delegate tasks.

10.6 Direct work to ensure that Healthcare Support Workers and Maternity Support

Workers are competent to undertake those tasks delegated to them by registered nurses and midwives in order to protect registrants' registration status and provide safe services to patients/service users.

10.7 Ensure that Healthcare Support Workers and Maternity Support Workers are working within a competency framework to enable registered nurses to deliver their responsibilities safely when delegating aspects of patient care.

10.8 Accountable and responsible for the referral of nursing and Midwifery staff to the NMC and Barring and Disclosure (ISA), in consultation with Associate Directors, when actions or allegations result in the registrants' fitness to practice being impaired and where the situation in question cannot be managed locally. In all situations, the safety of patients and the public must be paramount and this principle should underpin any actions taken.

10.9 Overall responsible for workforce and organisational development including workforce planning, role re-design, training and development for all areas of responsibility

10.10 Develop and deliver innovative career progression pathways within Nursing and Midwifery, including Consultant Midwife post, Advanced Practice Roles; clinical supervision; Staff development; leadership and service improvement.

10.11 Provide expert professional advice to the Board Executives, senior leaders and the workforce department on all midwifery issues relating regarding disciplinary and capability matters in respect of the clinical professions within the Directorate.

10.12 Lead on the development of excellent employee relations, working in partnership with staff representatives and ensuring the implementation of all Wales and Health Board policies for the effective management of issues relating to induction, career development, staff welfare, discipline, performance, grievance, equality and diversity, health and safety at work, sickness management.

10.13 Delivery of national workforce strategies for all professional groups with the Directorate to enable delivery of the Strategic objectives of the Local Health Board and commissioning of new roles.

10.14 Meet the requirements of the Nursing and Midwifery Council standards for learning and assessing in practice by ensuring frameworks in place to provide clinical experience, mentorship and support for pre and post registration nurses and other professional groups as appropriate.

10.15 Develop strong links with providers of education and professional bodies to ensure appropriate integration between services and training needs.

10.16 Maintain knowledge across the range of work areas, procedures and practices underpinned by theoretical knowledge and relevant practical experience.

10.17 Overall responsibility for the assessment of clinical staff training & professional needs in relation to Women's Services portfolio and provision of training opportunities to meet the needs of staff and patients working in conjunction with Associate Directors to enable the commissioning of education with Colleges and Higher Education that is fit for purpose, represents value for money and enables the development of a skilled workforce.

10.18 Develop annual workforce plans for all staff groups within the Directorate to meet service needs in line with national and local developments and commissioning, taking into account known local and national service change and developments

10.19 Responsible for ensuring compliance with safe staffing in Medical, Nursing and Midwifery within the Directorate – observing national workforce governance requirements for all staff groups.

11.0 Information Management

11.1 Commission the development, provision, management and implementation of appropriate Information Management and Technology systems to collect and analyse data to support Nursing and Midwifery services and statutory requirements.

11.2 Liaise with Information Management and Technology to ensure that accurate and timely information is available to monitor progress on an ongoing basis of the achievement of key targets, thereby contributing to the achievement of corporate targets.

11.3 Ensure the safety and confidentiality of manual and electronic held information encompassing both patient and staff held records.

11.4 Ensure Health Board workforce information systems are implemented within agreed timescales.

11.5 Produces high quality and coherent management and business reports and information, including those required by the Local Health Board.

General requirements

This post is subject to the Terms and Conditions of employment of the Betsi Cadwaladr University Local Health Board_Standard general items to be covered in job descriptions should include the following text:

Competence

You are responsible for limiting your actions to those which you feel competent to

undertake. If you have doubts about your competence during the course of your duties, you should immediately speak to your line manager/supervisor.

Registered Health Professional

All employees of the Trust who are required to register with a professional body, to enable them to practice within their profession, are required to comply with their code of conduct and requirements of their professional registration.

Supervision

Where the appropriate professional organisation details a requirement in relation to supervision, it is the responsibility of the post holder to ensure compliance with this requirement. If you are in any doubt about the existence of such a requirement speak to your Manager.

Risk Management

It is a standard element of the role and responsibility of all staff of the Local Health Board that they fulfil a proactive role towards the management of risk in all of their actions. This entails the risk assessment of all situations, the taking of appropriate actions and reporting of all incidents, near misses and hazards.

Records Management

As an employee of the Local Health Board, you are legally responsible for all records that you gather, create or use as part of your work within the Local Health Board (including patient health, financial, personal and administrative), whether paper based or on computer. All such records are considered public records, and you have a legal duty of confidence to service users (even after an employee has left the Local Health Board). You should consult your manager if you have any doubt as to the correct management of records for which you work.

Health and Safety Requirements

All employees of the Local Health Board have a statutory duty of care for their own personal safety and that of others who may be affected by their acts or omissions. Employees are required to co-operate with management to enable the Local Health Board to meet its own legal duties and to report any hazardous situations or defective equipment.

Confidentiality

All employees of the Local Health Board are required to maintain confidentiality of members of the public (patients and service users) and members of staff in accordance with Local Health Board policies.

Flexibility Statement

This is a generic job description and therefore should be considered as an outline of the role and functions you are expected to carry out. It is not intended to describe all specific tasks.

This Job description is effective from 2017

Date Prepared:2-11-2017

Prepared By: John Martin / Nigel Lee

Date Reviewed:

Reviewed By:

Agreed By: **Date:**

Employee's Name and Signature:

Agreed By **Date:**

Manager's Name and Signature:

PERSON SPECIFICATION

Job Title **Band: TBC**

ATTRIBUTES	ESSENTIAL	DESIRABLE	METHOD OF ASSESSMENT
Qualifications and/or Knowledge	Registered Midwife and RGN Qualification First degree or equivalent professional, expert/specialist knowledge Masters level qualification; Evidence of Continuous Professional development Experience at a Senior Level. Post Graduate Management qualification In depth professional specialist knowledge and experience of managing a number of disciplines acquired through training and experience over a significant period. Previous experience of leading significant change, governance and financial management.	PhD Professional publications; Personal acknowledgement at national level (publication/representation) PRINCE or other Project / Programme management qualification Leadership course/ qualification	Certificates and checks with NMC
Experience & Skills	Significant Clinical Skills with the competency to use evidenced based practice in terms of managing safe clinical services Advanced decision making skills In depth professional knowledge of nursing and Midwifery performance and staff management acquired through training and	Experience of facilities management within a complex environment.	Application form Interview References

	experience over extended period. Demonstrable experience delivering positive service improvement at a Senior Level. Extensive and varied experience based on working in a strategic Midwifery role with a track record of achievement. Extensive senior managerial and proven experience of budgetary and staff management across several services. Considerable experience of working at, or just below, Board level. Evidence of managing resources in a complex environment Ability to think, plan and deliver strategically Complaints management and experience of the litigation process Extensive experience of developing and preparing complex strategic & operational plans Extensive experience of leading and successfully implementing service improvement/redesign programmes in a multi-disciplinary environment/ across a range of services Developing and delivering governance systems including management and mitigation of risk. Extensive experience of effective patient/public		

	/customer involvement Extensive experience of implementing quality systems and benchmarking Extensive experience of policy development and implementation across a range of services Has significant experience and knowledge at a senior management level in a complex service organisation Ability to undertake research to ensure evidence based service development Ability to analyse complex clinical issues/problems, identify necessary action and make recommendations and follow these through Proven ability to work across organisational boundaries, develop networks and alliances, project a vision and obtain ownership and commitment from stakeholders. Successful project managements. Ability to use motivational, negotiating and reassurance skills to overcome any barriers to understanding. Ability to demonstrate vision and direction Highly developed communication and interpersonal skills both verbal and written and presentation and excellent listening skills i.e. ▪ Able to demonstrate effective engagement and provision of		

	information of a highly technical, highly complex, highly sensitive nature in an understandable format to all stakeholders ▪ Can demonstrate emotional leadership skills in complex situations and apply these appropriately Highly developed facilitation skills. Highly developed written communications and report writing skills. High level influencing and negotiable skills. Evidence of high levels of original thought, innovation and problem solving skills. Good organisational skills Highly developed keyboard and computer skills, with working knowledge of databases, spreadsheets and presentation packages. Highly developed leadership and influencing skills with the ability to enthuse, motivate and involve individuals and teams and have them understand the Health Board's and your performance expectations. Ability to provide formal teaching development to staff/colleagues. Education commissioning knowledge and experience of procurement and commissioning. Extensive financial and commissioning management and presenting complex		

	financial analysis.		
Aptitude and Abilities	Demonstrate the ability to work under pressure whilst supporting and getting the most out of staff High level of organisation,self-motivation and flexibility in approach and attitude Strong sense of commitment to openness, honesty and integrity in undertaking the leadership role Ability and experience of working at a very senior level with a multi professional group of staff Demonstrable political judgment and astuteness in understanding and working with complex policy and diverse interest groups, and common sense in knowing when to brief 'up the line'	Ability to speak Welsh	Interview
Knowledge	Demonstrates a broad understanding of the key determinants of health and healthcare. Expert knowledge of the current nursing and health agenda, NHS policy and other key policy drivers. Demonstrates an in depth knowledge of infection prevention, nutrition, spiritual care and all aspects of facilities management Knowledge of Standards for Healthcare Services as they relate to Medical and Midwifery, Nursing, Patient Services and Infection Prevention Control. Up to date knowledge of midwifery & nursing and		Application Form Interview References

	general Health care system management theory. Clear understanding of the concept and working arrangements of diverse clinical areas Demonstrate a working knowledge of clinical pathways Detailed knowledge of all aspects of research methodology and can demonstrate how research has influenced their practice		
Other	Committed to a culture of continuous improvement and development- underpinned by open communications and team working A strategic focus A completer finisher Resilience and drive Personal and professional integrity and confidence Self-motivated, proactive and innovative Flexible and adaptable. Able to travel across sites and Wales/UK as required Substantial personal & professional confidence & credibility Resourceful Able to demonstrate an understanding of the political environment within which the NHS. Ability to focus on the future & the need for service improvement.		Application form and interview

GENERAL REQUIREMENTS

Include those relevant to the post requirements

- **Values:** All employees of the Health Board are required to demonstrate and embed the Values and Behaviour Statements in order for them to become an integral part of the post holder's working life and to embed the principles into the culture of the organisation.

- **Registered Health Professional:** All employees who are required to register with a professional body, to enable them to practice within their profession, are required to comply with their code of conduct and requirements of their professional registration.

- **Healthcare Support Workers:** Healthcare Support Workers make a valuable and important contribution to the delivery of high quality healthcare. The national Code of Conduct for NHS Wales describes the standards of conduct, behaviour and attitude required of all Healthcare Support Workers employed within NHS Wales. Health Care Support Workers are responsible, and have a duty of care, to ensure their conduct does not fall below the standards detailed in the Code and that no act or omission on their part harms the safety and wellbeing of service users and the public, whilst in their care.

- **Competence:** At no time should the post holder work outside their defined level of competence. If there are concerns regarding this, the post holder should immediately discuss them with their Manager/Supervisor. Employees have a responsibility to inform their Manager/Supervisor if they doubt their own competence to perform a duty.

- **Learning and Development:** All staff must undertake induction/orientation programmes at Corporate and Departmental level and must ensure that any statutory/mandatory training requirements are current and up to date. Where considered appropriate, staff are required to demonstrate evidence of continuing professional development.

- **Performance Appraisal:** We are committed to developing our staff and you are responsible for participating in an Annual Performance Development Review of the post.

- **Health & Safety:** All employees of the organisation have a statutory duty of care for their own personal safety and that of others who may be affected by their acts or omissions. The post holder is required to co-operate with management to enable the organisation to meet its own legal duties and to report any hazardous situations or defective equipment. The post holder must adhere to the organisation's Risk Management, Health and Safety and associate policies.

- **Risk Management:** It is a standard element of the role and responsibility of all staff of the organisation that they fulfil a proactive role towards the management of risk in all of their actions. This entails the risk assessment of all situations, the taking of appropriate actions and reporting of all incidents, near misses and hazards.

- **Welsh Language:** All employees must perform their duties in strict compliance with the requirements of their organisation's Welsh Language Scheme and take every opportunity to promote the Welsh language in their dealings with the public.

- **Information Governance:** The post holder must at all times be aware of the importance of maintaining confidentiality and security of information gained during the course of their duties. This will in many cases include access to personal information relating to service users.

- **Data Protection Act 1998:** The post holder must treat all information, whether corporate, staff or patient information, in a discreet and confidential manner in accordance with the provisions of the Data Protection Act 1998 and Organisational Policy. Any breach of such confidentiality is considered a serious disciplinary offence, which is liable to dismissal and / or prosecution under current statutory

legislation (Data Protection Act) and the HB Disciplinary Policy.

- **Records Management:** As an employee of this organisation, the post holder is legally responsible for all records that they gather, create or use as part of their work within the organisation (including patient health, staff health or injury, financial, personal and administrative), whether paper based or on computer. All such records are considered public records and the post holder has a legal duty of confidence to service users (even after an employee has left the organisation). The post holder should consult their manager if they have any doubt as to the correct management of records with which they work.

- **Equality and Human Rights:** The Public Sector Equality Duty in Wales places a positive duty on the HB to promote equality for people with protected characteristics, both as an employer and as a provider of public services. There are nine protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. The HB is committed to ensuring that no job applicant or employee receives less favourable treatment of any of the above grounds. To this end, the organisation has an Equality Policy and it is for each employee to contribute to its success.

- **Dignity at Work:** The organisation condemns all forms of bullying and harassment and is actively seeking to promote a workplace where employees are treated fairly and with dignity and respect. All staff are requested to report and form of bullying and harassment to their Line Manager or to any Director of the organisation. Any inappropriate behaviour inside the workplace will not be tolerated and will be treated as a serious matter under the HB/Trust Disciplinary Policy.

- **DBS Disclosure Check:** In this role you will have * direct / indirect contact with* patients/service users/ children/vulnerable adults in the course of your normal duties. You will therefore be required to apply for a Criminal Record Bureau *Standard / Enhance Disclosure Check as part of the Trust's pre-employment check procedure. *Delete as appropriate.
  The post holder does not require a DBS Disclosure Check. *Delete as appropriate.

- **Safeguarding Children and Vulnerable Adults:** The organisation is committed to safeguarding children and vulnerable adults. All staff must therefore attend Safeguarding Children training and be aware of their responsibility under the Adult Protection Policy.

- **Infection Control:** The organisation is committed to meet its obligations to minimise infections. All staff are responsible for protecting and safeguarding patients, service users, visitors and employees against the risk of acquiring healthcare associated infections. This responsibility includes being aware of the content of and consistently observing Health Board Infection Prevention & Control Policies and Procedures.

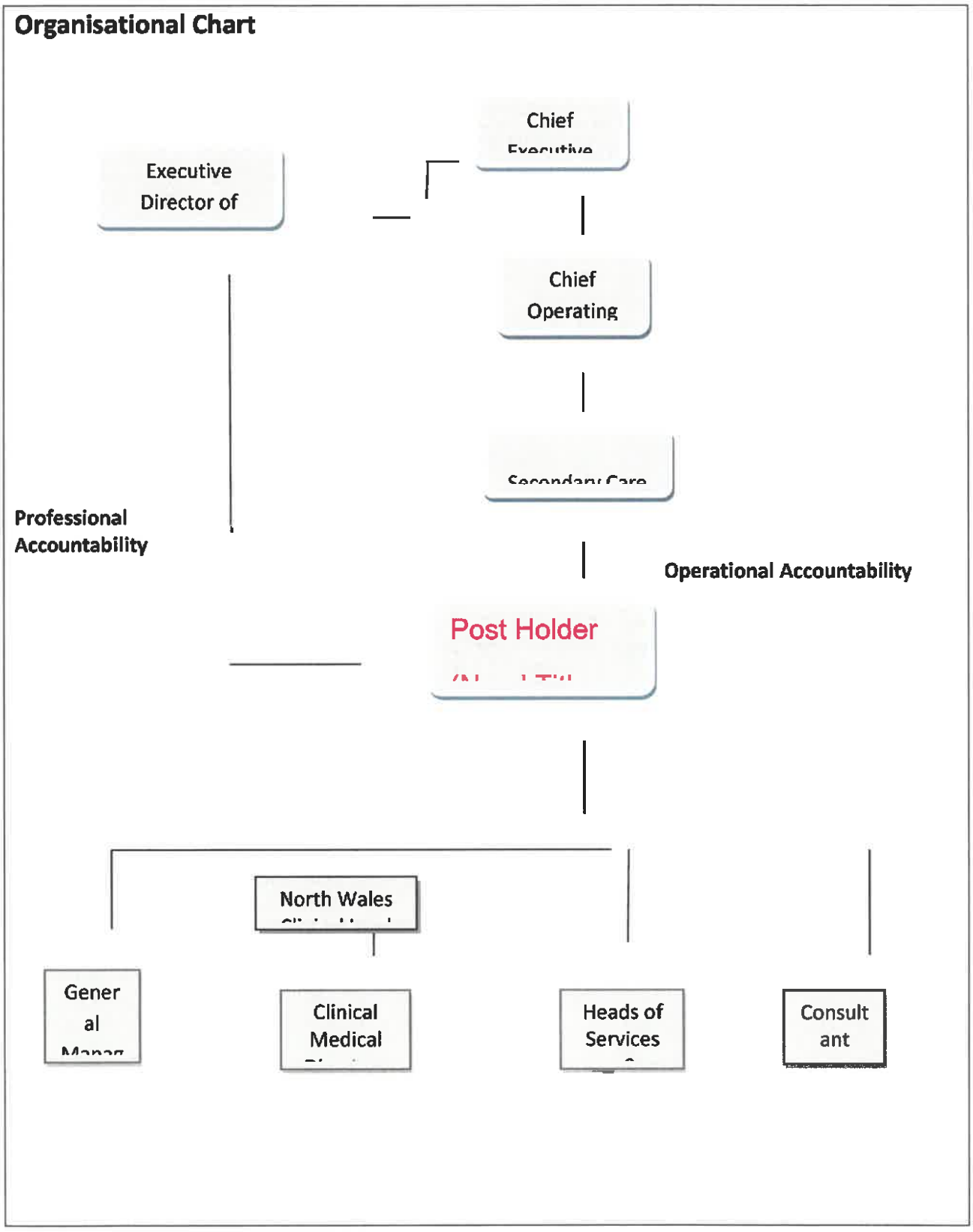
- **No Smoking:** To give all patients, visitors and staff the best chance to be healthy, all Health Board sites, including buildings and grounds, are smoke free.

Flexibility Statement: The duties of the post are outlined in this Job Description and Person Specification and may be changed by mutual agreement from time to time.

APPENDIX 1

Job Title:

Organisational Chart



APPENDIX 2

Job Title:

Supplementary Job Description Information

Please complete information on Physical Effort, Mental Effort, Emotional Effort and Working Conditions in order to assist the Job Matching process.

Physical Effort

This factor measures the nature, frequency and duration of physical effort (sustained effort at a similar level or sudden explosive effort) required for the job.

Please ensure any circumstances that may affect the degree of effort required, such as working in an awkward position; lifting heavy weights etc. are detailed, such as:

'Working in uncomfortable/unpleasant physical conditions; sitting in restricted positions; repetitive movements; lifting heavy weights; manipulating objects; kneeling, crouching, twisting; heavy duty cleaning; working at heights; using controlled restraint; driving as part of daily job - **N.B. Walking /driving to work is not included'**

Examples of Typical effort(s)	How often per day / week / month	For how long?	Additional Comments
There is regular requirement to travel between NHS and other sites often with a limited time between meetings.	**Daily**		Sitting at a computer for long periods formulating reports and in meetings.
Frequent VDU use is required for this post of periods of up to 3 or 4 hours at a time in order to produce highly complex / sensitive reports and analysis to support decision making.	**Daily**	**3-4 hrs**	Frequent requirement for sitting or standing in a restricted position e.g. driving across North Wales.
Required to move patients in wheel chairs, beds and trolleys this would be as a result of assisting moving patients during emergency pressures; use dynamap, hoists or other lifting equipment, administer intra-muscular injections, immunisations.	**Monthly**		

Mental Effort

This factor measures the nature, level, frequency and duration of mental effort required for the job, for example, concentration, responding to unpredictable work patterns, interruptions and the need to meet deadlines.

Please identify the normal requirement to concentrate in the post and determine, how often and for how long it is required to concentrate during a shift/working day, e.g. :

'Carrying out formal student assessments; carrying out clinical/social care interventions; checking documents; taking detailed minutes at meetings; operating machinery/equipment; carrying out screening tests/microscope work; carrying out complex calculations; carrying out non-clinical fault finding; responding to emergency bleep; driving a vehicle; examining or assessing patients/clients.

The work pattern of the Secondary Care Nurse Director is unpredictable and there is a need to address competing conflicting priorities within the role in order to achieve deadlines and targets etc. The post requires frequent checking of documents, statistics, writing detailed reports which need long periods of intense concentration.

Frequent concentration will be required on a wide variety of complex issues throughout the day.

The post holder will frequently have to adapt to changing priorities and re-focus the work of self and others on new priority areas that may require urgent action.

The post holder will participate in and facilitate meetings which require a high level of concentration on a wide range of topics, with a variety of audiences and mixtures of attendees.

Examples of Typical effort(s)	How often per day / week/month?	For how long?	Additional Comments
Required to change from planned activity to another e.g. requests from executives to identify and rectify unscheduled care pressures, request from WAST to identify reasons for and rectify ambulances delayed outside ED, coordinating hospital site management team site responses to other emergencies that impact on business continuity e.g. floods, snow, asbestos leak, blocked ward plumbing. This requires an immediate response and will result in all other planned activities being put on hold.	**Daily**		
Carry out calculations, analyse statistics and highly complex information e.g. infection control data, metrics data, hospital acquired pressure ulcer data, performance management data.	**Daily**		
Drive a vehicle to and from meetings on a number of sites across North Wales, operate non clinical equipment e.g. blackberry, laptop	**Daily**		
Operate clinical equipment e.g. hoist, dynamap.	**Monthly**		
Chair formal disciplinary, grievance hearings or serious incident reviews. Post holder will be expected to sustain continued concentration in relation to the subject matter in chairing a serious incident panel, when attending an employment tribunal or during cross examination in court.	**One to two monthly**		
Give evidence in court or NMC hearing	**Once or twice a year**		

chair senior health board meetings. Attend local and national meetings on behalf of the Executive Nurse. Attend/ chair meetings in various roles e.g. external advisor. Frequent requirement for increased concentration and in depth mental attention combined with active engagement of staff. Sustained concentration to lead services and make decisions operationally and professionally. Prepare detailed board level reports, check documents such as staffing reports, ombudsman responses submitted by hospital directors.	**Daily**		

Emotional Effort

This factor measures the nature, frequency and duration demands of the emotional effort required to undertake clinical or non clinical duties that are generally considered to be distressing and/or emotionally demanding.

Please identify how often the post holder has exposure to direct and/or indirect distressing and/or emotional circumstances and the type of situations they are required to deal with.

For example,' processing (e.g. typing/transmitting) news of highly distressing events; giving unwelcome news to patients/clients/carers/staff; caring for the terminally ill; dealing with difficult situations/circumstances; designated to provide emotional support to front line staff; communicating life changing events; dealing with people with challenging behaviour; arriving at the scene of an accident.' **N.B. Fear of Violence is measured under Working Conditions**

The role will require daily negotiation with senior NHS professionals, directors and

managers in a financially constrained health economy on issues that have a significant impact on the quality and services, challenging practice and established management processes, which involves frequent exposure to emotional circumstances e.g. imparting unwelcome news where contract performance targets have not been met etc.

The post holder will also be expected to deal positively and promptly with staff and patient/public concerns, and personal problems, challenge staff on any inappropriate behaviours or poor performance and investigate and deal with complaints as required.

The nature of the post is such that it will involve influencing, persuading, motivating others to change practises, locations, behaviours, teams and in these circumstances there will be resistance to change resulting in challenging behaviour. In addition some changes will be politically sensitive and or emotive and will require extreme tact and diplomacy to deal with

Examples of Typical effort(s)	How often per week / month?	For how long?	Additional Comments
Significant mental and emotional effort to 'Act Up' on behalf of the Director of Nursing and to manage professionals outside of sphere of own expertise e.g. therapists and healthcare scientists	**Daily/weekly**		
Frequent direct exposure to patients, families and staff in difficult circumstances e.g. patients delayed in emergency dept, families bereaved or unhappy with care. Staff concerns due to adverse incidents or staffing levels, underperformance issues of disciplinary.	**Daily/weekly**		
Dealing with staff undergoing difficult or challenging personal situations providing daily support and guidance on personal and professional issues. Requirement to impart unwelcome news to staff e.g. resolution of cross site issues, service change or following chairing a panel.	**Daily/weekly**		
Regular exposure to families unhappy with care, exposed to verbal aggression when there is little support. Post holder will encounter verbal aggression from staff and managers where proposals for change are made and this is deemed unacceptable by those parties involved deals with extremely sensitive situations.	**Daily/weekly**		
Responding to DGH pressures. Chairing teleconference cross organisational meetings cancelling patient care. Exposure to unpleasant information with regards to staff or patients e.g. complaints, serious incidents, POVA, safeguarding issues.	**Weekly**		

Working Conditions

This factor measures the nature, frequency and duration of demands on staff arising from inevitably adverse environmental conditions (such as inclement weather, extreme heat/cold, smells, noise and fumes) and hazards, which are unavoidable **(even with the strictest health and safety controls),** such as road traffic accidents, spills of harmful chemicals, aggressive behaviour of patients, clients, relatives, carers.

Please identify unpleasant working conditions or hazards which are encountered in the post holder's working environment and establish how often and for how long they are exposed to them during a working day / week / month.

Examples are – use of VDU more or less continuously; unpleasant substances/non-household waste; infectious material/foul linen; body fluids, faeces, vomit; dust/dirt; fleas/lice; humidity; contaminated equipment or work areas; driving/being driven in normal or emergency situations - ***Driving to and from work is not included**

Examples of Typical Conditions	How often per week / month?	For how long?	Additional Comments
There is regular requirement to travel between NHS and other sites often with a limited time between meetings.			
Exposure to unpleasant working conditions unpleasant smells and odours when undertaking walkabouts			
Office conditions with regular requirement to travel			
Frequent VDU use is required for this post of periods of up to 3 or 4 hours at a time in order to produce highly complex /sensitive reports and analysis to support decision making		**3-hrs**	

Submission of documents for job evaluation

Please sign and retain an original copy for manager and employee.
Send an electronic version of the documents to BCU.JobEvaluation@wales.nhs.uk

Betsi Cadwaladr University Health Board

Women's Directorate: Performance Accountability Framework and Process

1. Introduction

The purpose of this document is to set out the Performance Accountability Framework and Process for the Women's Directorate that will be introduced to hold individual sites (West, Central, and East) to account for the delivery of key quality, performance, workforce and financial objectives as described in the Health Board's Operational Plan.

In order for the Health Board to be assured that we are on track to deliver key performance targets, the performance management process by which we monitor all of our strategic and operational plans which demonstrate how our Annual Operating Plan meets the NHS Wales Delivery Framework needs to be effective.

Performance assurance, performance management and performance improvement is dependent on a clear framework of accountability, with teams and individuals clear as to the expectations placed on them, the resources available to them to deliver and awareness of the consequences of non-delivery.

2. Principles

The key objective of the accountability framework is to ensure that information is available which enables the Health Board, Women's Directorate and Operational Management Teams to understand, monitor, and assess the quality and performance of the organization/ Directorate, enabling appropriate action to be taken when performance against set targets deteriorate. The accountability framework will support the Directorate in delivering:

a. The strategy set out by the Board through the IMTP (3 Year Plan) and Operational Plan
b. Operational ownership of the Directorate priorities
c. Clarity of expectations as to a level of performance expected within resources allocated
d. Decision making based on visible performance information against key performance indicators
e. Opportunity for accountable officers to discuss support needed to achieve expected levels of performance

f. Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations

g. Clarity as to outcomes and consequences of poor performance through clear escalation process

To do this effectively, information must be timely, accurate, consistent and complete. It must also follow the principles set out under information governance and data quality policies, and evidence effective performance management.

3. BCUHB Purpose

The role of the Health Board is underpinned by the following:

3.1 Values

- Put Patients first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate openly and honestly

3.2 Purpose

- To improve health and deliver excellent care

3.3 Our Vision

- We will improve the health of the population, with particular focus upon the most vulnerable in our society
- We will do this by developing an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations
- We will develop our workforce so that it has the right skills and operates in a research-rich learning culture

3.4 Strategic Goals

- Improve health and wellbeing for all and reduce health inequalities
- Work in partnership to design and deliver more care closer to home
- Improve the safety and outcomes of care to match the NHS's best
- Respect individuals and maintain dignity and care

- Listen to and learn from the experiences of individuals
- Support, train and develop our staff to excel
- Use resources wisely, transforming services through innovation and research
- Observe and act on the priorities identified in section 6.0 of the Quality Improvement Strategy (2017-20) – Appendix 1.

4. Planning

The Women's **3 Year Plan** will continue to build upon the Directorates' previous delivery plan and the priorities identified in the *Health Boards Clinical Strategy: Living Healthier, Staying Well.*

The Women's Directorate 3 year plan has identified three key priority areas:

i. Maternity Services Strategy
ii. Gynaecology and Specialist Services
iii. Family Centred Care: First 1000 Days (shared priority with Children's)

5. Performance Accountability Arrangements

The Health Board is held to account through the *Welsh Government Accountability Framework* which is the formal mechanism for Health Board reporting against performance assurance, performance management and performance improvement. Therefore, the Women's Directorates' internal accountability / performance process has been revised to include focus on the key operational performance priorities under the following domains:

- Performance
- Safe Care
- Maternity Clinical Measures
- Maternity Commissioned Services
- Workforce
- Finance

6. Women's Directorate Performance Dashboard

The Women's Directorate Board has introduced a revised performance dashboard which will be used to monitor the performance priorities of each site against the five domains. The dashboard has been developed to direct/support operational performance against quality, performance, workforce and financial objectives/targets.

The revised dashboard will mean that the current multitude of performance information sources will be reduced to one integrated source. Additionally, progress against the

Directorate's business plan, site action plans and objectives will form part of the overall performance monitoring.

In preparation for the accountability meeting the revised dashboard is to be populated by the identified / responsible leads for the five domains by the **2nd week of each calendar month.**

- **Finance:** Nichola Bray
- **RTT/Performance:** Kathryn Lang
- **Concerns/Governance:** Maureen Wolfe/Jill Harrison/Linda Maurice
- **Workforce:** Heledd Jones/Paula Jones/Amy Taylor

The Women's Directorate Dashboard can be accessed via the following link:
http://bcuesharepoint/CPG/Womens/Midwifery/_layouts/viewlsts.aspx?BaseType=1

7. Accountability Performance Meetings

Accountability Performance Meetings will be chaired by the Director of Midwifery and Women's Services on a monthly basis and be supported by the Women's Services Clinical Director; Directorate Senior Financial Advisor; Clinical Risk and Governance Lead; Head of Women's Services, Women's Lead for Governance and Risk Lead and the General Manager.

Site team representation at each scheduled accountability meeting is to include:

- Site Clinical Director
- Matron
- Lead Manager

Accountability meetings with each site leadership team will be held on the **3rd week of each calendar month** and will last for no more than **ninety minutes**. The meeting will have a formal agenda (as per the five domains) and be given equal weighting. Meetings will be formally minuted and the outcomes from the discussion including the level of escalation will be confirmed at the end of each review and be formally communicated to the Directorate Board meeting the following week.

These reviews should be considered as a live process whereby site teams are monitoring, reviewing and planning on an ongoing basis and being held to account by the directorate board for delivery through the accountability performance meetings

At the meeting, each site will present against each of the five dimensions:

Progress against any previously agreed actions
Proposed mitigations against any newly identified performance risks or issues
Other assurances as required by the Women's Directorate Board

Terms of Reference for the Accountability Performance Meeting are shown in Appendix 2.

8. Outcomes of Meetings

Outcomes from the meetings, along with timescales for actions, will be documented and aligned to the escalation process (Appendix 2). As such where performance is satisfactory the level of escalation will be 0 and the team will proceed with earned autonomy to act to the next review.

Where performance is of concern 4 levels of escalation are possible.

- **Level 1**: Requires the provision of low level additional support with increased level of monitoring through the accountability performance meeting.
- **Level 2**: Requires enhanced monitoring and increased frequency of performance review to fortnightly meetings.
- **Level 3**: Requires targeted intervention via weekly holding to account meetings.
- **Level 4:** Requires intensive support

The Escalation Framework and decision tree is set out in Appendix 3.

Changes in the site's performance rating, along with any required escalation actions resulting from the accountability meeting will be communicated in writing to the directorate board within five working days of the accountability meeting.

List of Appendices

Appendix 1: BCUHB Quality Improvement Strategy
Appendix 2: Accountability Board: Terms of Reference
Appendix 3: Accountability Escalation Framework

Appendix 1: BCUHB Quality Improvement Strategy

Quality Improvement Strategy- 2017-2020

1.0 Introduction by Executive Director of Nursing and Midwifery, Executive Medical Director and Executive Director of Therapies and HealthCare Scientists

Improving health and providing excellent care is a responsibility BCUHB take very seriously, an ethos also echoed in the *'NHS Wales Delivery Framework ' and Future Plans*. The NHS Wales delivery Framework is aligned with Ministerial Policy and the need to drive up standards and outcomes. It sets out the processes which are in place to monitor progress and provide support and intervention as necessary.

Consisting of five quality 'domains' and evidenced in the 'Quality and Safety' domain is the seeking of assurance that services are safe, standards are improving and quality care for people in NHS Wales is provided in a safe environment, while protecting them from avoidable harm.

Whilst the Quality Improvement Strategy (2014-2017) established the background and principles of how the Health Board would progress improvement across a range of Quality Indicators, the pace and drive anticipated has not resulted in the significant improvements anticipated.

A position paper presented to the Quality Safety and Experience Committee (QSE) in March provided a very clear baseline of high level harms across the Health Board ahead of the ***'renew, refresh & refocussing'*** of the QIS. This will enable the organisation to monitor interventions which are being recommended are delivering demonstrable improvements and are embedded throughout BCUHB.

The methodology of this baseline position was intended to inform and enable the QSE to discuss and agree a clear trajectory for the next phase of the Quality Improvement Strategy (2017-2020).

The Health Board methodology to support the required pace and drive behind each "Harm objective" will be provided through a real time Quality performance Dashboard, which is currently under development. This will enable an overview of Health Board performance as well as an ability to drill down to site and then ward/department level performance. It will also support better analysis allowing targeted interventional support and early identification of best practice.

Gill Harris
Executive Director of Nursing and Midwifery

Dr Evan Moore
Executive Medical Director

Adrian Thomas
Executive Director of Therapies & Health Sciences

2.0 So what are we trying to accomplish?

This is the second stage/iteration of our Quality Improvement Strategy after the Health Board approved our initial Quality Improvement Strategy in 2014 (2014-2017)

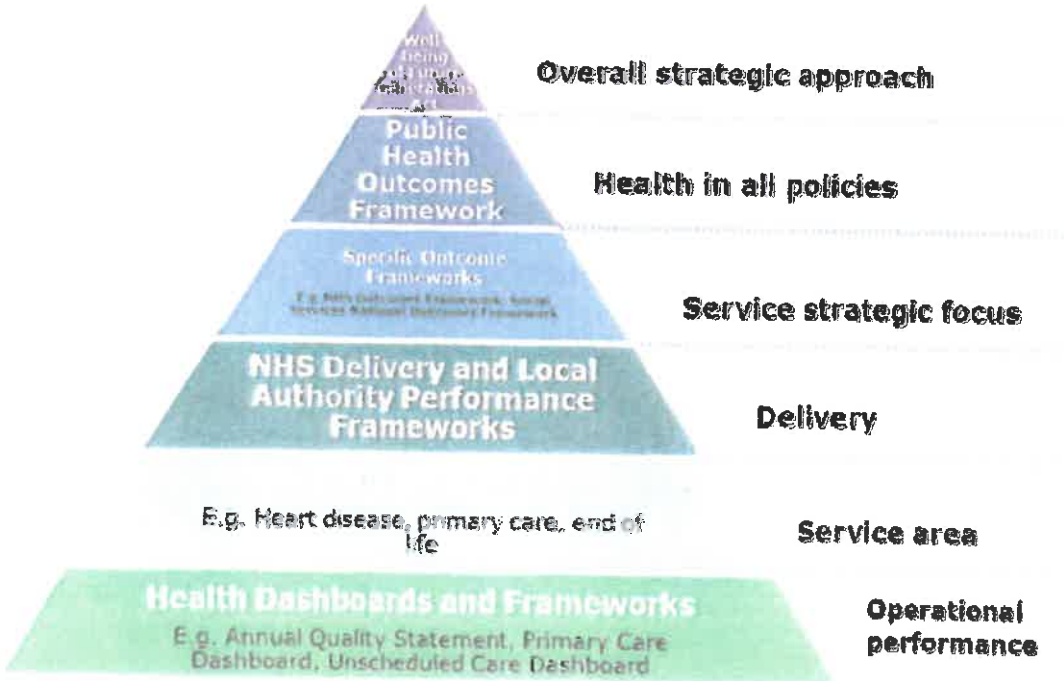
In our initial Strategy we established a range of tools and principles by which we intended to monitor and gain assurance about the Quality Improvements we intended to make. These systems and processes were and are based on national best practice and result from some of the lessons learnt and shared following Francis, Keogh, Berwick and more recently the Andrews report (2014).

We would recognise however, that as an organisation whilst we have made some improvements in some areas of our clinical practice, the pace and drive to continuously seek out and reduce patient harm and achieve a high level of reliability for Clinical care has not been consistently achieved.

3.0 Bringing Clarity to Quality

Developing a confidence in caring is the essence of what this version of the Quality Improvement Strategy (QIS) sets out to achieve with a clear intention to keep the patient focus at the heart of all areas of improvement. However, in reviewing, refining and refocussing our approach to this stage of our Quality Improvement journey we want to be clear about what we are trying to accomplish.

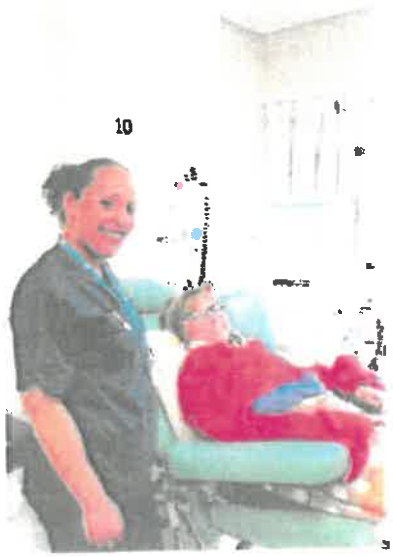
Within Wales, the Government's NHS legislative framework establishes the intent to improve the population health. This is aligned through the public health outcome framework and translated into operational delivery through the annual delivery framework. Both frameworks embrace the seven national domains of: Staying Healthy, Safe Care, Dignified Care, Individual Care, Effective Care, Timely Care and Use of Staff and Resources. Through our operational plan we will be adopting a model of outcome focussed improvement, shifting focus from inputs and activities to short, medium and long term results for our patients and the population of North Wales.



The revised priorities for our organisation have been discussed and agreed amongst our most senior clinical leaders and have also been shared with wider staff and patient groups. We want to deliver a "Safe, effective and Compassionate" approach to care and to *do no harm*. We will accomplish this by putting the needs of our patients, their families and carers first. We will continue to relentlessly pursue giving our patients, families and carers safe, effective and compassionate care every time.

The Quality and Outcomes Framework (QOF) will be utilised to achieve quality improvements in care provided by General Practitioners. The areas within the QOF are included within our web site and the outcomes will be published annually (www.//mylocalhealthservice.wales.gov.uk).

Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivered within BCUHB and not only monitor the clinical outcomes but a range of service user experience feedback methods developed as a framework of best practice in caring for patients.



A Strategy which establishes our ambitions for Quality Improvements

1. *Reduce avoidable deaths*
2. *Continuously seek out and reduce patient harm*
3. Achieve the highest level of reliability for clinical care
4. Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives.
5. Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living.

4.0 A Promise to learn- A commitment to Act

Our journey to raise the bar on quality

The Clinical Executive Directors have reviewed the previous Quality Improvement Strategy (2014-17) and improvement outcomes with senior colleagues and staff across BCUHB. All recognised the need to review and revise our approach to improvement. A consistent theme from external agencies and internal staff has been the explicit recognition that we need to demonstrate our learning from serious Incidents and complaints and to consistently practice to recognised evidence based standards. The commitment to act on any variations and hold each other to account for the delivery of required standards is an essential part of this Strategy. This aligns with our patient feedback which has enabled us to develop the key actions to raise the bar on quality across the Health Board, and make the most difference at pace.

5.0 Raising the bar on Quality and Safety at BCUHB

In asking staff "Are you doing *your best* to make this Health Board and our services *the best* for our staff and patients" we have collated some video sound bites from a range of staff to share their views on our web site. Some of the areas presented by staff were:

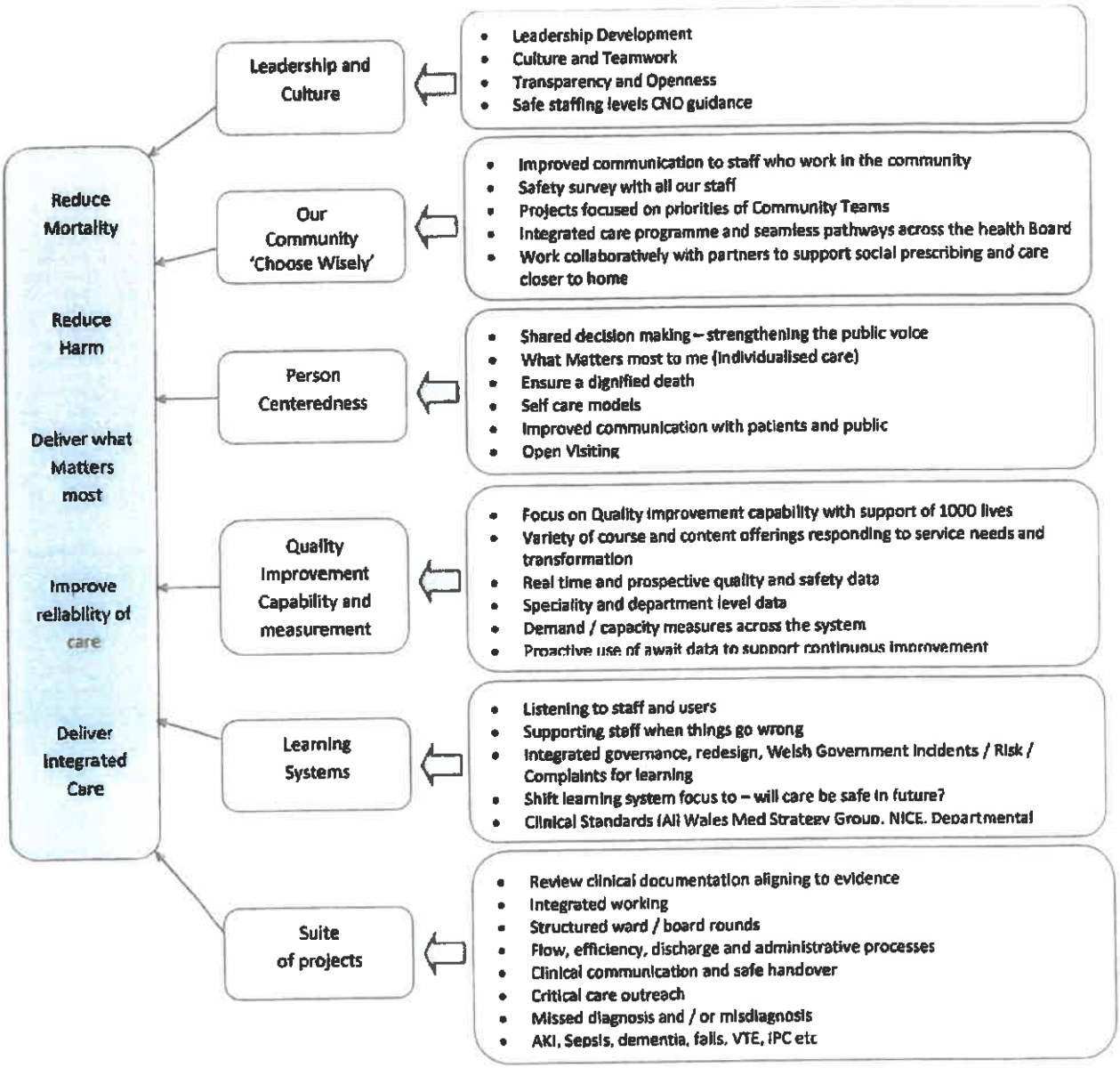
1. Ensure we do not expose people to harm
2. Adhere to clinical standards and reduce variation
3. Care and compassion to be at the centre of all our interactions and communications with users and staff
4. Have the right numbers of staff in the right place
5. Support train and develop our staff in their ambition to deliver great care
6. Ensure consistent support for all inpatients to maximise their nutrition and hydration intake in order to maximise recovery.

These were further tested and endorsed at the BCUBH Quality Conference on the 7th April prior to consideration of endorsing the priority list.

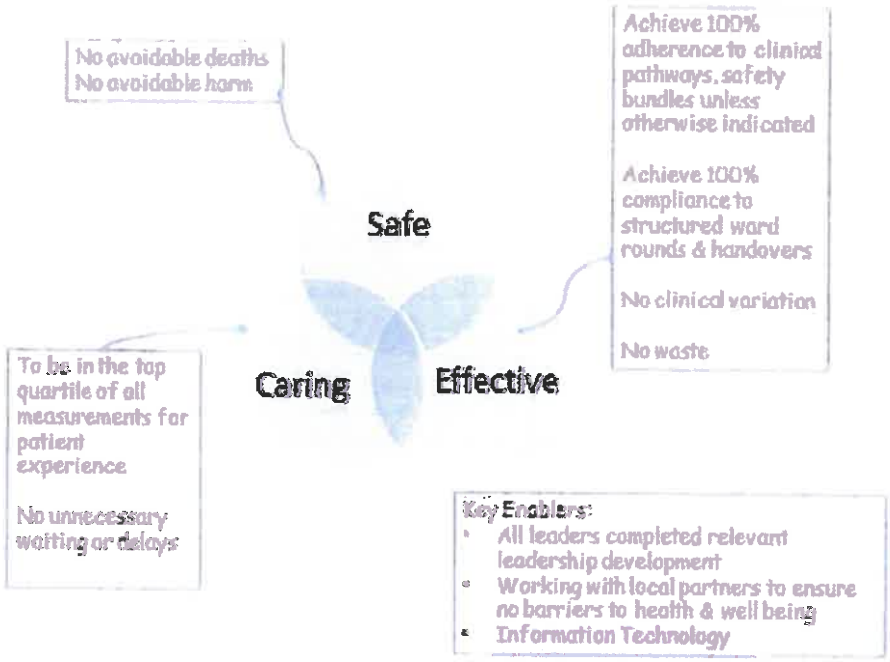
Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivered within BCUHB and not only monitor the clinical outcomes but a range of service user experience feedback methods developed as a framework of best practice in caring for patients.

6.0 What changes can we make that will result in improvement?

In order to accomplish our ambitious aims we will need a far reaching plan to engage with staff on finding solutions right across the Health Board. The following Driver Diagram summarises the areas of work we will tackle in the next three years while the following pages examine each primary driver and what projects will be need for each.



7.0 Agreed priorities: The engagement process and review of data across the Health Board has resulted in the following areas being adopted as the Health Board ambitions for improvement under the headings of *Safe, Effective and Caring*:



Aim 1 – No Avoidable Deaths:

The number of avoidable deaths in the NHS remains uncertain. During 2017/18 the health board will continue to address through the findings of universal mortality reviews themes relating to the reported deaths. Estimating preventable deaths becomes more difficult when reviewing cases of patients with complex conditions and co-morbidities; however, the organisation is committed to a multi-disciplinary case-note review methodology to ensure lessons are learned. We can use these mortality reviews to find defects in care that we can address in our services in our aspiration of having no avoidable deaths. Our measurement of both Crude and Amenable mortality per 100,000 of the European Age standardised population, will be used to determine whether impact of actions can be observed in the trends over time.

Monitoring our risk adjusted mortality rates is one way to understand how we are doing on eliminating avoidable deaths. Not every patient admitted to the hospital for a given condition has the same risk of death. For example, an otherwise healthy 40 year old with pneumonia has a different risk of death than a 90 year old lifelong smoker. In order to account for these differences, we use a risk adjusted ratio that incorporates the characteristics of each patient.

Our aim must be to learn from all aspects of our care in order to tackle the areas that make care consistently safer.

Safe	We will prevent deaths when possible and [illegible]
Measures	Using crude mortality as an indicator we will identify any variation from normal and initiate investigation at case-note level to ascertain lessons to be learned Serious untoward incidents that resulted in patient death

Incidence of still births

Number of patients able to die in their place of choice

Reduction in mental health suicides

Aim 2 – Safe; Continuously Seek Out and Reduce Patient Harm:

The Health Board has prioritised Harm Free Care as a priority. This will focus on a reduction in the following:

- VTE (Venous thromboembolism)
- HCAI (Healthcare Acquired Infections)
- Response to the Deteriorating Patient and adherence to Early Warning Scores
- Pressure ulcers
- Falls
- Medication Safety
- Identification and early treatment of Sepsis

An underpinning aim to support this will be to deliver care, 'in the right place, by the right member of staff, at the right time'. This will place an emphasis on our users receiving care in the right environment, including their own homes.

Safety	We will not harm anyone in our care
Measures	Unexpected admissions to critical care environment Number of Cardiac arrest calls in a non-critical environment Reduction in incidents reported with harm specifically: ❖ Reduction in pressure ulcers ❖ Reduction in falls ❖ Never Events ❖ Infection rates Quality Audit performance, including safety thermometer, maternity dashboard & accreditation frameworks Medication errors - Safety Thermometer

Aim 3 – Effective; Achieve the Highest Level of Reliability for Clinical Care:

Achieving the best outcomes for patients requires us to provide care that is effective and we want to do this in a way that provides the best possible patient experience. Clinical audit is a way to determine if the care we are providing is in line with recognised standards with the results informing those who use and provide our service both where we are meeting standards and where improvements need to be made. Through a focus on the National Clinical Audit and Outcome Review Panel and Corporate Clinical Audits we will

ensure that quality improvement takes place where it will be of most benefit to patient outcomes.

NICE and the All Wales Medicines Strategy Group standards and guidance set out the way care should be provided and these will become increasingly important in ensuring we provide effective care. Rapid dissemination of new standards to clinicians and supporting quality structures will contribute to their adoption and implementation with monitoring through the NICE and All Wales Medicines Strategy Group.

Effective	Achieve the Highest level of reliability in Clinical Care
Measures	Results of national audits Strengthen our clinical pathways to ensure reliability against NICE, NCEPOD, WHO checklists etc. Performance against the new *accreditation programme for wards, departments and community* Adherence to the GROW programme recommendations Adherence with Sepsis Six

Aim 4 – Caring; Deliver What Matters Most: Work in partnership with patients, carers and families to meet all their needs and actively improve their health:

Our staff strongly supported this goal and were keen to see performance being openly shared. This aligns with the Health Board's commitment to be open and honest in the work it undertakes. The Health Board's pledge to move towards visiting times being open, according to patient's needs and requirements was welcomed and helps us in our ambition to include patients, carers and families in the delivery of care. It also ensures that there is enough time to ensure that there is access to medical, midwives, nurses and Allied Health Professionals to discuss treatments with carers and families.

Caring	We will provide services that patients rate as better than the national average We will have minimal waiting or delays

Measures	Performance in national patient surveys Results of real time patient feedback The number of local resolutions managed by the introduction of the PALs team Number of serious complaints Number of service changes involving patients National waiting time standards (e.g., A&E waiting times) Hospital appointment cancellations The introduction of an *Open Visiting* policy across BCUHB to completely embed **'John's campaign'** Full implementation of the Dementia strategy Performance in staff feedback surveys

Aim 5 - Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living

In line with our drive for an integrated approach to care we will support patients, carers and families to fully engage and understand the pathway of care they are following to receive seamlessly co-ordinated care.

Caring	Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living
Measures	Community Dashboard Performance against the Accreditation Frameworks Patient Surveys in community and intermediate settings Responsiveness of our community crisis teams Number of patients able to die at home if this is their choice

The Health Board will also pursue the introduction of ***Always Events,*** to including embedding the #hello my name is... to continue to support the principles of the campaign, as it has been introduced across the Health Board and it is monitored through the monthly scores which are consistently between 91% and 95% compliance from a patients perspective for the past 6 months.

The Always Events which have been tested out patients/ public with the support of the Community Health Council and staff are as follows:

Staff will always communicate with, inform and respect the patient and/ or carers.
Patients, families and/or Carers will always know who is in Charge of their care.
Patients, families and /or carers are always listened to.

Patients' physical, social and emotional needs will always be reviewed
Patients, families and/ or carers will always receive information and education to facilitate self –care
Patients, families and /or carers will always be included in the discharge process

8.0 Ensuring that Quality Drives our Agenda

8.1 Actively engaging patients, staff and other key stakeholders on Quality

In order to ensure that this Strategy was influenced by the public, patients and staff, an engagement process commenced in late 2013 and early 2014 with significant engagement and contribution to the development of the original strategy. This included Quality Improvement drop in sessions and Quality Improvement Workshops. To refresh and refocus this second stage Strategy, we have sought to engage staff and many of their views have been integrated into this Strategy.

We also originally undertook a number of processes to elicit staff views on the principle values of the organisation. Our ambition was to be described in 3 years' time as a Health Board which operates according to an explicit set of values with all our partners in promoting health and delivering care. These were and are described as:

- Put patients first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate openly and honestly

8.2 Vision for the future: Working together in an Integrated way to promote a seamless service

8.3 Quality delivery through front line staff

Our staff are our most valuable resource and are key to the successful delivery of this strategy. By describing our expectations, every member of staff will be clear on the part they play in eliminating harm and providing an excellent patient experience.

The Health Board, will work closely with our universities, organisational development support and the 1000 lives team to ensure our staff have the skills and leadership

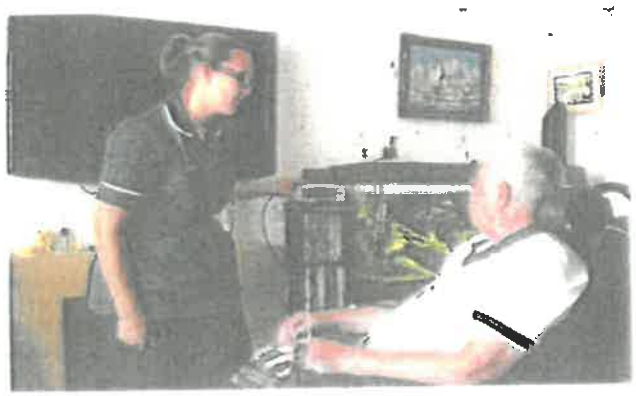
capabilities to support the expectations described in this strategy. With the staff knowledge of the services and the support described, they will freed to implement local improvement strategies to transform and progress our services to best meet the needs of our population.

This strategy outlines the Health Board expectations that there will be an increasing focus on improving outcomes and experiences for the people who use their services, particularly safeguarding vulnerable and frail elderly and ensuring 'Dignity in Care'.

We are resolute in protecting the rights of staff to speak out about poor care or workplace concerns. We will make it easier for staff to raise concerns about poor care or attitudes to patients or carers. There will be zero tolerance of direct threats to the physical safety of front line staff.

The responsibility for quality and safety at the Board is with the Director of Nursing and Midwifery but it is acknowledged that the quality of care is everyone's responsibility.

8.4 Evidence-based interventions, implementing best practice and innovation in Quality and Safety



The Quality Improvement Strategy will require increased use of benchmarking and continued implementation of evidence-based safety interventions and recognised best practice to achieve excellent clinical outcomes for patients.

Having robust clinical services and teams driving their own clinical audit programmes will enable the Health Board to demonstrate the year on year improvements outlined in the Strategic Implementation Plan and the evidence required by the Quality and Safety Committee to provide assurance that the Quality Improvement Strategy is being implemented effectively.

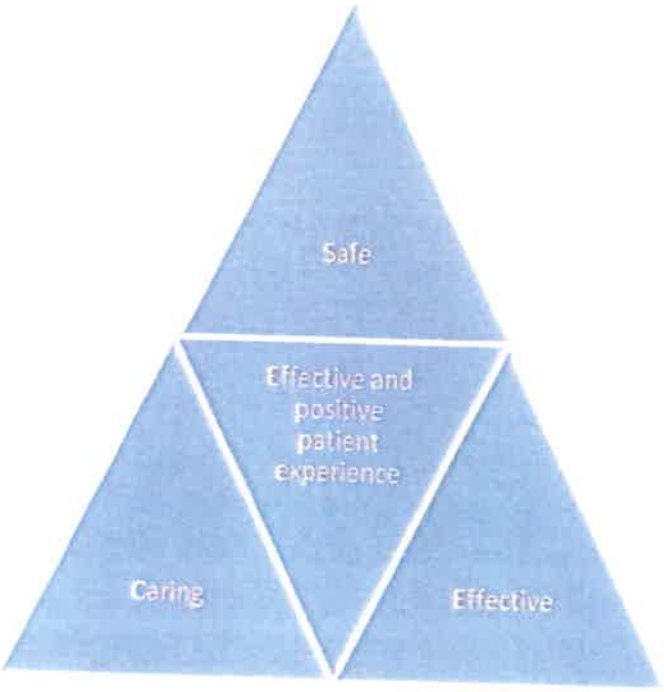
Measuring Success:

Implementation and Monitoring

The quality strategy will be driven by the transparent and open reporting of achievements against agreed standards providing the golden thread of communication and assurance from ward, department and community to Board.

The Health Board has undertaken a baseline of harm which will be used to provide individual reduction trajectories which will be monitored via the quality dashboard. This will be aligned with key metrics to provide the Board with assurances on Progress.

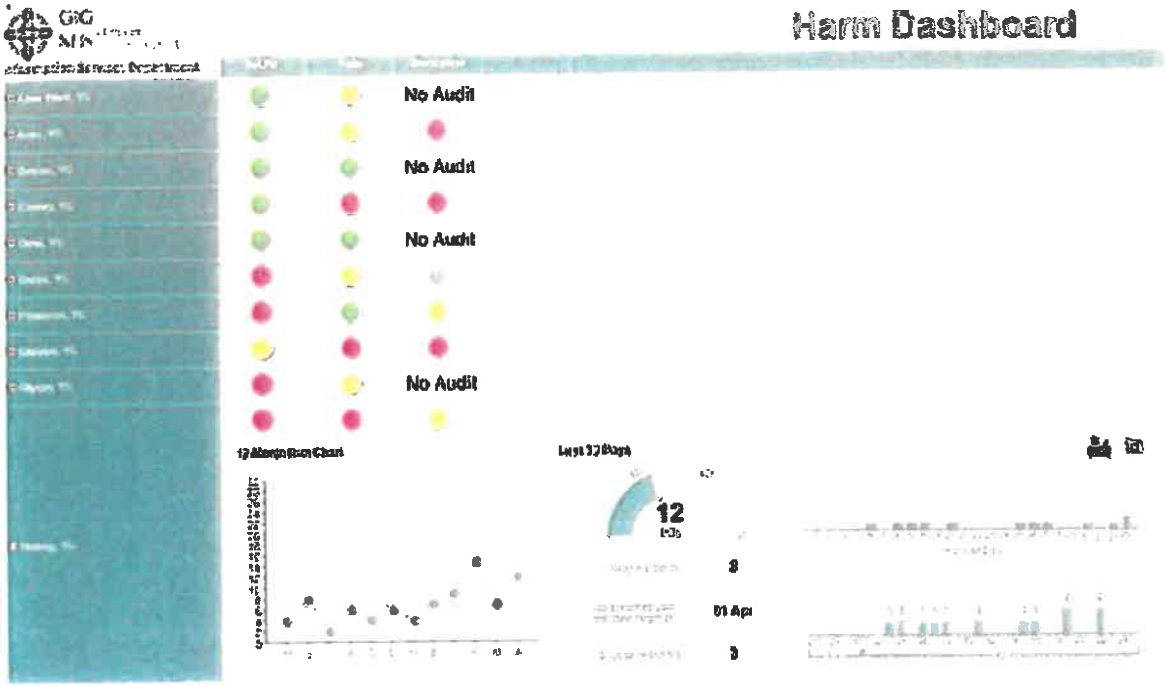
Triangulate information:



The newly developed dashboard will enable local teams to review their own information, engage in local improvement plans, and seek assistance, alongside sharing good practice. Incorporating safe staffing and roster management, incidents, harm and audit outcomes, this will provide intelligence to teams to support early intervention and the introduction of real time patient acuity allowing staff to be safely allocated.

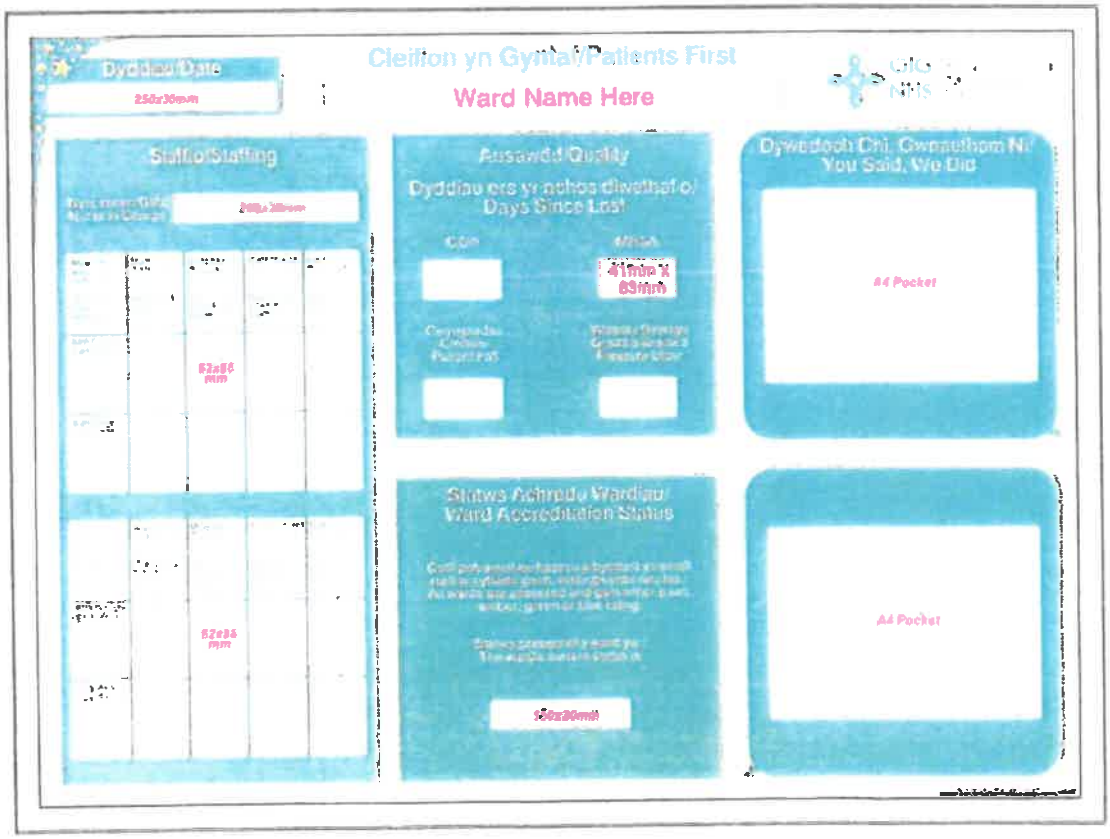
The measurement against individual department profiles for improvement will be monitored the dashboard. Whilst initially focussing on harm, this will evolve to incorporate patient feedback, staffing levels and patient acuity. Each department will have access to their own dashboard information, with visibility from '*Service to Board*'. An escalation framework will provide timely access to resources to help support improvement.

Information technology is a key enabler to delivering and measuring the impact of our refreshed Quality Strategy. The Health Board already proactively engages with IT solutions to help our staff to deliver timely and effective care in many areas, but this will need to be further strengthened to enable us to deliver our ambitions.



Quality Board

Each clinical area will openly display their performance against key indicators to better inform our staff and patients.



9.0 Conclusion

Health Board commitment to Quality Improvement and Health promotion.

The Health Board approach to continuous improvement requires commitment, an inclusive approach and continuous review. The Board will utilise its Quality, Safety and Experience Committee to formally monitor the implementation of this Strategy and provide assurance to the Board.

A core component of this Strategy is to ensure that it represents the integrated nature of the Health Board and that sufficient focus is placed on the Public Health priorities, which will enable the Health Board's programme of quality improvement to cover all aspects of prevention and health promotion in its Quality Improvement intentions.

The formal evaluation of the implementation of this Strategy and the impact of the quality improvements in care provision is essential for BCUHB. We will therefore continue to work with staff, service users and stakeholders to ensure that the full range of patient specific measures of care and experience are robust to provide transparent information for them.

The Health Board will encourage and promote innovation in quality and safety improvement at all levels and ensure achievements and successes (big and small) are recognised, rewarded and shared widely both internally and externally to the community, patients and partners.

Progress against the Quality Improvement Strategy will be reported in the Annual Quality Statements to be published each year.

Chair

Chief Executive

Women's Directorate Performance Accountability Framework & Process Meeting

Terms of Reference

Contents

1. Introduction

1.1. The *Women's Directorate Performance Accountability Framework & Process* is accountable for the delivery of key quality, performance, workforce and financial objectives for the directorate within North Wales. It aims is to ensure that information is available which enables the Health Board, Women's Services Directorate and Operational Management Teams to understand, monitor, and assess the quality and performance of the organization/Directorate, enabling appropriate action to be taken when performance against set targets deteriorate.

2. Purpose

2.1. This paper sets out the Terms of Reference in line with the Women's Directorate Performance Accountability Framework and Process.

2.2. The Performance Accountability Framework includes colleagues from within the Women's Directorate responsible for performance management objectives/targets

3. Duties

3.1. All members have a duty to comply with these terms of reference and commit to participate actively in the work of the Performance Accountability Framework and Process

3.2. In undertaking their duties all members must adhere to the Performance Accountability Framework and Process principles:

- The strategy set out by the Board through the IMTP (3 Year Plan) and Operational Plan
- Operational ownership of the directorate priorities
- Clarity of expectations as to a level of performance expected within resources allocated
- Decision making based on visible performance information against key performance indicators
- Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
- Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations
- Clarity as to outcomes and consequences of poor performance through clear escalation process

3.3. The Chair of the Performance Accountability Framework has responsibility to ensure that meetings are effective in achieving their purpose, administered appropriately as outlined below, and that all members participate appropriately.

4. **Membership**

4.1. The membership of Women's Performance Accountability Framework will comprise of:

Core Members:

- Director of Midwifery and Women's Services (Chair)
- Women's Services North Wales Clinical Lead
- Directorate's Senior Financial Advisor
- Head of Women's Services
- Women's Lead for Governance and Risk
- General Manager.

4.2 Site team representation at each scheduled accountability meeting will include:

- Site Clinical Director
- Matron
- Lead Manager

4.3 Additional or alternative members may be co-opted as necessary.

4.4. Members may nominate a deputy for any meetings they are unable to attend

5. **Quorum**

5.1. No business shall be transacted at a meeting unless there is a quorum.

5.2. The meeting will be quorate if at least 4 core members (including the Chair or Vice Chair) are present and at least representation of 2 site team colleagues.

5.3. In the absence of the Director of Midwifery and Women's Services (Chair) the Women's Directorate General Manager will act as Chair

6. **Frequency of Meetings**

6.1. Meetings will be held monthly. Dates of the meeting will be circulated in advance at the beginning of the year.

6.2. The Performance Accountability Framework will meet a minimum of 12 times per year. The Chair may convene additional meetings if there is urgent business as per the Accountability Escalation Framework

6.3. To enable reports to be received in a timely fashion, Performance Accountability meetings will be held every **3rd week of each month**. This will allow updates to be provided to the Women's Directorate Board the following week.

7. **Attendance at Meetings**

7.1. All members of the Performance Accountability Framework will be required to attend a minimum of 75% of meetings held annually.

8. **Reporting Arrangements**

8.1 Minutes and papers will be available on the Directorate SharePoint.

8.2. The meeting will have a formal agenda as per the five key operational performance priorities:

- Performance
- Safe Care
- Maternity Clinical Measures
- Maternity Commissioned Services
- Workforce
- Finance

8.3 The Performance Accountability Framework will receive Chair approved key actions

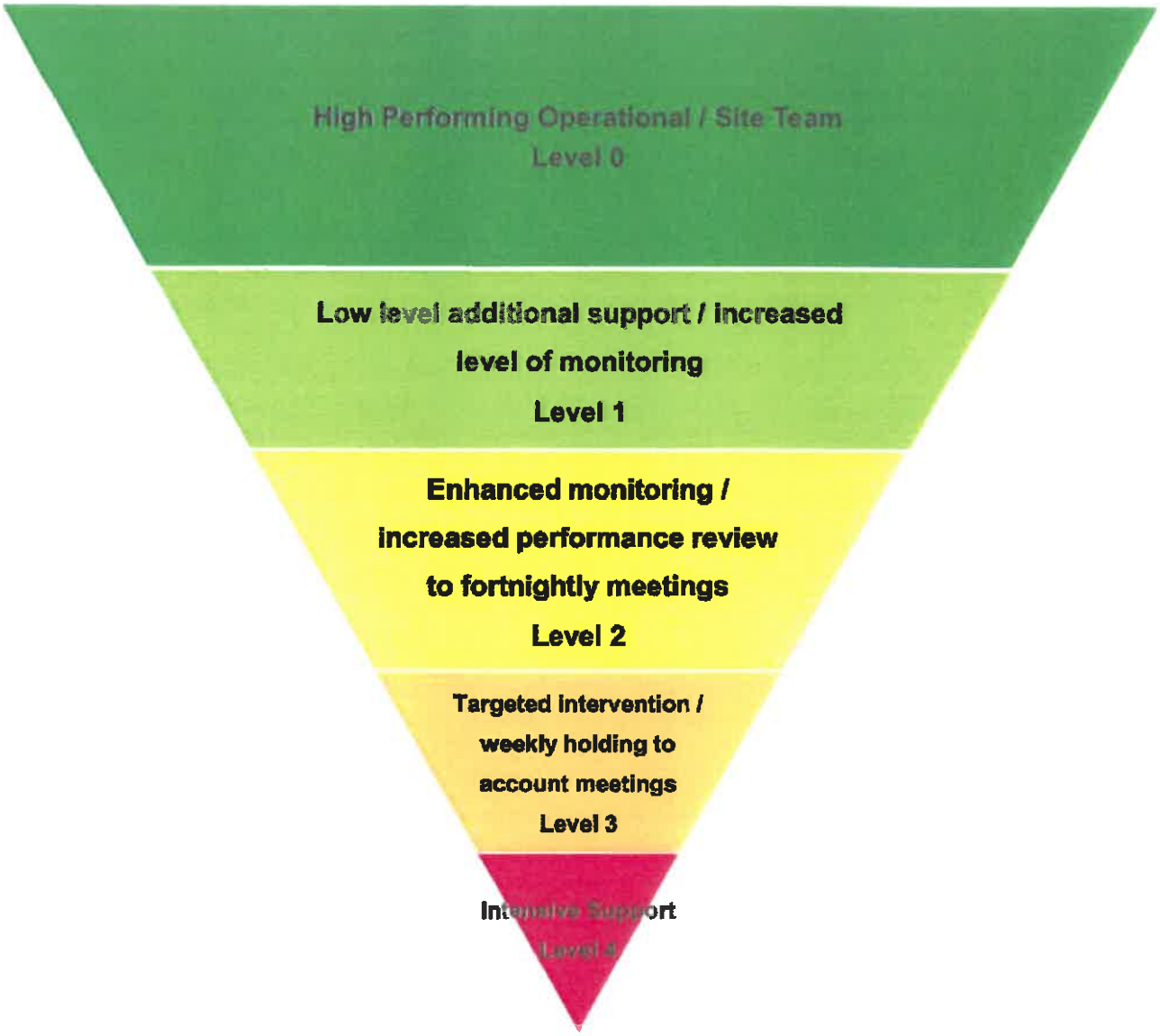
9. **Administration Arrangements**

9.1. The Performance Accountability Framework will be administered by the General Manager

9.2 The Agenda will be sent to members 5 working days in advance of the Performance Accountability Framework meeting, and supporting papers shall accompany the agenda.

Appendix 3: Performance Accountability Escalation Framework

This performance accountability escalation framework is aligned to the Health Boards Escalation Framework, with actions arising from the levels of escalation described below:



Examples of the trigger points, and associated actions are detailed below:

Key Performance Triggers & Associated Actions

Level	Multiple KPI Trigger	Description	Actions
Level 0	All targets achieved	On plan for quality, finance, workforce and operational delivery	Continue monitoring via accountability meeting
Level 1	· More than one KPI off target for one period (month) · Exception report and recovery plan required within **two weeks**	· Evidence of minor continued movement from profile · Concerns raised regarding delivery of agreed recovery plan(s)	· Continued monitoring via accountability meeting · Focused support re: deliverability of recovery plan(s) as determined by minuted actions · The **site leadership team** required to attend the **Women's Directorate Board** to explain its position
Level 2	· More than one KPI off target for longer than one period (month) · Revised exception report and recovery plan required within **two weeks**	· Failure to deliver one or more key target · Variances across key domains · Lack of confidence re: recovery plan	· Increase performance review to fortnightly accountability meetings · Revise exception report and recovery plan(s) · The **site leadership team** required to attend the **Women's Directorate Board** to explain its position
Level 3	· More than one KPI off target for three periods (months) without explainable cause · Lack of evidence of effectiveness/ deliverability of recovery plan	· Multiple variances across all domains, with significant impact on patients · Performance continuing to deteriorate	· Undertake risk meeting including Directorate Board members · Conduct weekly holding to account meetings with clear documented actions · Consider support from Corporate/Turn Around office · Consider external review and support
Level 4	· More than one KPI off target for four periods (months) · No effective recovery plan · Ineffective response to weekly holding to account meetings	· Issues as per Level 3 · Failure to achieve improvements within agreed timescales	· Review leadership of Site Management Team led by the Director of Nursing & Midwifery/Clinical Director · Consider engaging alternative leadership support

Betsi Cadwaladr University Health Board

Interim Accountability Framework and Processes

Summary

- Interim accountability review arrangements to run in 2019 with intent to learn from process and adapt and adopt for 2019-2022 planning period.
- Delivering our plans requires a team focus.
- Accountability is exercised via a) the Board and committees, b) individual objective setting, and c) quarterly accountability review meetings.
- Health Economy based accountability reviews (three economies: west central and east) with the performance of divisions and areas as a 'subset' of geographic economy based performance.
- Escalation framework mirroring Welsh Government framework of tiered escalation.

Purpose

This paper sets out the proposed interim accountability framework for the Health Board and aims to replace the current framework approved by the Finance and Performance Committee in December 2017. It will run for the bulk of 2019 with a view to learning from the quarter 3 process, adapting and adopting as the framework for the 2019-2022 health board's three year plan.

Flowing from the plan and this accountability framework the integrated performance reporting framework arises. This reporting framework will be the subject of a further paper setting out the arrangements proposed from team/site to board.

Background

The current framework requires review following the change of Executive portfolios and reflections on changes needed to support the organisation achieve strategic and operational objectives.

As part of our duties the NHS Wales planning framework requires all Health Boards in Wales to produce 3 year Integrated Medium Term Plans (IMTPs), or Annual Plans explaining how they will meet their objectives and deliver improvements with pace and purpose.

In order for the Health Board to be assured that we are on track to deliver this improvement, the performance management process needs to be effective. Performance assurance, performance management and performance improvement are dependent on a clear framework of accountability with teams and individuals clear as to the expectations placed on them, the resources available to them to deliver and awareness of the consequences of non-delivery.

Principles

Best practice shows that in order to ensure an organization assesses performance across all aspects of business, it is vital that different perspectives are captured to provide a fully integrated view of performance across the Health Board – delivering our plan is a team responsibility.

The key objective of the accountability framework is to ensure that information is available which enables the Board and senior management teams to understand, monitor, and assess the quality and performance of the organization, enabling appropriate action to be taken when performance against set targets deteriorates.

The accountability framework needs to support the organization in delivering:

a) The strategy set out by the Board through the our plans.
b) Operational ownership of the key organisational priorities.
c) Clarity of expectations as to level of performance expected.
d) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
e) Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations.

To do this effectively, information must be timely, accurate, consistent and complete.

Proposed Accountability Arrangements

It is proposed that existing arrangements for accountability are strengthened in the following ways:

a) The Board through its meetings and committees will hold the Executive responsible for areas within their portfolios. **BOARD AND COMMITTEES**
b) The Chief Executive will through objective setting and personal performance reviews hold Executives to account for the performance management of their portfolios - the executive sponsor of each of the indicators within the National Outcome Framework will be assigned to a named Executive. **SETTING OBJECTIVES**
c) Each Executive Director will through objective setting and personal performance reviews hold direct line reports to account for delivery of agreed objectives. There will be a matrix management approach; this means that Divisional Directors will have objectives to meet which fall within an Executive Portfolio outside of their Executive Line Management. **SETTING OBJECTIVES**
d) The Executive Management Group (EMG), chaired by the CEO is responsible for performance monitoring of the indicators within the NHS Wales Delivery Framework. **ACCOUNTABILITY REVIEWS**
e) The Chief Executive will monitor performance across geographically defined health economies on a quarterly basis to support delivery of integrated health care. **ACCOUNTABILITY REVIEWS**

The remainder of this paper proposes a new approach to accountability reviews.

The Chief Executive will chair quarterly performance reviews. This process will be led by the Executive Director of Planning and Performance, with support from the Director of Performance.

Crucially, the Divisions will also have the opportunity to raise issues where support or discussion is required.

The scope of the reviews will be performance achievements and challenges against the 2018/19 core delivery priorities (January and April 19), and the operating plan from July 19 onwards.

The accountability review will have a formal agenda, be minuted and the outcomes from the discussion including the overall assessment will be communicated to the divisional directors in a timely fashion. Within these meetings individual directors will normally assume overall responsibility for reports from within their own portfolio.

Discussions relating to individual performance will be conducted on a 1:1 basis by individual directors in accordance with normal line management arrangements. (see above)

The information provided within the reviews will align to the indicators used by the Board through the operational planning and integrated quality and performance reporting processes, reflected in a disaggregated manner through the Health Economy performance reports. Divisional performance reports will continue as sub-sets of the Health Economy performance report. The Divisional Governance structure will mirror that of the Board and its committees with Divisional Directors responsible for holding their direct reports accountable for delivery of quality and performance at a disaggregated level, with escalation as appropriate from the Division to the Executive.

In order to have a single version of the truth validated and submitted information will be used and this will be locked down 7 days prior to the meeting to ensure all participants are sighted on the same information.

The focus of the accountability reviews will be geographically health economy based performance with the performance of divisions and areas as a subset of these as described above.

There will be three in-depth performance reviews held on a quarterly basis for the place based systems:

- West and Ysbyty Gwynedd
- Central and Ysbyty Glan Clwyd
- East and Wrexham Maelor Hospital

The hosted services will be discussed under the host placed based review e.g. palliative care services will be discussed in the East and YGC health economy meeting with the East Area team accountable.

Mental health and learning disability services, North Wales Clinical Services and Womens services will be discussed in each health economy review with information disaggregated where possible to each of the health economies.

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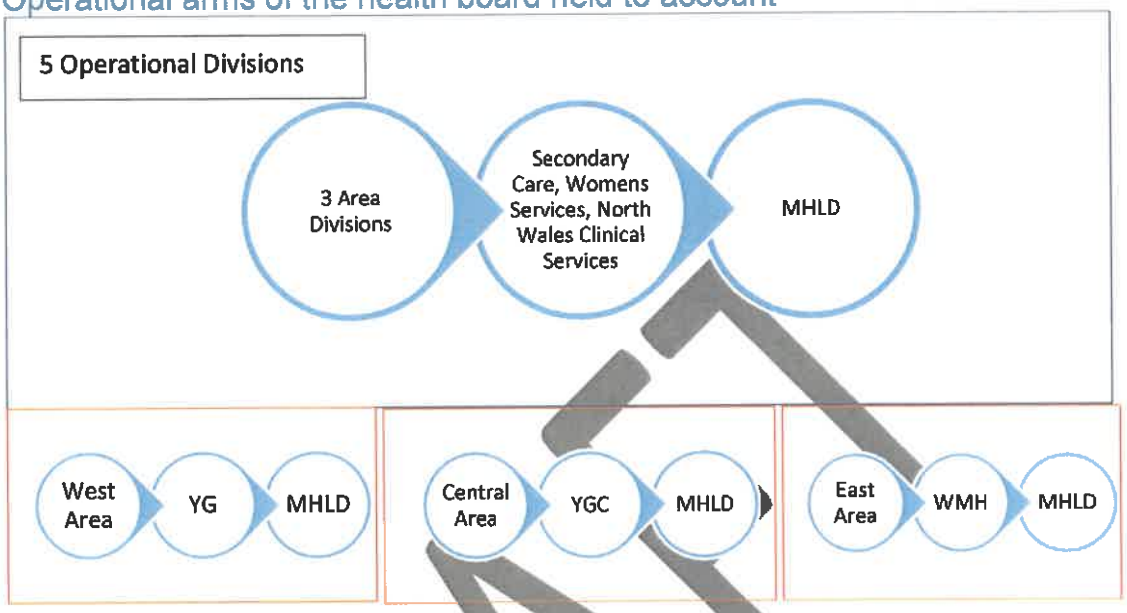
Operational arms of the health board held to account



A typical format will be scheduled for around 2 hours and would generally include:

- Health Economy based responsibilities;
  - Mental health and learning disability services
  - Secondary care, womens and N.Wales managed clinical services
  - Area responsibilities

The format will enable the health economy to present its current position and challenges against the core health board priority areas and discussion to be framed in relation to those indicators themed to:

  - Quality and Safety
  - Performance
  - Use of Resources – Finance, Workforce, Estate
  - Organisational development and learning

Attendance is required from respective Area, Secondary care, Womens, North Wales Managed Clinical Services and Mental health and LD directors to cover the agenda items. Usually attendees will include:

- Secondary care, Area, and Mental health and LD Directors
- Area and Secondary Care Medical Directors
- Area and Secondary Care Nurse Directors

All executive directors will be requested to prioritise this process.

Following the review day the Executives will confirm outcomes and determine escalation levels. Escalation processes will be in line with the WG framework and designed to ensure issues of concern are given increased support to improve performance within an agreed timeframe.

Escalation is possible on individual issues of concern, divisional responsibilities within the health economy or across the whole health economy. The escalation process within the performance framework is based on the outputs and outcomes against the core priorities and may not be directly aligned to performance of individuals.

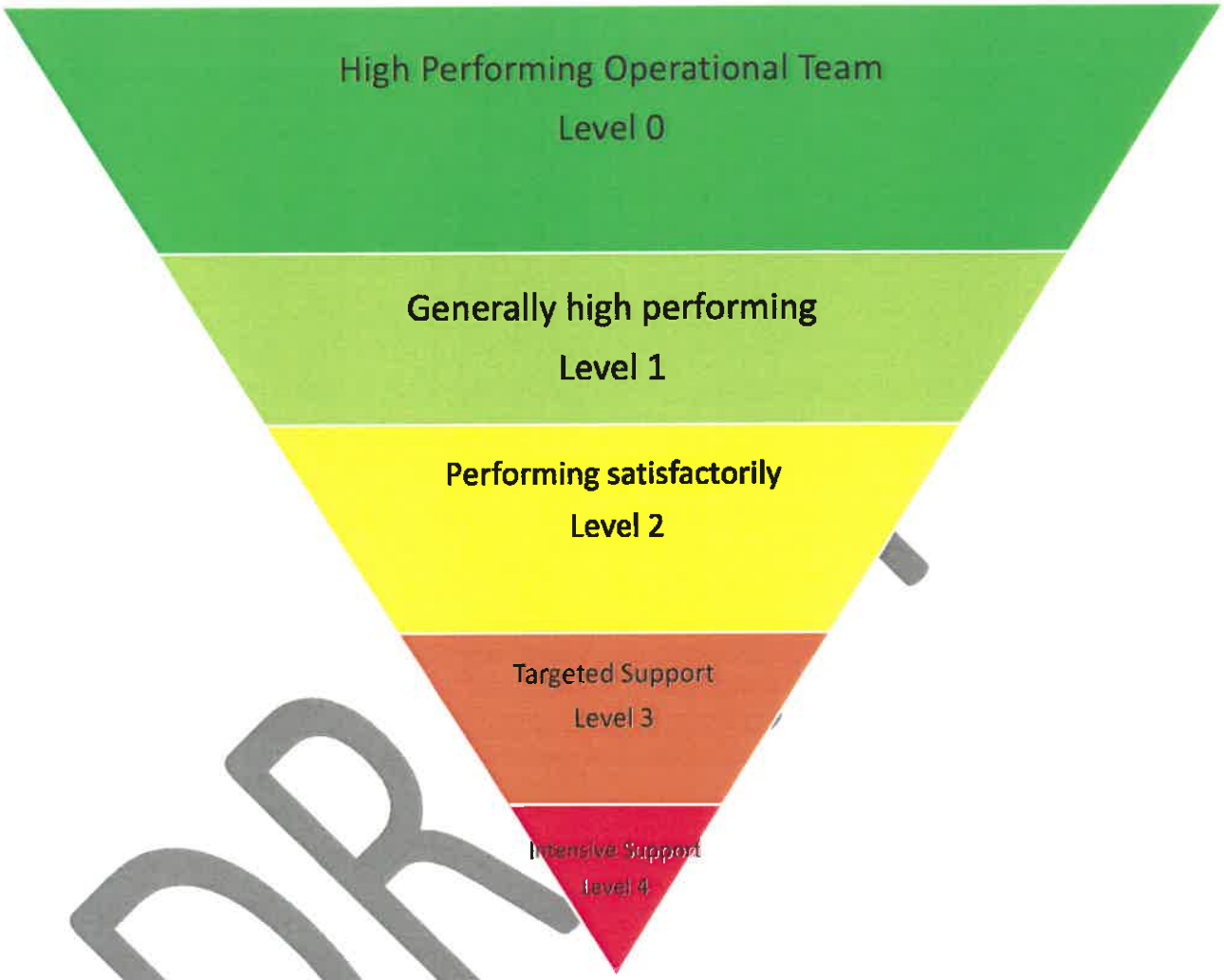
The escalation levels will be triangulated with individual personal development and PADRs. Assessment of individual performance against agreed objectives will not necessarily be consistent with the level of Departmental escalation (an area could be progressing well against a target but individual progress against objectives could need improvement and vice versa).

Initiation of the process

The process will commence in January 2019 and reviewed in a collaborative manner at the end of Quarter 4 with a view to adapting based on learning and adopting formally for use throughout the 3 year operational plan period 2019-2022.

Appendix 1: Escalation Framework

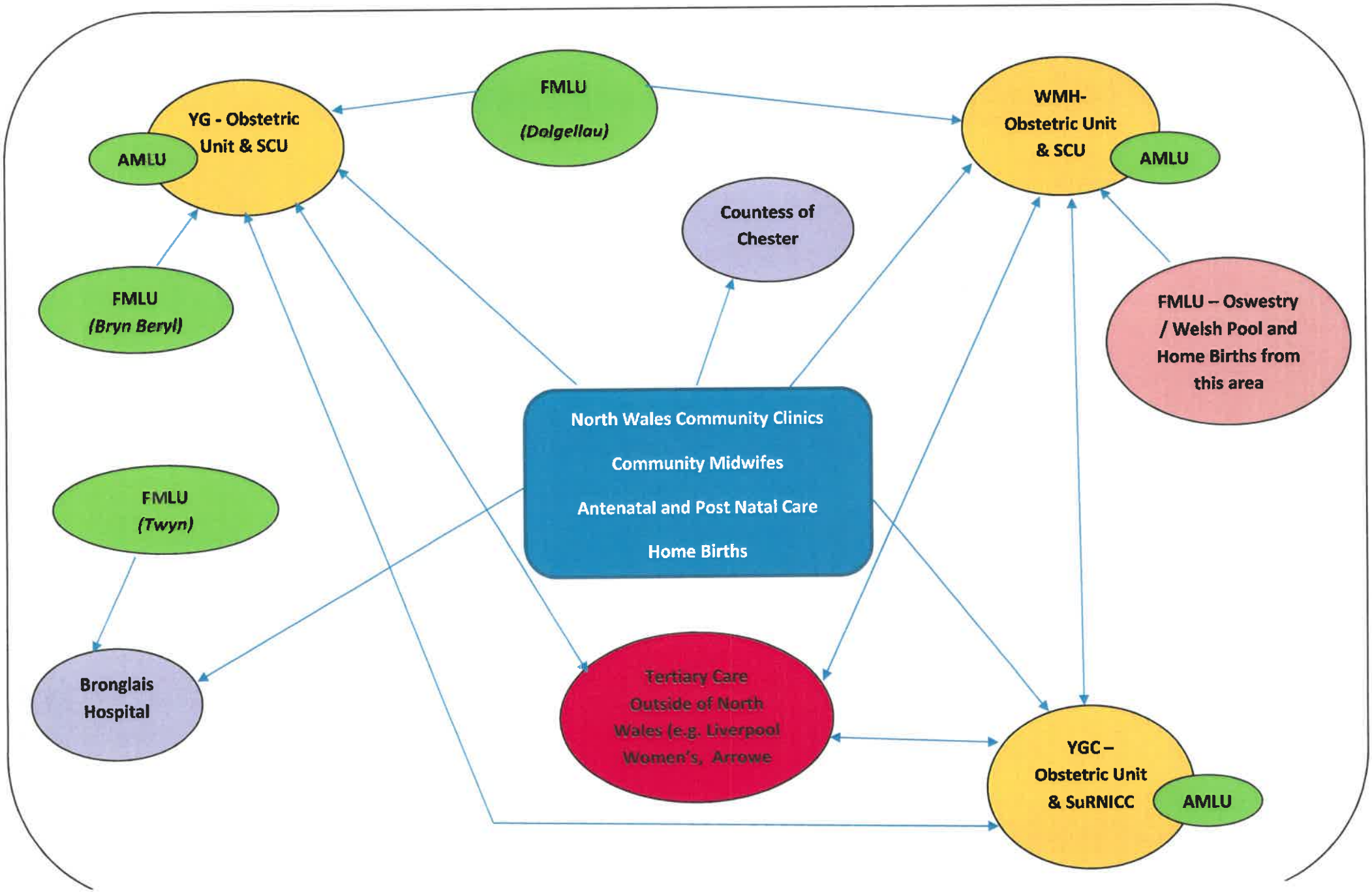
The levels of escalation are shown below:



Governance arrangements

The overall results for each of the Health Economy Reviews will be presented to the EMG and the Finance and Performance Committee of the Board.

BCUHB - Network of Services and Flow



Application Process for Women requesting to Birth Outside of BCUHB

Community Midwife sees the woman as first point of contact. If woman wishes to birth outside of BCU she is given an application form to complete. The Community Midwife then sends the completed application form to the **BCU Birth Choices** inbox

↓

BCU Birth Choices inbox accessed by Site Secretary or in her absence the Matron for Outpatient Services or the Head the Women's Inpatient Services and applications are considered at the weekly Monday meetings

↓

Site Secretary sends letter to the woman detailing the decision within 2 working days and informs the Community Midwife

↓

If the woman wishes to appeal she contacts the Site Secretary who forwards details to the Matron for Outpatient Services or Community Team Leader to contact the women to discuss an appeal

↓

Matron for Outpatient Services or Community Team Leader to send appeals to FG and decision communicated to Site Secretary who will send letter to woman and inform Community Midwife

↓

Community Midwife to contact Site Secretary with date of first appointment at hospital outside of BCU

Maternal, Newborn and Infant
Clinical Outcome Review Programme

MBRRACE-UK

Betsi Cadwaladr University Health Board

MBRRACE-UK perinatal mortality report: 2015 births

This report concerns stillbirths and neonatal deaths among the 6,572 babies born within your Health Board in 2015, EXCLUDING births before 24 weeks gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	21	3.20	3.73 (2.87 to 4.59)	○ Up to 10% lower
Neonatal	9	1.37	1.33 (0.77 to 2.17)	○ Up to 10% lower
Extended perinatal	30	4.56	5.05 (4.17 to 6.42)	○ Up to 10% lower

The crude mortality rate is the observed rate for your Health Board and is a snapshot of mortality for births in 2015. The stabilised & adjusted mortality rate gives a more reliable estimate of the underlying mortality rate taking into account key factors known to increase the risk of stillbirth and neonatal mortality as well as the effects of chance variation, particularly where the number of deaths was small. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Health Board in 2015.

The stabilised & adjusted mortality rates for your Health Board were lower than those seen across similar Trusts and Health Boards (see page 7 for more details). However, if the aspiration of your Health Board is to seek rates comparable with the best performing countries, for example those in Scandinavia, a local review would be justified to ensure all avoidable factors have been identified and any appropriate changes to care implemented.

Important reporting issues

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2015, we received over 99% of information on key data items for the deaths which occurred within your Health Board.

Late fetal losses relating to births before 24 weeks gestational age have been reported separately as the reporting of these to MBRRACE-UK by some Trusts and Health Boards is known to have been poor in previous years. Please continue to ensure that all late fetal losses at 22 to 23 weeks gestational age are reported to MBRRACE-UK.

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford with members from the University of Leicester (who lead the perinatal aspects of the work), University of Liverpool, University of Birmingham, Bradford Teaching Hospitals NHS Foundation Trust, Sands (Stillbirth and neonatal death charity) and a general practitioner from Oxford.

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. HQIP's aim is to promote quality improvement, and it hosts the contract to manage and develop the Clinical Outcome Review Programmes, one of which is the Maternal, Newborn and Infant Clinical Outcome Review Programme, funded by NHS England, NHS Wales, the Health and Social Care division of the Scottish government, the Northern Ireland Department of Health, the States of Jersey, Guernsey, and the Isle of Man. The programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. More details can be found at: www.hqip.org.uk/clinical-outcome-review-programmes-2.

Introduction

This is the third MBRRACE-UK perinatal mortality surveillance report produced for Trusts and Health Boards across the UK. It includes details of the late fetal losses (22^{+0} to 23^{+6} weeks gestational age), stillbirths and neonatal deaths for births that occurred in your Health Board in 2015, as well as background information on all births. Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Methods

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics (ONS), Personal Demographics Service (PDS), National Records of Scotland (NRS), Information Services Division (ISD), Northern Ireland Maternal and Child Health (NIMACH), States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2016.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other local or national reported rates as births before 24 weeks gestational age have been excluded from most tables due to the known poor reporting of such births by some Trusts and Health Boards in previous years. Further details on the methods we have used are available from the MBRRACE-UK website.

Nationally recommended actions

For those Trusts and Health Boards whose mortality rates are marked ● a detailed local review is indicated to try to assess the deaths that were potentially avoidable and investigate local factors that might explain the high rate. Similar reviews are suggested for those whose mortality rates are marked ●.

Definitions

Late fetal loss:	A baby delivered between 22^{+0} and 23^{+6} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby delivered at or after 24^{+0} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died before 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

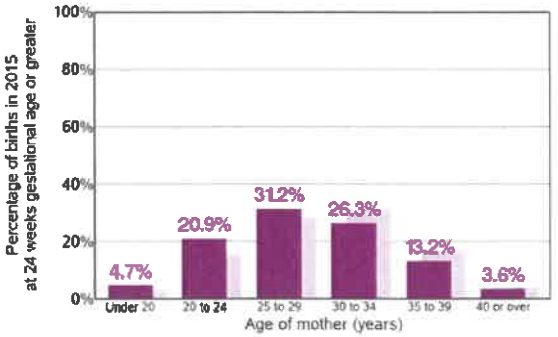
Your births

■ Your Health Board □ UK-wide

Age of mother

The proportion of mothers under 25 years of age was considerably higher than that of the UK as a whole: 25.7% versus 19.0%.

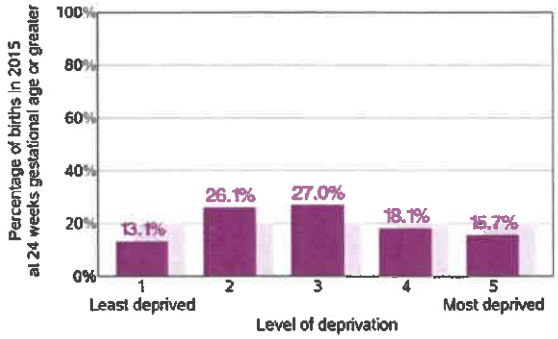
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

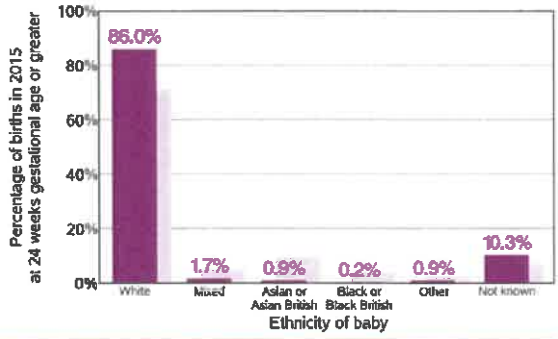
The mothers giving birth in your Health Board lived in areas of similar deprivation to those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 3.7% versus 21.2%.

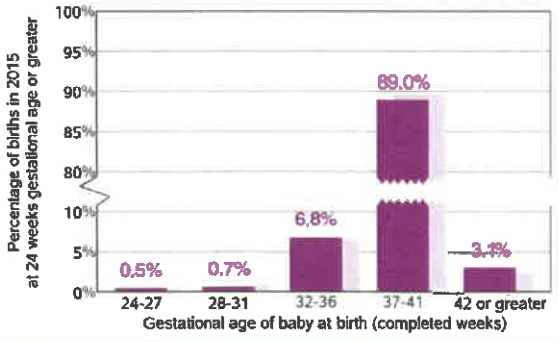
However, for 10.3% of your births the baby's ethnicity was reported as not known. This information is dependent on the accurate coding of babies' ethnicity within the routine reporting of all births.



Gestational age

In your Health Board, 31 babies (0.5%) were born at 24 to 27 weeks gestational age, similar to the 0.4% seen in the UK as a whole. The percentage of babies born at 28 to 31 weeks was also similar to the national average: 0.7% versus 0.9%.

In addition, 202 babies (3.1%) were born post-term (42 weeks or greater), a similar percentage to the UK average of 2.5%.

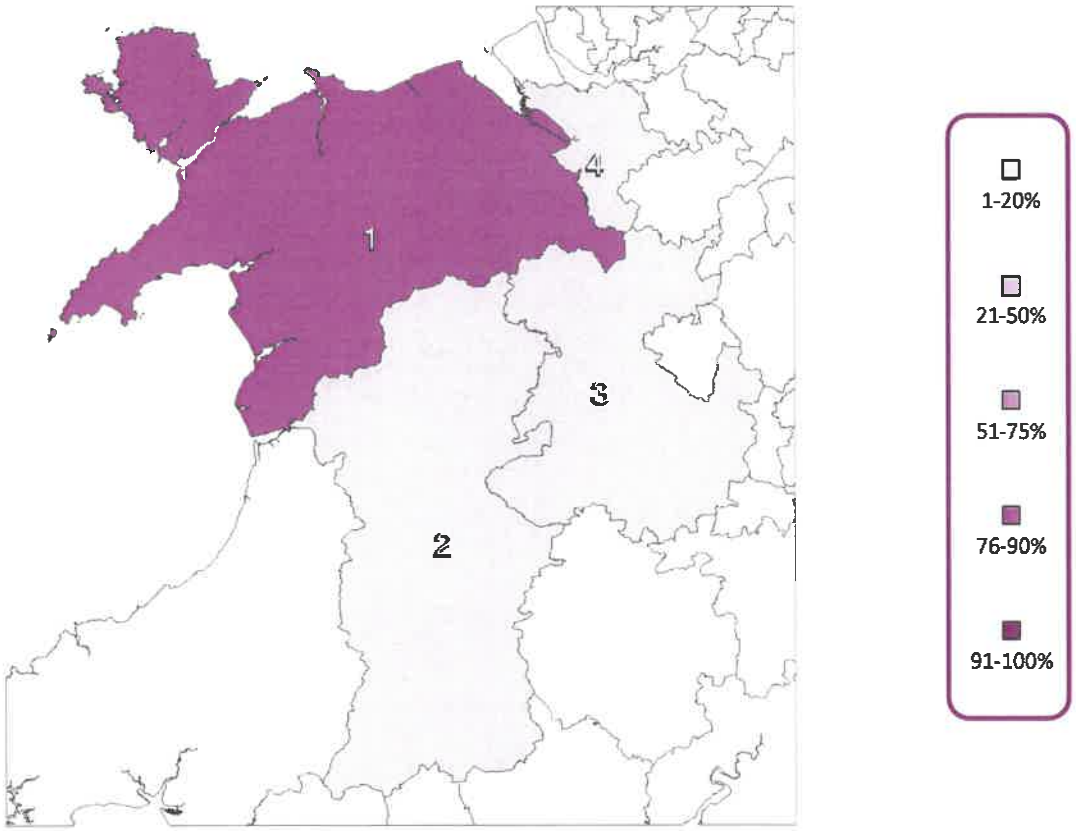


Your births *continued*

Percentage of births taking place in your Health Board by commissioning organisation

The map below shows those commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Health Board. These organisations are Clinical Commissioning Groups (CCGs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

On the map, the area covered by each organisation is shaded according to the percent of their births which occurred within your Health Board. In total, the births from these organisations accounted for 99.5% of your births at 24 weeks gestational age or later in 2015.



The table below provides the percentage and number of births in your Health Board at 24 weeks gestational age or later from each of the commissioning organisations.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. Betsi Cadwaladr University	86.0% (6093)	2. Powys Teaching	16.4% (183)
3. NHS Shropshire CCG	8.6% (234)	4. NHS West Cheshire CCG	1.1% (28)

Your perinatal deaths

Deaths of babies born within your Health Board

The crude mortality rates reported here are for babies born within your Health Board, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 7 which provide more reliable estimates of the underlying (long-term) mortality rates for your Health Board.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your HB	*Rate (N)*	3.0	(20)	0.2	(1)	0.0	(0)	0.8	(5)	0.6	(4)	4.6	(30)
UK-wide	*Rate*	3.6		0.4		0.2		1.2		0.5		5.9	

The rates of extended perinatal death are shown below for your Health Board by gestational age at delivery. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0}-27^{+6}$		$28^{+0}-31^{+6}$		$32^{+0}-36^{+6}$		$37^{+0}-41^{+6}$		$\geq 42^{+0}$	
Your HB	*Rate (N)*	258.1	(8)	93.0	(4)	15.8	(7)	1.9	(11)	0.0	(0)
UK-wide	*Rate*	346.5		111.1		22.4		2.3		1.4	

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Health Board and for neonatal deaths of babies who were born in your Health Board. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In your Health Board, 66.7% of stillbirths were reported as having an Unknown or Missing cause of death, which is higher than the UK average. We recognise that this was the first time many clinicians had used the CODAC system. In order to ensure accurate, consistent reporting, we recommend that the coding of cause of death is undertaken by small, local, multidisciplinary teams.

			Infection		Neonatal		Intra-partum		Congenital anomaly		Fetal	
Stillbirths	Your HB	*% (N)*	0.0%	(0)	0.0%	(0)	4.8%	(1)	9.5%	(2)	4.8%	(1)
	UK-wide	*%*	3.1%		1.4%		5.8%		6.4%		4.6%	
Neonatal Deaths	Your HB	*% (N)*	11.1%	(1)	44.4%	(4)	0.0%	(0)	22.2%	(2)	0.0%	(0)
	UK-wide	*%*	7.3%		44.1%		4.8%		27.9%		4.8%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your HB	*% (N)*	0.0%	(0)	14.3%	(3)	0.0%	(0)	66.7%	(14)	0.0%	(0)
	UK-wide	*%*	4.0%		21.9%		3.5%		46.0%		3.4%	
Neonatal Deaths	Your HB	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	11.1%	(1)	11.1%	(1)
	UK-wide	*%*	0.1%		1.7%		0.3%		5.1%		3.8%	

Your perinatal deaths *continued*

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of liveborn babies who were born and subsequently died within your Health Board and those who were born within your Health Board but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0}-27^{+6}$		$28^{+0}-31^{+6}$		$32^{+0}-36^{+6}$		$37^{+0}-41^{+6}$		$\geq 42^{+0}$	
Within your HB	*% (N)*	50%	(1)	100%	(1)	50%	(1)	75%	(3)		(0)
Outside your HB	*% (N)*	50%	(1)	0%	(0)	50%	(1)	25%	(1)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Health Board and those who were born within your Health Board but died elsewhere.

For births within your Health Board, a post-mortem was offered for 100% of stillbirths and 78% of neonatal deaths, compared with 96% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your HB	*% (n/N)*	100%	(21/21)	100%	(6/6)
Outside your HB	*% (n/N)*			33%	(1/3)
UK-wide	*%*	96%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You are encouraged to update the reported cause of death on the MBRRACE-UK data reporting system once the post-mortem results are known.

		Post-mortem			
		Offered		Consent obtained	
Unknown cause of death	*% (N)*	100%	(15/15)	0%	(0/15)

Babies born at 22 to 23 weeks gestation

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is vital that you ensure there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Health Board for babies born in 2015 was 8. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

		Deaths at 22^{+0} to 23^{+6} weeks gestational age	
		Late fetal losses	Neonatal deaths
Your HB	*N*	4	4

Your perinatal deaths *continued*

Comparisons with similar Trusts, Health Boards and the UK average

The mortality rates are reported for babies born within your Health Board at 24 weeks gestational age or later, excluding terminations of pregnancy. A 'crude' rate and a 'stabilised & adjusted' rate are presented for stillbirths, neonatal deaths and extended perinatal deaths. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2015. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies.

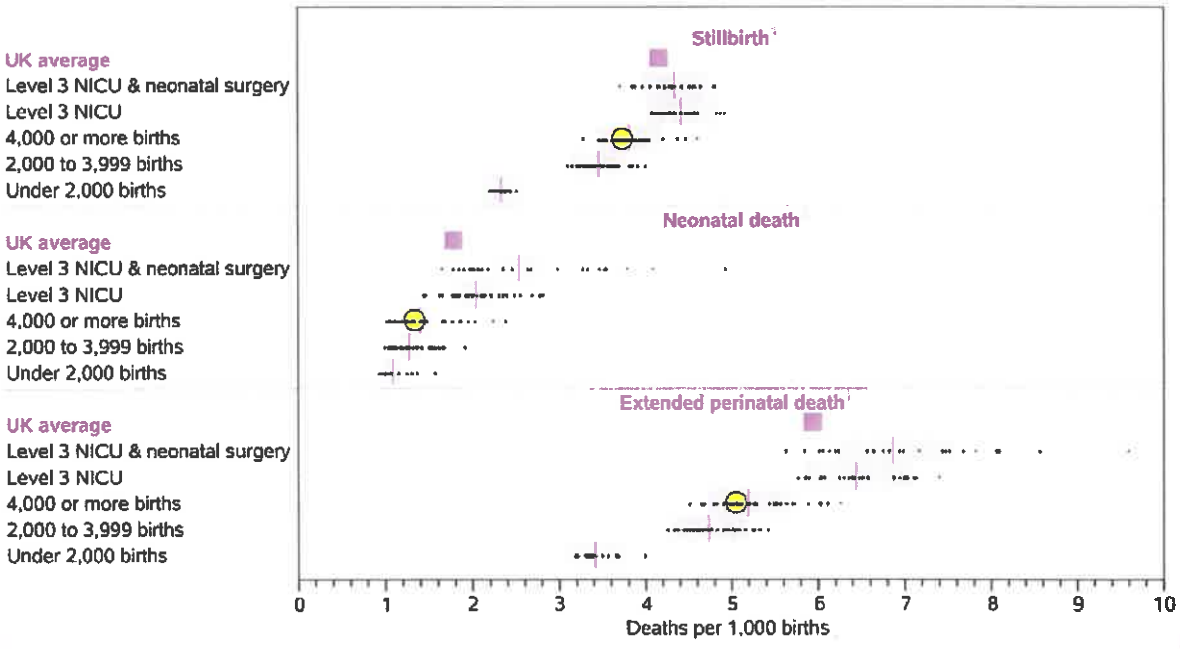
The **stabilised & adjusted mortality rate** is also reported which provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. In addition, to account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision (units routinely accepting for birth babies with a known congenital anomaly likely to require surgery in the neonatal period); (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 24 weeks or later; (iv) 2,000-3,999 births per annum at 24 weeks or later; (v) under 2,000 births per annum at 24 weeks or later. You have been included in the comparator group with 4,000 or more births per annum.

	Mortality rate per 1,000 births [§] (95% confidence interval)		
	Stillbirth [†]	Neonatal [‡]	Extended perinatal [†]
Crude	3.20	1.37	4.56
Stabilised & adjusted [◊]	3.73 (2.87 to 4.59)	1.33 (0.77 to 2.17)	5.05 (4.17 to 6.42)

[§] excluding terminations of pregnancy and births <24[+0]; [†] per 1,000 total births; [‡] per 1,000 live births.

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a circle:

- more than 10% lower than the average for the group
- up to 10% lower than the average for the group
- up to 10% higher than the average for the group
- more than 10% higher than the average for the group



Data completeness

Completeness of key data items for DEATHS AT YOUR HEALTH BOARD

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Health Board, these tables show the overall completeness of data for **deaths at your Health Board no matter where the babies were born.** The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- ♦ less than 70.0% complete
- ♦ 70.0% to 84.9% complete
- ♦ 85.0% to 96.9% complete
- ♦ 97.0% to 99.9% complete
- ♦ 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Health Board. For those items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.

Mother's details	Completeness
Name	100.0% ♦
Postcode of residence	100.0% ♦
Ethnicity	100.0% ♦
Age	100.0% ♦

Birth	Completeness
Type of onset of labour	100.0% ♦
Actual place of birth	100.0% ♦
Date and time of birth	100.0% ♦
Final mode of birth	96.8% ♦

Booking and antenatal care†	Completeness
Smoking	100.0% ♦
Body mass index	100.0% ♦
Intended type of care at booking	100.0% ♦
Estimated date of delivery	100.0% ♦

Baby's outcome	Completeness
Date death confirmed‡	100.0% ♦
Whether alive at onset of care‡	96.0% ♦
Whether admitted to NNU§	100.0% ♦
Main cause of death	96.8% ♦

Baby's characteristics	Completeness
Birth weight	100.0% ♦
Gestational age at birth	100.0% ♦

† excluding mothers reported as never booked; ‡ this data item is collected for stillbirths only; § this data item is collected for neonatal deaths only.

MBRRACE-UK
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Maternal, Newborn and Infant
Clinical Outcome Review Programme

MBRRACE-UK

Betsi Cadwaladr University Health Board

MBRRACE-UK perinatal mortality report: 2016 births

This report concerns stillbirths and neonatal deaths among the 6,620 babies born within your Health Board in 2016, EXCLUDING births before 24 weeks gestational age and all terminations of pregnancy. Neonatal deaths are reported by place of birth irrespective of where death occurred.

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	28	4.23	3.88 (3.24 to 4.71)	Up to 10% higher
Neonatal	10	1.52	1.25 (0.86 to 1.84)	Up to 10% higher
Extended perinatal	38	5.74	5.12 (4.49 to 6.37)	Up to 10% higher

The crude mortality rate is the observed rate for your Health Board and is a snapshot of mortality for births in 2016. The stabilised & adjusted mortality rate gives a more reliable estimate of the underlying mortality rate taking into account key factors known to increase the risk of stillbirth and neonatal mortality as well as the effects of chance variation, particularly where the number of deaths was small. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Health Board in 2016.

As all of the stabilised & adjusted mortality rates shown here are high compared with similar Trusts and Health Boards (see page 7 for more details), it is important to: a) review the data that was entered locally about your Health Board to ensure it is accurate and complete; and b) review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care implemented.

Important reporting issues

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2016, we received 98% of information on key data items for the deaths which occurred within your Health Board.

Deaths relating to births before 24 weeks gestational age have been reported separately as there is variation across the UK as to whether babies at this gestation are reported as a late fetal loss or a neonatal death which biases mortality rates. Please continue to ensure that all late fetal losses at 22 to 23 weeks gestational age are reported to MBRRACE-UK.

About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford with members from the University of Leicester (who lead the perinatal aspects of the work), University of Liverpool, University of Birmingham, Bradford Institute for Health Research, Sands (Stillbirth and neonatal death charity) and a general practitioner from Oxford.

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Scotland Government Health and Social Care Directorate, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS), the States of Guernsey, the States of Jersey, and the Isle of Man Government.

Introduction

This is the fourth MBRRACE-UK perinatal mortality surveillance report produced for Trusts and Health Boards across the UK. It includes details of the late fetal losses (22^{+0} to 23^{+6} weeks gestational age), stillbirths and neonatal deaths for births that occurred in your Health Board in 2016, as well as background information on all births. Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Methods

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics (ONS), Personal Demographics Service (PDS), National Records of Scotland (NRS), Information Services Division (ISD), Northern Ireland Maternal and Child Health (NIMACH), States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2017.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other local or national reported rates as births before 24 weeks gestational age have been excluded from most tables due to the known poor reporting of such births by some Trusts and Health Boards in previous years. Further details on the methods we have used are available from the MBRRACE-UK website.

Nationally recommended actions

Trusts and Health Boards whose mortality rates are marked ● or ○ should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

Definitions

Late fetal loss:	A baby delivered between 22^{+0} and 23^{+6} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby delivered at or after 24^{+0} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died before 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

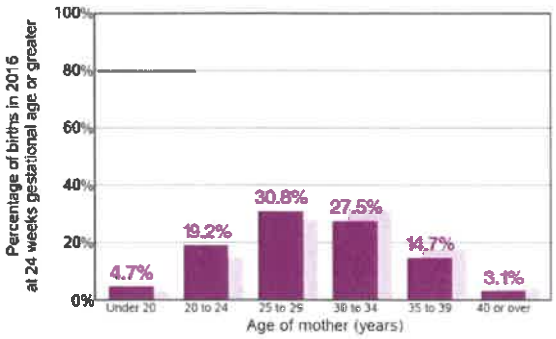
Your births

■ Your Health Board ☐ UK-wide

Age of mother

The proportion of mothers under 25 years of age was considerably higher than that of the UK as a whole: 23.9% versus 18.2%.

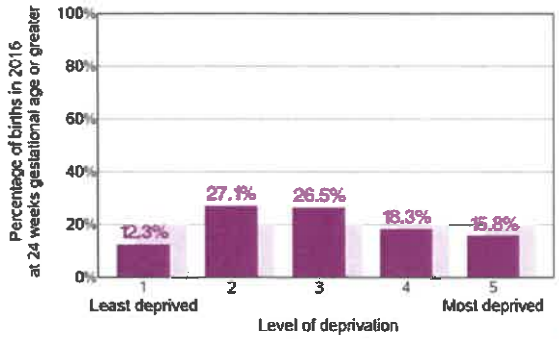
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

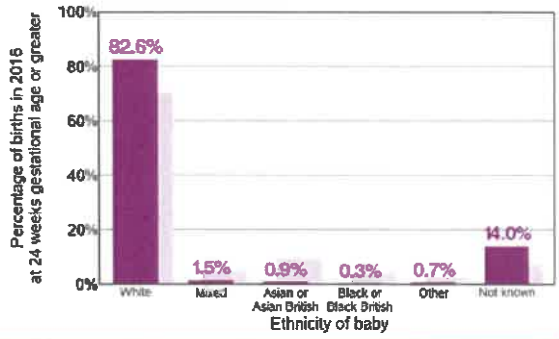
The mothers giving birth in your Health Board lived in areas of similar deprivation to those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 3.4% versus 21.8%.

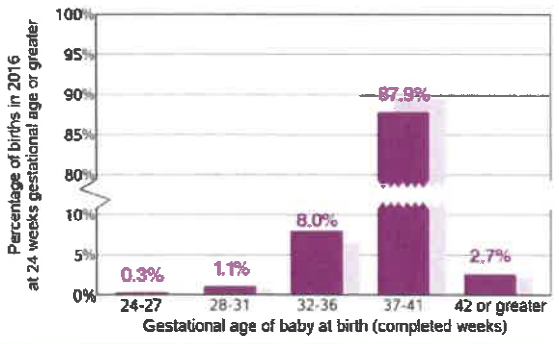
However, for 14.0% of your births the baby's ethnicity was reported as not known. This information is dependent on the accurate coding of babies' ethnicity within the routine reporting of all births.



Gestational age

In your Health Board, 22 babies (0.3%) were born at 24 to 27 weeks gestational age, similar to the 0.4% seen in the UK as a whole. The percentage of babies born at 28 to 31 weeks was also similar to the national average: 1.1% versus 0.9%.

In addition, 175 babies (2.7%) were born post-term (42 weeks or greater), a similar percentage to the UK average of 2.4%.

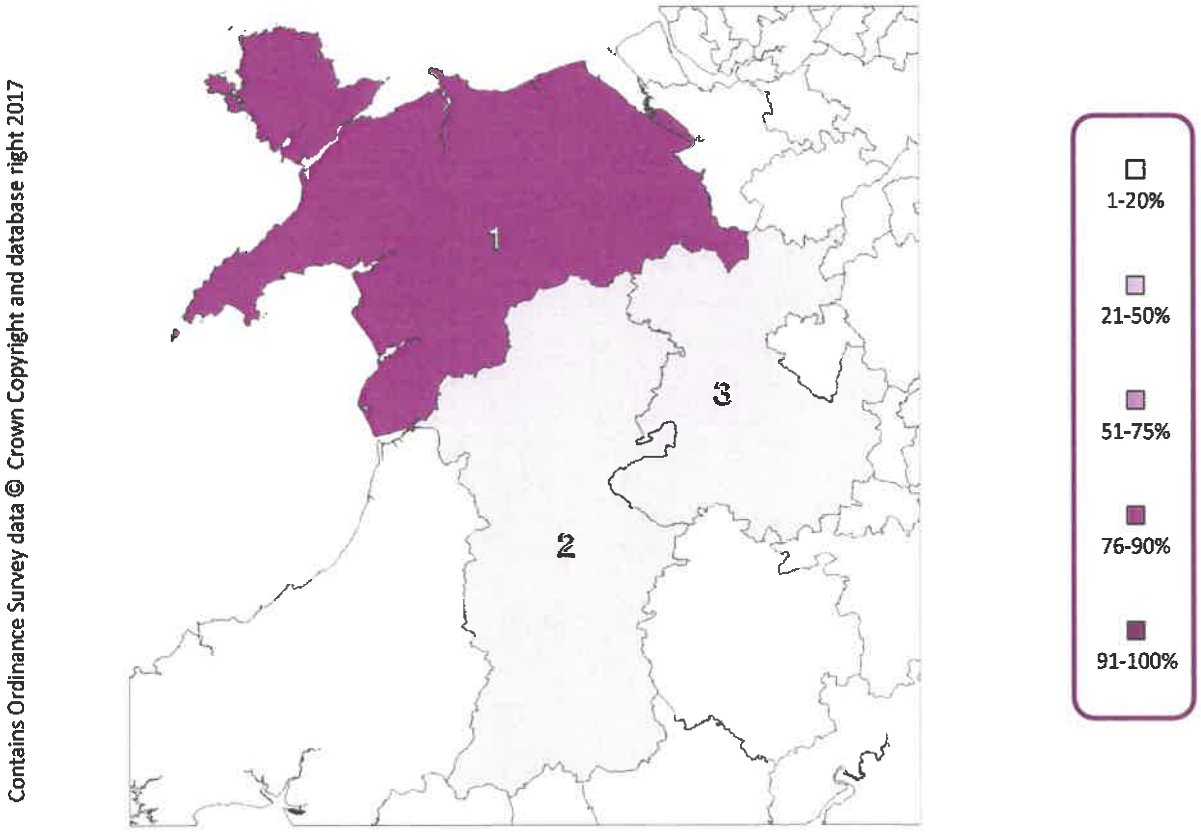


Your births *continued*

Percentage of births taking place in your Health Board by commissioning organisation

The map below shows those commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Health Board. These organisations are Clinical Commissioning Groups (CCGs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

On the map, the area covered by each organisation is shaded according to the percent of their births which occurred within your Health Board. In total, the births from these organisations accounted for 99.1% of your births at 24 weeks gestational age or later in 2016.



The table below provides the percentage and number of births in your Health Board at 24 weeks gestational age or later from each of the commissioning organisations.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. Betsi Cadwaladr University Health Board	88.4% (6193)	2. Powys Teaching Health Board	11.8% (140)
3. NHS Shropshire CCG	7.7% (226)		

Your perinatal deaths

Deaths of babies born within your Health Board

The crude mortality rates reported here are for babies born within your Health Board, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 7 which provide more reliable estimates of the underlying (long-term) mortality rates for your Health Board.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your HB	*Rate (N)*	4.2	(28)	0.0	(0)	0.0	(0)	1.1	(7)	0.5	(3)	5.7	(38)
UK-wide	*Rate*	3.6		0.4		0.2		1.2		0.5		5.9	

The rates of extended perinatal death are shown below for your Health Board by gestational age at delivery. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0}-27^{+6}$		$28^{+0}-31^{+6}$		$32^{+0}-36^{+6}$		$37^{+0}-41^{+6}$		$\geq 42^{+0}$	
Your HB	*Rate (N)*	409.1	(9)	135.1	(10)	13.2	(7)	2.1	(12)	0.0	(0)
UK-wide	*Rate*	346.5		111.1		22.4		2.3		1.4	

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Health Board and for neonatal deaths of babies who were born in your Health Board. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In your Health Board, 78.6% of stillbirths were reported as having an Unknown or Missing cause of death, which is much higher than the UK average. In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.m.

			Infection		Neonatal		Intra-partum		Congenital anomaly		Fetal	
Stillbirths	Your HB	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	3.6%	(1)	3.6%	(1)
	UK-wide	*%*	3.1%		1.4%		5.8%		6.4%		4.6%	
Neonatal Deaths	Your HB	*% (N)*	0.0%	(0)	60.0%	(6)	0.0%	(0)	10.0%	(1)	10.0%	(1)
	UK-wide	*%*	7.3%		44.1%		4.8%		27.9%		4.8%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your HB	*% (N)*	0.0%	(0)	10.7%	(3)	3.6%	(1)	75.0%	(21)	3.6%	(1)
	UK-wide	*%*	4.0%		21.9%		3.5%		46.0%		3.4%	
Neonatal Deaths	Your HB	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	10.0%	(1)	10.0%	(1)
	UK-wide	*%*	0.1%		1.7%		0.3%		5.1%		3.8%	

Your perinatal deaths *continued*

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Health Board and those who were born within your Health Board but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0}-27^{+6}$		$28^{+0}-31^{+6}$		$32^{+0}-36^{+6}$		$37^{+0}-41^{+6}$		$\geq 42^{+0}$	
Within your HB	*% (N)*	80%	(4)	100%	(1)	50%	(1)	100%	(2)		(0)
Outside your HB	*% (N)*	20%	(1)	0%	(0)	50%	(1)	0%	(0)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Health Board and those who were born within your Health Board but died elsewhere.

For births within your Health Board, a post-mortem was offered for 96% of stillbirths and 60% of neonatal deaths, compared with 96% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your HB	*% (n/N)*	96%	(27/28)	75%	(6/8)
Outside your HB	*% (n/N)*			0%	(0/2)
UK-wide	*%*	96%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You are encouraged to update the reported cause of death on the MBRRACE-UK data reporting system once the post-mortem results are known.

		Post-mortem			
		Offered		Consent obtained	
Unknown cause of death	*% (N)*	96%	(22/23)	4%	(1/23)

Babies born at 22 to 23 weeks gestation

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is vital that your Health Board ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Health Board for babies born in 2016 was 3. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

	Deaths at 22^{+0} to 23^{+6} weeks gestational age	
	Late fetal losses	Neonatal deaths
Your HB *N*	3	2

Your perinatal deaths *continued*

Comparisons with similar Trusts, Health Boards and the UK average

The mortality rates are reported for babies born within your Health Board at 24 weeks gestational age or later, excluding terminations of pregnancy. A 'crude' rate and a 'stabilised & adjusted' rate are presented for stillbirths, neonatal deaths and extended perinatal deaths. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2016. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies.

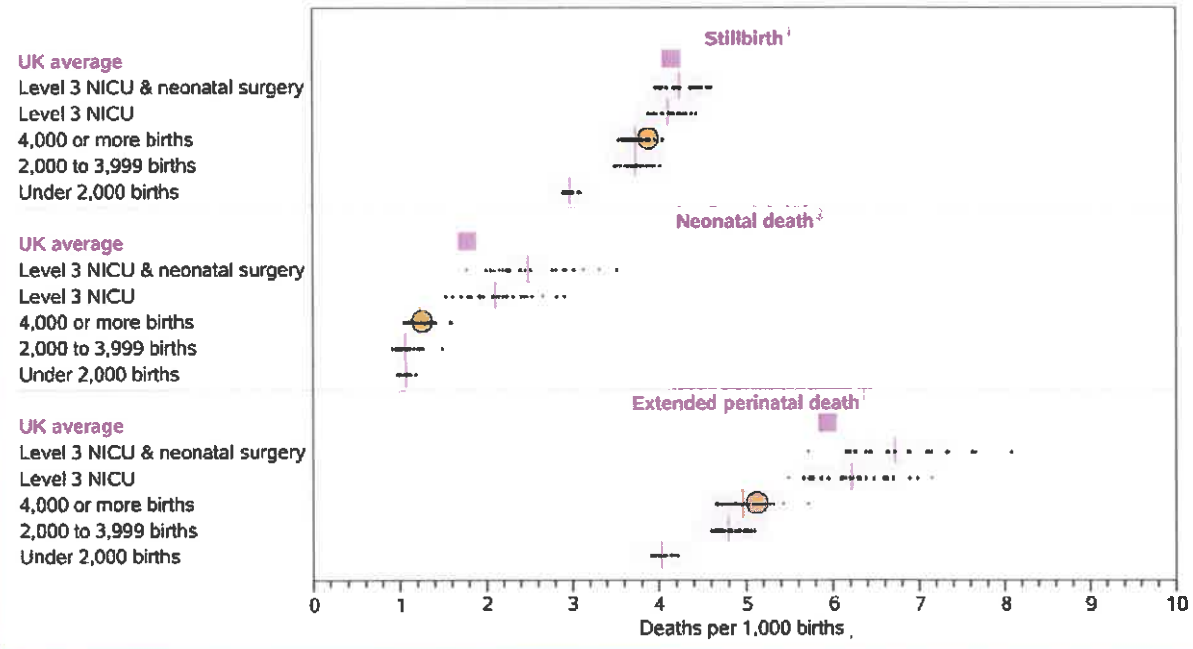
The **stabilised & adjusted mortality rate** is also reported which provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. In addition, to account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision (units routinely accepting for birth babies with a known congenital anomaly likely to require surgery in the neonatal period); (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later. Your Health Board has been included in the comparator group with 4,000 or more births per annum.

	Mortality rate per 1,000 births [§] (95% confidence interval)		
	Stillbirth [†]	Neonatal [‡]	Extended perinatal [†]
Crude	4.23	1.52	5.74
Stabilised & adjusted [◊]	3.88 (3.24 to 4.71)	1.25 (0.86 to 1.84)	5.12 (4.49 to 6.37)

[§] excluding terminations of pregnancy and births <24[+0]; [†] per 1,000 total births; [‡] per 1,000 live births.

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a circle:

- more than 10% lower than the average for the group
- up to 10% lower than the average for the group
- up to 10% higher than the average for the group
- more than 10% higher than the average for the group

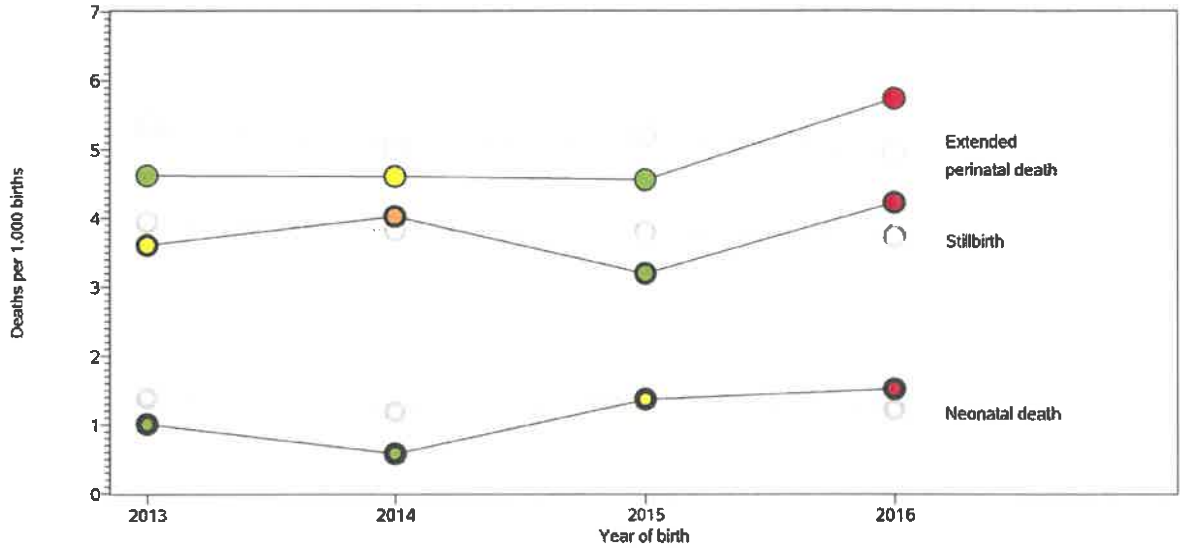


Mortality rates over time

Crude mortality by year of birth

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

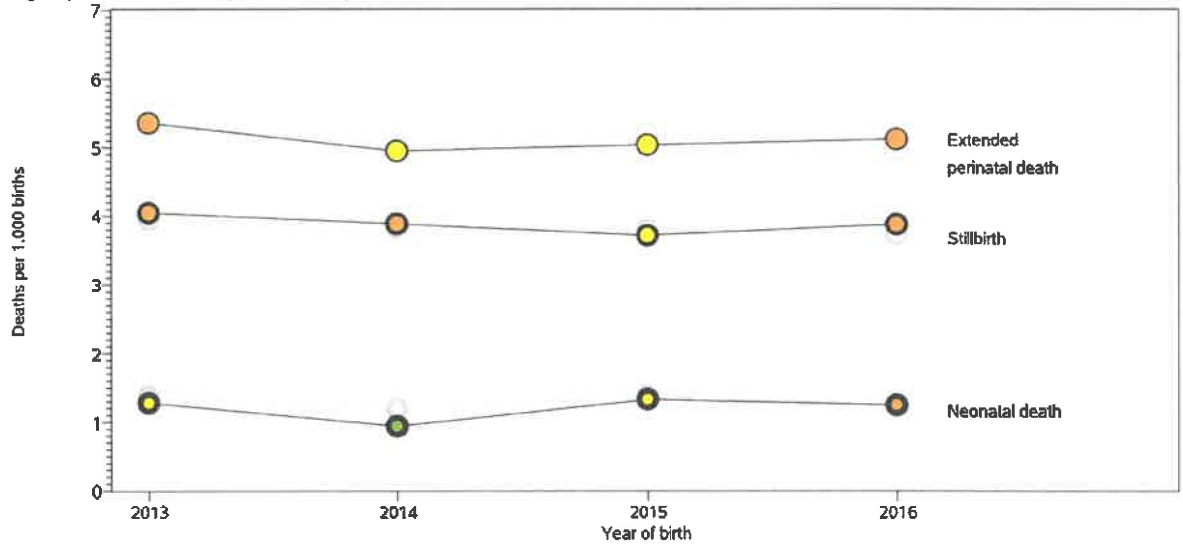
Due to updates to the data, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Data reporting

Completeness of key data items for DEATHS AT YOUR HEALTH BOARD

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Health Board, these tables show the overall completeness of data for **deaths at your Health Board no matter where they were born.** The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- less than 70.0% complete
- 70.0% to 84.9% complete
- 85.0% to 96.9% complete
- 97.0% to 99.9% complete
- 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Health Board. For those items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.

Mother's details	Completeness
Name	100.0%
Postcode of residence	100.0%
Ethnicity	100.0%
Age	100.0%

Birth	Completeness
Type of onset of labour	100.0%
Actual place of birth	100.0%
Date and time of birth	100.0%
Final mode of birth	100.0%

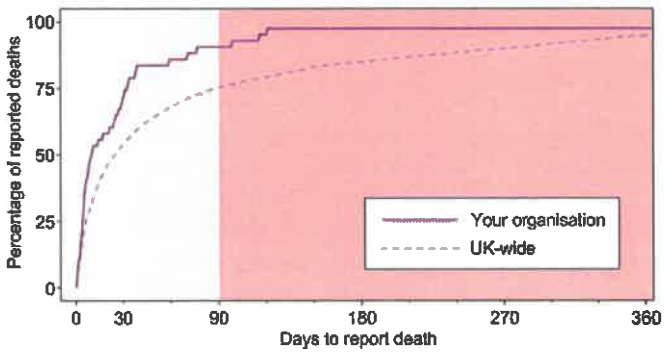
Booking and antenatal care†	Completeness
Smoking	94.1%
Body mass index	100.0%
Intended type of care at booking	97.0%
Estimated date of delivery	88.2%

Baby's outcome	Completeness
Date death confirmed‡	100.0%
Whether alive at onset of care‡	100.0%
Whether admitted to NNU§	100.0%
Main cause of death	94.1%

Baby's characteristics	Completeness
Birth weight	100.0%
Gestational age at birth	100.0%

† excluding mothers reported as never booked; ‡ this data item is collected for stillbirths only; § this data item is collected for neonatal deaths only.

Timing of reporting against 30 and 90 day benchmarks



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Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Saving Lives, Improving Mothers' Care

Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16

November 2018

HQIP Healthcare Quality Improvement Partnership
University of Leicester
TIMMS
University of Birmingham
Sands stillbirth & neonatal death charity
NHS Bradford Teaching Hospitals NHS Foundation Trust
NPEU
University of Oxford

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Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16

Marian Knight, Kathryn Bunch, Derek Tuffnell, Hemali Jayakody, Judy Shakespeare, Rohit Kotnis, Sara Kenyon, Jennifer J Kurinczuk (Eds.)

November 2018

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Funding

The Maternal, Newborn and Infant Clinical Outcome Review Programme, delivered by MBRRACE-UK, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as one of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP's aim is to promote quality improvement and is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. The Maternal, Newborn and Infant Clinical Outcome Review Programme is funded by NHS England, NHS Wales, the Health and Social Care division of the Scottish government, The Northern Ireland Department of Health, the States of Jersey, Guernsey, and the Isle of Man.

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Individual chapters from this report should be cited using the format of the following example for chapter 4:

Tuffnell D, Knight M and Mackillop L on behalf of the MBRRACE-UK VTE chapter-writing group. Lessons for prevention and treatment of thrombosis and thromboembolism. In Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018: p34-41.

Foreword

Since the first of the maternal confidential enquiry reports produced by the MBRRACE-UK collaboration, user and support groups have been involved in producing a lay summary of the report results. Whilst drafting the lay summary of report this year, we were struck by three important messages for health professionals and policy makers that were apparent from the case reviews covering both physical and mental health:

Firstly, it is essential for doctors, midwives and allied health professionals to challenge assumptions, both their own and those of others. This includes an assumption that symptoms relate to normal pregnancy even where they are concerning and persistent, hence leading to delay in diagnosis, or an assumption that some women have simply too many or complex problems to be helped, or a default assumption that stopping medication is appropriate in pregnancy without considering the benefits and risks to the mother.

Secondly, we could quite clearly see the value of continuity of care and shared record keeping, particularly that provided by midwives and GPs - ensuring women are able to be heard and develop trusting and supportive relationships with health professionals to disclose and discuss their concerns, enabling women to receive the right specialist care with appropriate communication between different hospital and community services, and rapid referral when it is needed.

Thirdly, it was very evident that there needs to be a major emphasis on training for non-specialists in the management of pregnant and postpartum women - whether this be training for liaison, crisis and home treatment mental health teams on the specific features of perinatal mental illness, or medical and surgical teams on treatment of pregnant women with comorbidities.

It is striking that there are two areas where we seem to be making little impact. Research is urgently needed to understand why black women are five times more likely and Asian women twice as likely to die compared to white women. More research is needed to understand the specific causes of the deaths of women from these ethnic groups. Yet again in this report it has been noted that maternal mortality is increasingly a problem for women with multiple vulnerabilities. Specifically, it highlights yet again that a number of women died by suicide after a pregnancy or postnatal loss, or after removal of their infant into care. For some women, pre-existing mental health conditions were exacerbated when their child was removed, and it is essential that care for the mother increases rather than decreases in these circumstances. On too many occasions the mother was forgotten once services were appropriately reassured that her child was safe.

Each of our organisations values the ability to contribute to developing the lay summary and associated infographics. The key messages are used not only to help empower and inform women and families, but as a focus for dissemination activities and to open conversations with policy makers and politicians to drive further improvements in care. We urge all readers to do the same with this main report.

Nancy Keen
AIMS

Sarah McMullen
NCT

Karen Middleton
Maternal Mental Health Alliance

Maureen Treadwell
Birth Trauma Association

Pete Wallroth
Mummy's Star

Liz Thomas
Action against Medical Accidents (AvMA)

Key messages from the report 2018

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

In 2014-16 **9.8** women per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

Most women who died had multiple health problems or other vulnerabilities.

Balancing choices:

Always consider individual benefits and risks when making decisions about pregnancy

Things to think about:

Many medicines are safe during pregnancy

Continuing medication or preventing illness with vaccination may be the best way to keep both mother and baby healthy - ask a specialist

Be body aware - some symptoms are normal in pregnancy but know the red flags and always seek specialist advice if symptoms persist

Black and Asian women have a higher risk of dying in pregnancy

White women		8/100,000
Asian women	2x	15/100,000
Black women	5x	40/100,000

Older women are at greater risk of dying

Aged 20-24		7/100,000
Aged 35-39	2x	14/100,000
Aged 40 or over	3x	22/100,000

Overweight or obese women are at higher risk of blood clots including in early pregnancy

Executive Summary

Introduction

This report, the fifth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2014 and 2016 in the UK. In addition, it also includes Confidential Enquiries into the care of women who died between 2014 and 2016 in the UK and Ireland from mental health conditions, thrombosis and thromboembolism, malignancy and homicide, as well as morbidity Confidential Enquiries into the care of women with major obstetric haemorrhage.

Surveillance information is included for 545 women who died during or up to one year after the end of pregnancy between 2014 and 2016. The care of 247 women who died and 34 with severe morbidity from major obstetric haemorrhage was reviewed in depth for the Confidential Enquiry chapters.

Methods

Maternal deaths are reported to MBRRACE-UK, NIMACH or to MDE Ireland by the staff caring for the women concerned, or through other sources including coroners, procurators fiscal and media reports. In addition, identification of deaths is cross-checked with records from the Office for National Statistics and National Records of Scotland. Full medical records are obtained for all women who die as well as those identified for the Confidential Enquiry into Maternal Morbidity, and anonymised prior to undergoing confidential review. The anonymous records are reviewed by a pathologist, together with an obstetrician or physician as required to establish a woman's cause of death. The care of each woman is then assessed by one or two obstetricians, midwives, pathologists, anaesthetists and other specialist assessors as required, including psychiatrists, general practitioners, physicians, emergency medicine specialists and intensive care experts. Each woman's care is thus examined by between ten and fifteen expert reviewers. Subsequently the expert reviews of each woman's care are examined by a multidisciplinary writing group to enable the main themes for learning to be drawn out for the MBRRACE-UK report. These recommendations for future care are presented here, alongside a surveillance chapter reporting three years of UK statistical surveillance data.

Causes and trends

There was statistically non-significant increase in the overall maternal death rate in the UK between 2011–13 and 2014-16, which suggests that implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths. Assessors judged that 28% of women who died and 12% of women surviving with major obstetric haemorrhage had good care. However, improvements in care may have made a difference to the outcome for 38% of women who died and 74% of women with major obstetric haemorrhage who survived. **ACTION: Policy makers, service planners/commissioners, service managers, all health professionals.**

Maternal deaths from direct causes are unchanged with no significant change in the rates between 2011–13 and 2014–16. Thrombosis and thromboembolism remain the leading cause of direct maternal death during or up to six weeks after the end of pregnancy.

Maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy. However, it remains the leading cause of direct deaths occurring within a year after the end of pregnancy, with a mortality rate of 2.8 per 100,000 maternities (95% CI 2.2-3.5).

Key areas for action

Improving overall care

There is a five-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared to white women. Action is needed to address these disparities. **ACTION: Policy makers, service planners/ commissioners, service managers, all health professionals.**

There is an urgent need to establish pathways for release of mental health records with the Chief Medical Officers and Departments of Health of Ireland and the four UK nations to MBRRACE-UK. **ACTION: Policy makers.**

There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy. **ACTION: Policy makers, professional organisations.**

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant. **ACTION: Professional organisations, all health professionals.**

Improving care of women with haemorrhage

Women who have had a previous caesarean section who also have either placenta praevia or an anterior placenta underlying the old caesarean section scar at 32 weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations for surgery made. **ACTION: Service planners/commissioners, service managers, health professionals.**

Any woman with suspected placenta praevia accreta should be reviewed by a consultant obstetrician and consultant anaesthetist in the antenatal period. The different risks and treatment options should have been discussed and a plan agreed. The plan should always be followed especially in the event of an emergency delivery. **ACTION: Service planners/commissioners, service managers, health professionals.**

Any woman going to theatre electively with suspected placenta praevia accreta should be attended by a consultant obstetrician and anaesthetist. If the delivery is unexpected, out-of-hours consultant obstetric and anaesthetic staff should be alerted and attend as soon as possible. **ACTION: Service managers, health professionals.**

Young women are vulnerable to pressure sores and care should be taken of pressure points in the obstetric population as well as other populations. **ACTION: Service managers, health professionals.**

Improving prevention and treatment of thrombosis and thromboembolism

There is clear evidence that doctors and midwives find existing scoring systems for thromboembolic risk difficult to apply in practice. There is a need for development of a tool to make the current risk assessment system simpler and more reproducible. **ACTION: Professional organisations, service planners/commissioners, service managers, health professionals.**

If women need thromboprophylaxis as soon as they become pregnant there should be clear pathways for them to access prescriptions and support to ensure compliance. **ACTION: Service planners/ commissioners, service managers, health professionals.**

Women with a high BMI should be given information about the symptoms of VTE. **ACTION: Service planners/commissioners, service managers, health professionals.**

All women should undergo a documented assessment of risk factors for venous thromboembolism in early pregnancy or pre-pregnancy. Risk assessment should be repeated if the woman is admitted to hospital for any reason or develops other intercurrent problems. Risk assessment should be repeated again intrapartum or immediately postpartum. **ACTION: Service managers, health professionals.**

Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth. **ACTION: Service managers, health professionals.**

Improving care of women with mental health problems

Liaison, crisis and home treatment staff should have specific training, at induction and continuing professional development, in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out-of-hours care for pregnant and postnatal women. Formal links should be made with local specialist perinatal mental health services to facilitate training. **ACTION: Service planners/commissioners, service managers, health professionals.**

Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lowered thresholds and direct access for maternity and primary care professionals. **ACTION: Service planners/commissioners, service managers, health professionals.**

Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour. **ACTION: Service managers, health professionals.**

Women should receive continuity of mental health care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care. **ACTION: Service planners/commissioners, service managers, health professionals.**

In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination. **ACTION: Service managers, health professionals.**

New expressions or acts of violent self-harm, or new and persistent expressions of incompetency as a mother or estrangement from the infant are 'red flag' symptoms and should always be regarded seriously. **ACTION: Health professionals.**

Improving care of women from vulnerable groups

Healthcare professionals need to be alert to the symptoms or signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure. **ACTION: Health professionals.**

Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse. This is even more important with increasing use of electronic records to ensure all agencies involved in a woman's care are aware of her risk of domestic abuse. This would be further facilitated by support for the intra-operability of systems to support information sharing through electronic records. **ACTION: Service planners/commissioners, service managers, health professionals, police and safeguarding (social care) professionals.**

Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues. **ACTION: Service planners/commissioners, service managers, health professionals.**

The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange. **ACTION: Service planners/commissioners, service managers, health professionals.**

Improving care of women with malignancy

Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause. **ACTION: Health professionals.**

If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same timescale as for a non-pregnant woman, but with caution when there is evidence of specific risks to the fetus. In such instances, a discussion of potential risks and benefits with the woman should be used to determine the most appropriate pathway of investigation. **ACTION: Service planners/commissioners, service managers, health professionals.**

For women with cancer, advice on postponement of pregnancy should be individualised and based on treatment needs and prognosis over time. Most women with breast cancer should wait at least two years after treatment, which is when the risk of breast cancer recurrence is highest. **ACTION: Service planners/ commissioners, service managers, health professionals.**

Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum. **ACTION: Health professionals.**

Pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team. **ACTION: Service managers, health professionals.**

All pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered, particularly, but not only hereditary non-polyposis colorectal cancer, with appropriate investigations, including tumour testing, performed and family testing offered as appropriate. **ACTION: Service planners/commissioners, service managers, health professionals.**

Conclusions

The themes of 'too much, too soon' and 'too little too late' were highlighted in the 2016 Lancet series on maternal health as the extremes of maternity care at which we need to focus to improve maternal health globally. These themes provide a useful framework to illuminate the messages to improve care identified in this report. We see a need for earlier pro-active care of women with mental health problems, particularly thinking about the benefits that could be obtained by early identification of risk and putting in place postnatal review and monitoring strategies to allow early detection and treatment of potential relapse. There is very clear evidence of that the care of vulnerable women, particularly those who misuse drugs and alcohol, and in prevention of thromboembolism can be improved. The review of the care of women who survived severe haemorrhage reflects a need for earlier recognition that a woman is bleeding. The almost five-fold higher mortality rate amongst black women compared with white women requires urgent explanation and hence development of actions to address this. There is a clear place for engaging further with third sector organisations to address advocacy and support needs for ethnic minority women as well as further research on the underlying causes of disparity.

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Glossary of terms

AFE	Amniotic Fluid Embolism
AIP	Abnormally Invasive Placenta
ALSO	Advanced Life Support in Obstetrics
BMI	Body mass index
BP	Blood pressure
CEMD	Confidential Enquiries into Maternal Deaths
CEMM	Confidential Enquiries into Maternal Morbidity
CI	Confidence interval
CMACE	Centre for Maternal and Child Enquiries
CPAP	Continuous positive airway pressure
CPN	Community psychiatric nurse
CRHT	Crisis resolution and home treatment
CT	Computerised Tomography
CTPA	Computerised tomography pulmonary angiogram
DIC	Disseminated intravascular coagulation
DNA	Deoxyribonucleic acid
DVT	Deep venous thrombosis
ECMO	Extracorporeal membrane oxygenation
ECT	Electroconvulsive therapy
EWS	Early warning scores
FAST	Focussed Assessment with Sonography in Trauma
GCS	Glasgow Coma Score
GP	General practitioner
HELLP	Haemolysis, Elevated Liver enzymes, Low Platelet count
HES	Hospital Episode Statistics
HQIP	Healthcare Quality Improvement Partnership
HSE	Health Service Executive
ICD	International Classification of Diseases
ICD-MM	International Classification of Diseases – Maternal Mortality
IHP+	Health Partnership and related initiatives
IMD	Index of Multiple Deprivation
IOL	Induction Of Labour
IVF	In vitro fertilisation
LMWH	Low molecular weight heparin
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MBU	Mother and Baby Unit
MDE	Maternal Death Enquiry
MEmO	Medical Emergencies in Obstetrics
MEOWS	Modified Early Obstetric Warning Score
MMR	Maternal mortality ratio
mMOET	Managing Medical and Obstetric Emergencies and Trauma
MNI-CORP	Maternal Newborn and Infant Clinical Outcome Review Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIMACH	Northern Ireland Maternal and Child Health
NMPA	National Maternal and Perinatal Audit
PE	Pulmonary embolism
PMCT	Post mortem Computerised Tomography
PPH	Postpartum Haemorrhage
PVA	Polyvinyl alcohol

Key to colour coding

Vignettes concerning the care of women who died are described in blue boxes

Vignettes concerning the care of women who had severe morbidity but survived are described in purple boxes

Recommendations are presented in green boxes.

The majority of recommendations arise from existing national guidelines or previous reports and these are cited alongside the recommendation. Where no citation is given, the recommendation is based on improvements in care noted by MBRRACE reviewers for which there is no current national guidance. The recommendations identified by MBRRACE reviewers as the most frequently needed improvements are highlighted in the key messages section at the start of each chapter. The specific individuals or professional groups who need to take action are indicated alongside the key messages, where appropriate.

Contents

1. Introduction and methodology

Marian Knight

1.1 The 2018 Saving Lives, Improving Mothers' Care report

The 2016 Lancet series on maternal health (The Lancet Maternal Health Series study group 2016) highlighted the themes of 'too much, too soon' and 'too little too late' representing the extremes of maternity care on which we need to focus to improve maternal health globally. It is striking that both are themes which could be applied to the messages identified in this report. We see a need for pro-active care of women with mental health problems, particularly thinking about the benefits that could be derived by early identification of risk and putting in place postnatal review and monitoring strategies to allow early detection and treatment of potential relapse. We should be mindful of 'too little, too late' in the care of vulnerable women, particularly those who misuse drugs and alcohol; on several occasions healthcare staff were unable to see beyond the women's substance misuse problems to identify additional underlying illness.

The theme is also reflected amongst the messages for prevention of thrombosis and thromboembolism. Whilst in both the UK and Ireland we have very detailed guidelines about assessment of women's risk and prescription of thromboprophylaxis at different stages of pregnancy and the postpartum period (Royal College of Obstetricians and Gynaecologists 2015a, Royal College of Obstetricians and Gynaecologists 2015b, Institute of Obstetricians and Gynaecologists Royal College of Physicians of Ireland, HSE Clinical Care Programme in Obstetrics and Gynaecology et al. 2016), there is confusion around their application. The guidelines are clearly being interpreted variably in different hospitals and by different clinicians, with the result that women are not necessarily getting the thromboprophylaxis they need, or for too short a time (too little) or after a delay (too late). The challenge remains of how to ensure women with risk factors very early in pregnancy can access thromboprophylaxis; a substantial proportion of deaths from thromboembolism continue to occur in the first trimester before women have accessed either their GP or maternity care. This emphasises the importance of ongoing public health interventions to address risk factors such as obesity and smoking, and further consideration of the impact of rising maternal age.

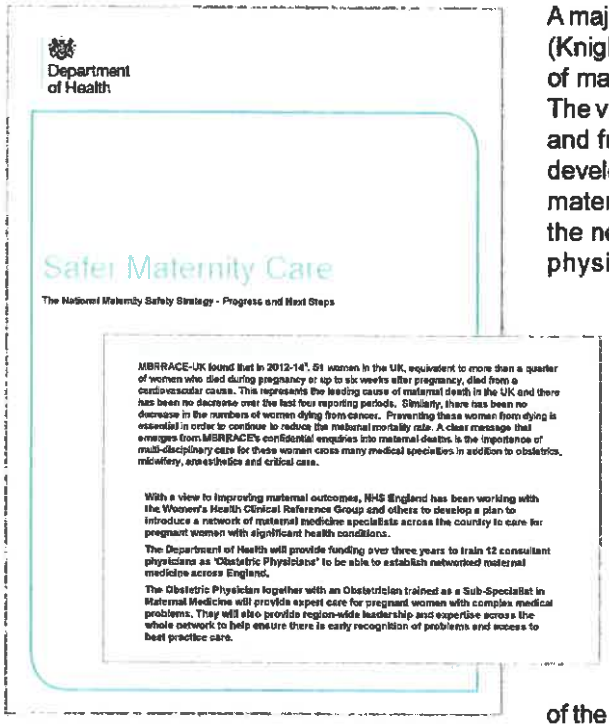
It is encouraging, however, that 'too little, too late' in the care of women with malignancy was a much less prominent theme in this report compared with the 2015 report (Knight, Tuffnell et al. 2015); there was evidence that women received appropriate treatment, particularly chemotherapy, and it was not being delayed simply because women were pregnant or postpartum.

'Too much, too soon' is, in contrast, theme worth when considering in the context of severe maternal haemorrhage. This report includes a confidential enquiry into the care of women with major obstetric haemorrhage, all of whom survived. The majority of the women reviewed had haemorrhage in relation to a complication of caesarean section, either because of abnormally invasive placentation, linked to a previous caesarean birth, or because of complicated angle tears which occurred at caesarean section undertaken in the late stages of labour. Excessive treatment was evident in some of the other causes of haemorrhage, for example several women had haemorrhage following uterine hyperstimulation. Additional evidence of 'too much, too soon' was seen when examining fluid replacement during and after haemorrhage; over-replacement with crystalloids led to the development of pulmonary oedema in several women. However, treatment delay was more evident in these women's care. On many occasions the fact that women were bleeding was not recognised, often due to concealed bleeding which was apparent from deteriorating vital signs but these were missed, indicating an ongoing need to improve identification of deterioration through physiological measures. Perhaps most concerning is the fact that young, previously healthy women are left with pressure sores after management of their haemorrhage due to lack of consideration of the need to manage pressure points.

Once again the Enquiry did not identify any disparity in maternal mortality rates between women born in the UK and those born in other countries, which is an encouraging reflection of universal health care free at the point of access. However, there still remains a large disparity between the maternal mortality rate of women of white ethnicity compared to women from black and Asian ethnic groups. The almost five-fold higher mortality rate amongst black women compared with white women requires urgent explanation and action. Previous research has suggested that this inequality of outcome may be partly explained by gestational diabetes during their current pregnancy, medical comorbidities, previous pregnancy problems and inadequate use of antenatal care, all of which could provide an initial focus for action to reduce this

inequality (Nair, Knight et al. 2016). Nevertheless there is a clear place for engaging further with third sector organisations to address advocacy and support needs for ethnic minority women as well as further research on the underlying causes of these disparities.

1.2 Actions following the release of the 2014-2017 reports


Department of Health

Safer Maternity Care

The National Maternity Safety Strategy - Progress and Next Steps

MBRRACE-UK found that in 2012-14*, 91 women in the UK, equivalent to more than a quarter of women who died during pregnancy or up to six weeks after pregnancy, died from a cardiovascular cause. This represents the leading cause of maternal death in the UK and there has been no decrease over the last four reporting periods. Similarly, there has been no decrease in the numbers of women dying from cancer. Preventing these women from dying is essential in order to continue to reduce the maternal mortality rate. A clear message that emerges from MBRRACE's confidential enquiries into maternal deaths is the importance of multi-disciplinary care for these women cross many medical specialties in addition to obstetrics, midwifery, anaesthetics and critical care.

With a view to improving maternal outcomes, NHS England has been working with the Women's Health Clinical Reference Group and others to develop a plan to introduce a network of maternal medicine specialists across the country to care for pregnant women with significant health conditions.

The Department of Health will provide funding over three years to train 12 consultant physicians as 'Obstetric Physicians' to be able to establish networked maternal medicine across England.

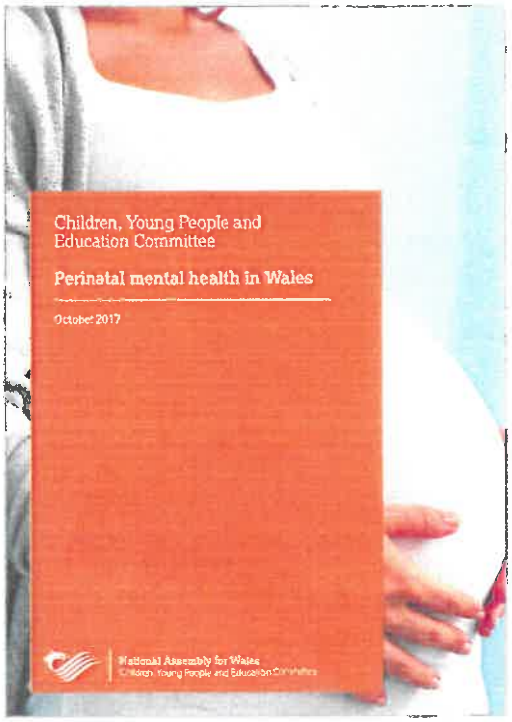
The Obstetric Physician together with an Obstetrician trained as a Sub-Specialist in Maternal Medicine will provide expert care for pregnant women with complex medical problems. They will also provide region-wide leadership and expertise across the whole network to help ensure there is early recognition of problems and access to best practice care.

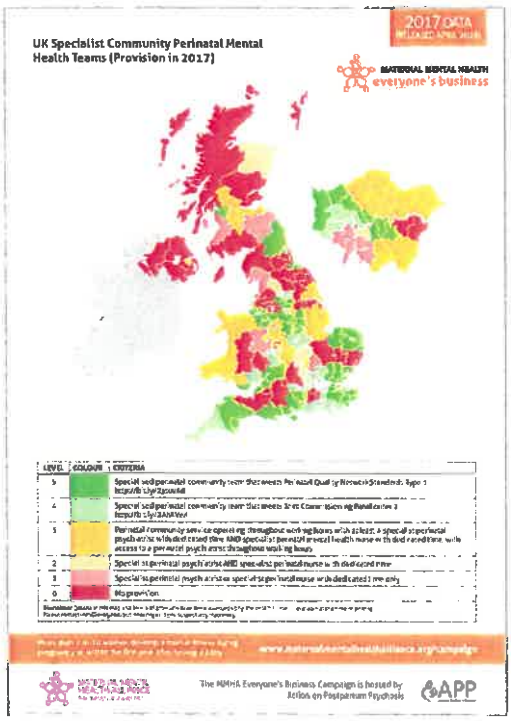
A major announcement in England made after the 2017 report (Knight, Nair et al. 2017) went to press was the introduction of maternal medicine networks (Department of Health 2017). The vision to develop 12 regional maternal medicine networks, and funding to train the required medical professionals was developed directly on the basis of recommendations from the maternal Enquiry reports. Alongside the announcement of the networks, funding was announced to train 12 consultant physicians as obstetric physicians to work alongside obstetricians specialising in maternal medicine to deliver the essential multi-disciplinary care needed to begin to address the improvements in care needed for pregnant and postpartum women with medical co-morbidities.

Linked to the need to improve care for women with pre-existing or new onset medical conditions, and the increasing recognition of 'human factors' underlying many maternal deaths, an evaluation of a new multi-disciplinary simulation-based training programme designed to address Medical Emergencies in Obstetrics (MEmO) (Lavelle, Abthorpe et al. 2018), specifically designed to address the recommendations of the 2014 report (Knight, Kenyon et al. 2014), showed that the training improved the participants' management of medical deterioration in pregnancy as well as their awareness of human factors. In a similar development, the Managing Medical and Obstetric Emergencies and Trauma (mMOET) course has been renamed to highlight the need to address medical emergencies together with the trauma components of the course (Advanced Life Support Group 2016).

In November 2017 the Health Service Executive in the Republic of Ireland launched a new model of care for perinatal mental health services, including for the first time plans for an inpatient mother and baby unit, a facility not previously available to women in Ireland (Health Service Executive 2017). The new planned service includes specialist perinatal mental health services aligned with maternity networks across the whole country. The importance of access to specialist perinatal mental health services for women for both prevention and treatment of mental health problems in pregnancy and the postpartum period has repeatedly been highlighted in these reports (Knight, Tuffnell et al. 2015, Knight, Nair et al. 2017), and is reiterated once again in chapter 5.

The Scottish Government also committed to funding the introduction of a Managed Clinical Network to improve the recognition and treatment of perinatal mental health problems in its 2017 Mental Health Strategy (The Scottish Government 2017).





In response to a report from the National Assembly for Wales (Children Young People and Education Committee 2017), the Welsh Government has also agreed to further support the development of perinatal mental health services in Wales, in particular recognising the need for a new Mother and Baby Unit in southern Wales (Gething 2018). Alongside these reports, the Maternal Mental Health Alliance has updated its mapping exercise, which shows that gaps still exist in the provision of perinatal mental health services with more action still needed (Maternal Mental Health Alliance 2017). Other reviews have highlighted the need for an inpatient mother and baby unit in Northern Ireland (The Regulation and Quality Improvement Authority 2017). The Perinatal Mental Health Care Pathway for Northern Ireland was revised in July 2017.

1.3 Topics covered in MBRRACE-UK maternal reports 2014-18

The programme now requires the production of annual CEMD reports. Reports were previously produced on a triennial basis, because the number of maternal deaths from individual causes is small, and three years' worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality. Clearly the need to undertake annual reporting does not change this requirement, therefore, each topic-specific chapter which appeared in the previous triennial report now

appears in an annual report once every three years on a cyclical basis, alongside a surveillance chapter reporting three years of statistical data. All causes of maternal death have now been covered once in this three-year cycle; this report is the second of the next three-year cycle:

- **2014 report:** Surveillance data on maternal deaths from 2009-12. Confidential Enquiry reports on severe morbidity and deaths from sepsis, deaths from haemorrhage, amniotic fluid embolism (AFE), anaesthesia, neurological, respiratory, endocrine and other indirect causes.
- **2015 report:** Surveillance data on maternal deaths from 2011-13. Confidential Enquiry reports on deaths from psychiatric causes, deaths due to thrombosis and thromboembolism, malignancy, homicides and late deaths.
- **2016 report:** Surveillance data on maternal deaths from 2012-14. Confidential Enquiry reports on deaths and severe morbidity from cardiac causes, deaths from pre-eclampsia and eclampsia and related causes and deaths in early pregnancy, messages for critical care.
- **2017 report:** Surveillance data on maternal deaths from 2013-15. Confidential Enquiry reports on severe morbidity from psychosis, severe morbidity and deaths from epilepsy, deaths from haemorrhage, amniotic fluid embolism (AFE), anaesthesia, stroke, respiratory, endocrine and other indirect causes.
- **2018 (this report):** Surveillance data on maternal deaths from 2014-16. Confidential Enquiry reports on deaths from psychiatric causes, deaths due to thrombosis and thromboembolism, malignancy and homicides, and morbidity from major obstetric haemorrhage.

Alongside the confidential enquiries into maternal deaths we also conduct enquiries into maternal morbidity topics, which can be proposed by anyone. Proposals for topics are accepted annually between October and December. Further details are available at *https://www.npeu.ox.ac.uk/mbrrace-uk/topics*

1.4 The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity Methods

Maternal Deaths

The methods for the Confidential Enquiry into maternal deaths remain unchanged, and readers are therefore referred to the 2016 report (Knight, Nair et al. 2016) for a full description of the methods (*https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf*).

1.4.1 Maternal Morbidity

Women are identified for the Confidential Enquiries into Maternal Morbidity in different ways according to the topic. The women with major obstetric haemorrhage were identified from an existing UKOSS study of massive transfusion in major obstetric haemorrhage, which identified women fulfilling the criteria in Box 1.1 between July 2012 and June 2013 (Green, Knight et al. 2016).

Box 1.1: Case definition used in the UKOSS massive transfusion for major obstetric haemorrhage study

Any pregnant woman of 20 weeks gestation or more identified as having 8 or more units of RBC transfusion (excluding cell salvage) within a 24 hour period.

All surviving women notified nationally were used as the sampling frame. A geographically representative sample of 40 women was drawn at random from this group. A full set of medical records was requested from each hospital concerned. The records then underwent expert assessment in exactly the same way as the records of the women who died. Consent was requested from women in Northern Ireland to participate, since legislation does not exist to allow inclusion of their data without consent. Hospitals provided only 34 of 40 requested sets of records; the care of these 34 women is described in Chapter 3.

2. Maternal Mortality in the UK 2014–16: Surveillance and Epidemiology

Kathryn Bunch and Marian Knight

2.1 Key points

There was a statistically non-significant increase in the overall maternal death rate in the UK between 2011-13 and 2014-16, which suggests that implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths. **ACTION: Policy makers, service planners/ commissioners, service managers, all health professionals.**

There is a five-fold difference in maternal mortality rates amongst women from black ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared to white women. Action is needed to address these disparities. **ACTION: Policy makers, service planners/ commissioners, service managers, all health professionals.**

Maternal deaths from direct causes are unchanged with no significant change in the rates between 2011-13 and 2014-16. Thrombosis and thromboembolism remain the leading cause of direct maternal death during or up to six weeks after the end of pregnancy.

Maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy. However, it remains the leading cause of direct deaths occurring within a year after the end of pregnancy.

For almost one fifth of women who died in 2016, there was no evidence they had been asked about a history of mental health problems. Eliciting any relevant history is essential to ensure appropriate pro-active management of risk of mental health problems. **ACTION: All health professionals.**

2.2 Causes and trends

Overall, 259 women died in 2014-16 during or within 42 days of the end of pregnancy in the UK. The deaths of 34 women were classified as coincidental. Thus in this triennium 225 women died from direct and indirect causes, classified using ICD-MM (World Health Organisation 2012), among 2,301,628 maternities, a maternal death rate of 9.78 per 100,000 maternities (95% CI 8.54 – 11.14). This compares to the rate of 8.76 per 100,000 maternities (95% CI 7.59 – 10.05) in 2013-15. As in previous MBRRACE-UK maternal reports, information on deaths from the Republic of Ireland is not included in this chapter and therefore rates and numbers presented here are comparable with all previous UK reports.

Table 2.1 and Figure 2.1 show rolling three-yearly maternal death rates since 2003 using ICD-MM. There remains an overall decrease in maternal death rates between 2003-05 and 2014-16 (rate ratio (RR) 0.70, 95% CI 0.59-0.84; p=0.002 for trend in rolling rates over time). The direct maternal death rate has decreased by 37% since 2003-05 with a RR of 0.63 (95% CI 0.48-0.82, p=0.009) and there was a 23% decrease in the rate of indirect maternal deaths (RR 0.77, 95% CI 0.60 to 0.98, p=0.018).

However, the rates of overall mortality, direct and indirect maternal death in the 2014-16 triennium were not significantly different from the rates in 2011-13, the immediately preceding triennium (RR for overall mortality = 1.08, 95% CI = 0.90 to 1.31, p=0.398; RR for direct deaths = 1.22, 95% CI = 0.90 to 1.65; RR for indirect deaths = 1.00, 95% CI = 0.78 to 1.29, p=0.998).

All cause-specific rates have seen a statistically non-significant increase over the past few years, with overall maternal death rates now on a par with those in 2010-12, indirect maternal death rates on a par with 2011-13 and direct maternal death rates on a par with 2008-10. Detailed analysis shows that the changes in rates are due to small increases in numbers of women dying from most causes of death, both direct and indirect, none of which are individually statistically significant. The nadir in the overall UK

maternal mortality rate was observed in 2012-14, and this highlights further the challenge of achieving the Government ambition of reducing maternal deaths in England by 50% by 2025 (Department of Health 2017).

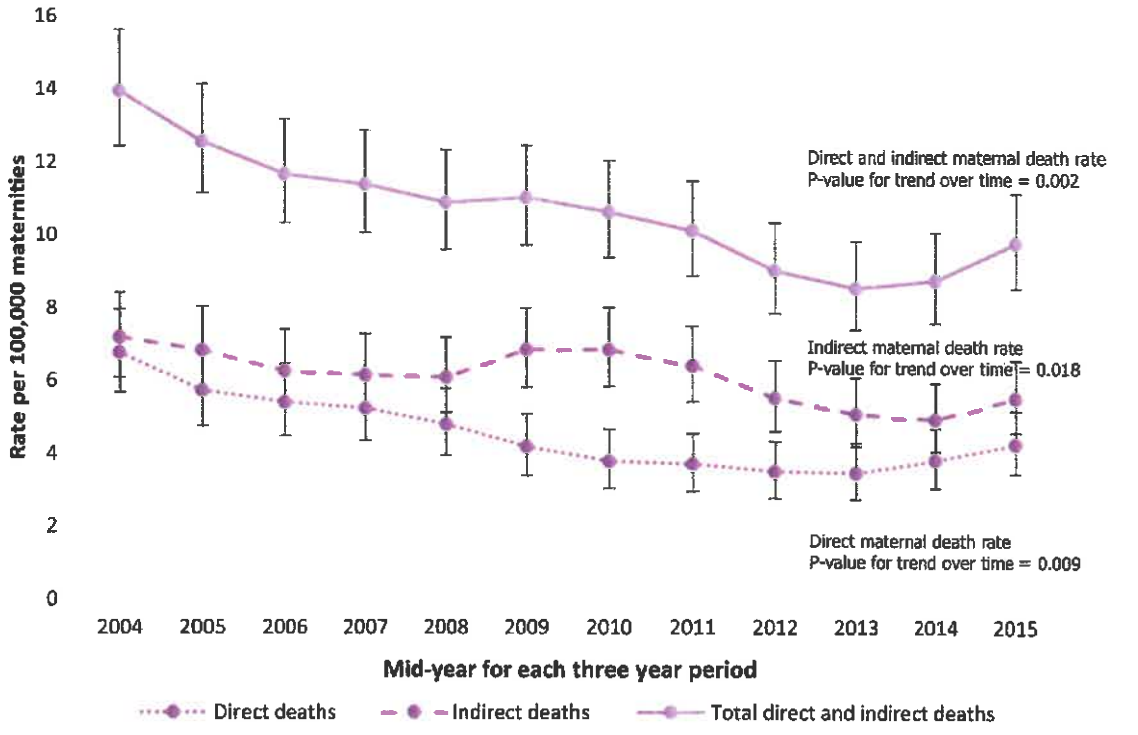
Triennial rates are shown in Table 2.2 and Figure 2.2. A comparison of figures 2.1 and 2.2 clearly shows the benefit of annual monitoring and presentation of rolling three-year rates.

Table 2.1: Rolling three-year average direct and indirect maternal mortality rates per 100,000 maternities, deaths classified using ICD-MM; UK 2003–16

3-year period	Total UK maternities	Direct deaths			Indirect deaths			Total Direct and Indirect deaths		
		n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI
2003–05	2 114 004	143	6.76	5.70–7.97	152	7.19	6.09–8.43	295	13.95	12.45–15.64
2004–06	2 165 909	124	5.73	4.76–6.83	148	6.83	5.78–8.03	272	12.56	11.15–14.14
2005–07	2 220 979	120	5.40	4.48–6.46	139	6.26	5.26–7.39	259	11.66	10.32–13.17
2006–08	2 291 493	120	5.24	4.34–6.26	141	6.15	5.18–7.26	261	11.39	10.09–12.86
2007–09	2 331 835	112	4.80	3.95–5.78	142	6.09	5.13–7.18	254	10.89	9.59 -12.32
2008–10	2 366 082	99	4.18	3.40–5.09	162	6.85	5.83–7.99	261	11.03	9.73–12.45
2009–11	2 379 014	90	3.78	3.04–4.65	163	6.85	5.84–7.99	253	10.63	9.36–12.03
2010–12	2 401 624	89	3.71	2.98–4.56	154	6.41	5.44–7.51	243	10.12	8.89–11.47
2011–13	2 373 213	83	3.50	2.79–4.34	131	5.52	4.62–6.55	214	9.02	7.85–10.31
2012–14	2 341 745	81	3.46	2.75–4.30	119	5.08	4.21–6.08	200	8.54	7.40–9.81
2013–15	2 305 920	88	3.82	3.06–4.70	114	4.94	4.08–5.94	202	8.76	7.59–10.05
2014-16	2 301 628	98	4.26	3.46–5.19	127	5.52	4.60–6.57	225	9.78	8.54–11.14

Sources: CMACE, MBRRACE-UK, Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency

Figure 2.1: Direct and indirect maternal mortality rates per 100,000 maternities using ICD-MM and Previous UK classification systems; rolling three year average rates 2003–2016



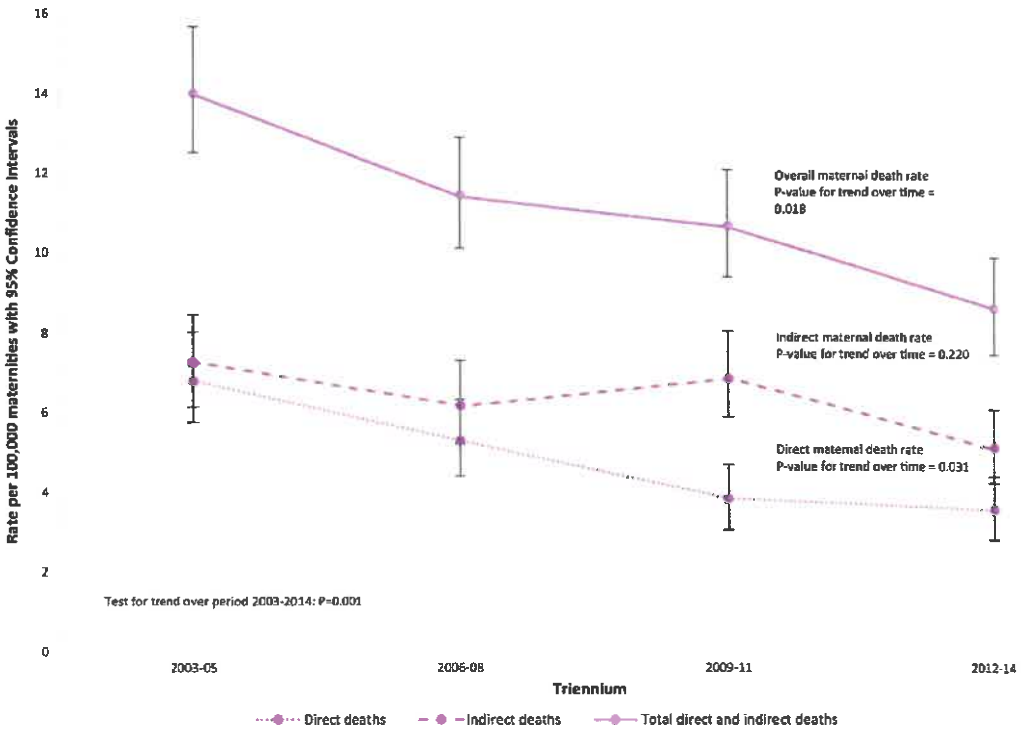
Sources: CMACE, MBRRACE-UK

Table 2.2: Direct and indirect maternal deaths and mortality rates per 100,000 maternities by triennium, UK using ICD-MM; UK 2003-14

Triennium	Direct deaths recorded			Indirect deaths recorded			Total Direct and Indirect deaths recorded		
	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI
2003–05	143	6.76	5.70–7.97	152	7.19	6.09–8.43	295	13.95	12.45–15.64
2006–08	120	5.24	4.34–6.26	141	6.15	5.18–7.26	261	11.39	10.09–12.86
2009–11	90	3.78	3.04–4.65	163	6.85	5.84–7.99	253	10.63	9.36–12.03
2012–14	81	3.46	2.75–4.30	119	5.08	4.21–6.08	200	8.54	7.40–9.81

Sources: CMACE, MBRRACE-UK, Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency

Figure 2.2: Direct and indirect maternal mortality rates per 100,000 maternities; UK: 2003–2014 (using ICD-MM)

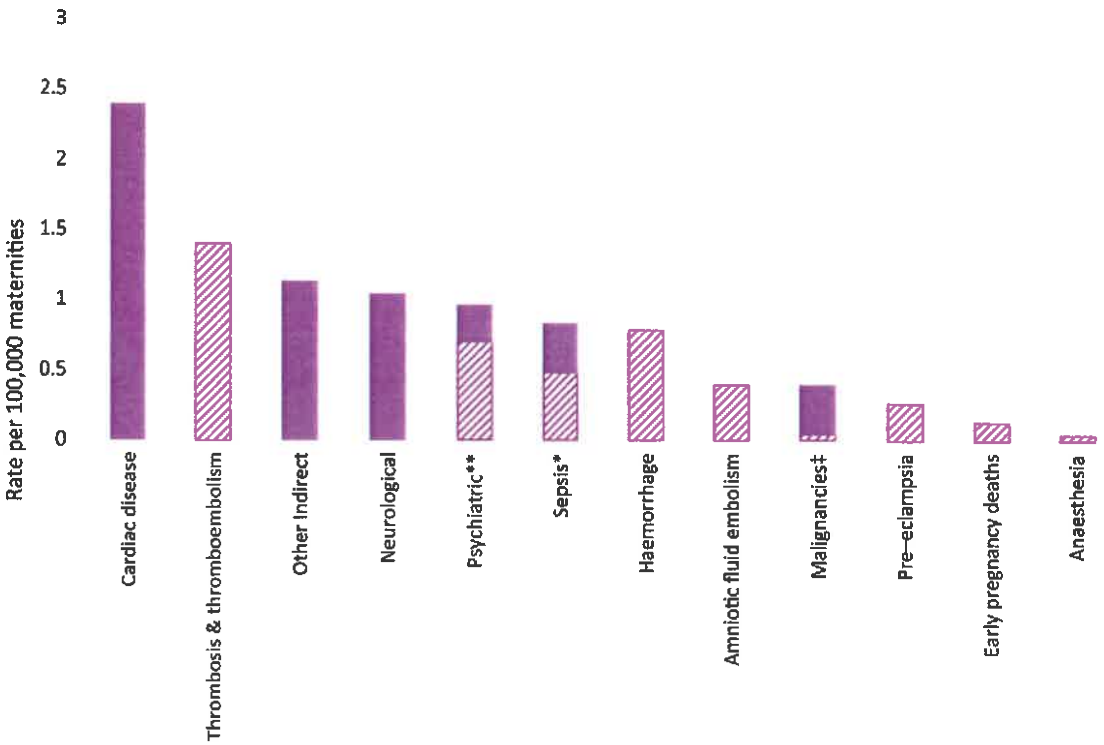


Sources: CMACE, MBRRACE-UK

Deaths due to individual causes

Maternal deaths by cause are shown in Tables 2.3 and 2.4, and Figure 2.3. Rolling three year rates for individual causes are presented for five overlapping triennial reporting periods (2010-12, 2011-13, 2012-14, 2013-15 and 2014-16) (Table 2.3 and Figure 2.3) and for non-overlapping triennial periods between 1985-7 and 2012-14 (Table 2.4). Since there has not been a complete triennium since the previous report, Table 2.4 is the same as included in the 2016 and 2017 reports; deaths by suicide have been included amongst indirect deaths in Table 2.4 to allow for comparability to earlier years. Three-year rolling rates for causes of death classified according to ICD-MM sub-groups are presented in Table 2.5.

Figure 2.3: Maternal mortality by cause 2014-16



Hatched bars show direct causes of death, solid bars indicate indirect causes of death;

*Rate for direct sepsis (genital tract sepsis and other pregnancy related infections) is shown in hatched and rate for indirect sepsis (influenza, pneumonia, others) in solid bar

**Rate for suicides (direct) is shown in hatched and rate for indirect psychiatric causes (drugs/alcohol) in solid bar

‡Rate for direct malignancies (choriocarcinoma) shown in hatched and rate for indirect malignancies (breast/ovary/cervix) in solid bar

Source: MBRRACE-UK

Table 2.3: Maternal mortality rates by cause, per 100,000 maternities, 2010 to 2016

Cause of death	2010–12			2011–13			2012–14			2013–15			2014–16		
	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI
All Direct and Indirect deaths	243	10.12	8.89–11.47	214	9.02	7.85–10.31	200	8.54	7.40–9.81	202	8.76	7.59–10.05	225	9.78	8.54–11.14
Direct deaths															
Pregnancy related infections - Sepsis*	13	0.54	0.29–0.93	8	0.34	0.15–0.66	7	0.29	0.12–0.61	10	0.43	0.21–0.79	11	0.48	0.24–0.86
Pre-eclampsia and eclampsia	9	0.38	0.18–0.71	6	0.25	0.09–0.55	2	0.08	0.01–0.31	3	0.13	0.03–0.38	6	0.26	0.10–0.57
Thrombosis and thromboembolism	26	1.08	0.71–1.59	24	1.01	0.65–1.50	20	0.85	0.52–1.32	26	1.13	0.74–1.65	32	1.39	0.95–1.96
Amniotic fluid embolism	8	0.33	0.14–0.66	10	0.42	0.20–0.78	16	0.68	0.39–1.11	8	0.35	0.15–0.68	9	0.39	0.18–0.74
Early pregnancy deaths	8	0.33	0.14–0.66	6	0.25	0.09–0.55	7	0.29	0.12–0.61	4	0.17	0.05–0.44	3	0.13	0.03–0.38
Haemorrhage	11	0.46	0.23–0.82	13	0.55	0.29–0.94	13	0.56	0.29–0.95	21	0.91	0.56–1.39	18	0.78	0.46–1.24
Anaesthesia	4	0.17	0.05–0.43	3	0.13	0.03–0.37	2	0.09	0.01–0.31	2	0.09	0.01–0.31	1	0.04	0.001–0.24
Psychiatric causes - Suicides	10	0.42	0.20–0.77	13	0.55	0.29–0.94	14	0.60	0.33–1.00	12	0.52	0.27–0.91	16	0.70	0.40–1.13
Malignancy - direct													1	0.04	0.001–0.24
Unascertained - direct	-	-	-	-	-	-	-	-	-	2	0.09	0.01–0.31	1	0.04	0.001–0.24
All Direct	89	3.71	2.98–4.56	83	3.50	2.79–4.34	81	3.46	2.75–4.30	88	3.82	3.06–4.70	98	4.26	3.46–5.19
Indirect															
Cardiac disease	54	2.25	1.69–2.93	49	2.06	1.53–2.73	51	2.18	1.62–2.86	54	2.34	1.76–3.06	55	2.39	1.80–3.11
Indirect Sepsis - Influenza	13	0.54	0.29–0.93	9	0.38	0.17–0.72	1	0.04	0.001–0.24	1	0.04	0.001–0.24	2	0.09	0.01–0.31
Indirect Sepsis–Pneumonia/ others	21	0.87	0.54–1.34	20	0.84	0.52–1.30	14	0.60	0.33–1.00	3	0.13	0.03–0.38	6	0.26	0.10–0.57
Other Indirect causes	26	1.08	0.71–1.59	22	0.93	0.58–1.40	23	0.98	0.62–1.47	26	1.13	0.74–1.65	26	1.13	0.74–1.66
Indirect neurological conditions	31	1.29	0.88–1.83	24	1.01	0.65–1.5	22	0.94	0.59–1.42	19	0.82	0.49–1.29	24	1.04	0.67–1.55
Psychiatric causes–Drugs/alcohol/others	6	0.25	0.09–0.54	6	0.25	0.09–0.55	4	0.17	0.05–0.44	4	0.17	0.05–0.44	6	0.26	0.10–0.57
Indirect malignancies	3	0.13	0.03–0.37	1	0.04	0.001–0.24	4	0.17	0.05–0.44	7	0.30	0.12–0.63	8	0.35	0.15–0.69
All Indirect	154	6.41	5.44–7.51	131	5.52	4.62–6.55	119	5.08	4.21–6.08	114	4.94	4.08–5.94	127	5.52	4.60–6.57
Coincidental															
Homicide	10	0.42	0.20–0.77	8	0.34	0.15–0.66	9	0.38	0.18–0.73	9	0.39	0.18–0.74	10	0.43	0.21–0.80
Other coincidental	16	0.67	0.38–1.08	18	0.76	0.45–1.20	32	1.37	0.94–1.93	29	1.26	0.84–1.81	24	1.04	0.67–1.55
All coincidental	26	1.08	0.71–1.59	26	1.10	0.72–1.61	41	1.75	1.26–2.38	38	1.65	1.17–2.26	34	1.48	1.02–2.06
Late deaths	313	13.03	11.63–14.56	335	14.12	12.64–15.71	323	13.79	12.33–15.38	326	14.14	12.64–15.76	286	12.43	11.03–13.95

*Genital/ urinary tract sepsis deaths, including early pregnancy deaths as a result of genital/ urinary tract sepsis. Other deaths from infectious causes are classified under indirect causes.
Source: MBRRACE-UK, Office for National Statistics, National Records Scotland, Northern Ireland Statistics and Research Agency.

Table 2.4: UK Maternal deaths and mortality rates per 100,000 maternities by cause 1985–2014 (Maternal deaths by suicide classified as indirect for comparability)

Cause of death	Numbers										Rates per 100,000 maternities									
	1985–87	1988–90	1991–93	1994–96	1997–99	2000–02	2003–05	2006–08	2009–11	2012–14	1985–87	1988–90	1991–93	1994–96	1997–99	2000–02	2003–05	2006–08	2009–11	2012–14
All Direct and Indirect deaths	223	238	228	268	242	261	295	261	253	200	9.83	10.08	9.85	12.19	11.4	13.07	13.95	11.39	10.63	8.54
Direct deaths																				
Sepsis*	9	17	15	16	18	13	18	26	16	7	0.40	0.72	0.65	0.73	0.85	0.65	0.85	1.13	0.63	0.29
Pre-eclampsia and eclampsia	27	27	20	20	16	14	18	19	10	2	1.19	1.14	0.86	0.91	0.75	0.70	0.85	0.83	0.42	0.08
Thrombosis and thromboembolism	32	33	35	48	35	30	41	18	30	20	1.41	1.40	1.51	2.18	1.65	1.50	1.94	0.79	1.26	0.85
Amniotic fluid embolism	9	11	10	17	8	5	17	13	7	16	0.40	0.47	0.43	0.77	0.38	0.25	0.80	0.57	0.29	0.68
Early pregnancy deaths	16	24	17	15	17	15	14	11	4	7	0.71	1.02	0.73	0.68	0.80	0.75	0.66	0.48	0.17	0.29
Haemorrhage	10	22	15	12	7	17	14	9	14	13	0.44	0.93	0.65	0.55	0.33	0.85	0.66	0.39	0.59	0.56
Anaesthesia	6	4	8	1	3	6	6	7	3	2	0.26	0.17	0.35	0.05	0.14	0.30	0.28	0.31	0.12	0.09
Other Direct‡	27	17	14	7	7	8	4	4	-	-	1.19	0.72	0.60	0.32	0.33	0.40	0.19	0.17	-	-
All direct	139	145	128	134	106	106	132	107	82	67	6.13	6.14	5.53	6.10	4.99	5.31	6.24	4.67	3.49	2.84
Indirect deaths																				
Cardiac disease	23	18	37	39	35	44	48	53	51	51	1.01	0.76	1.60	1.77	1.65	2.20	2.27	2.31	2.14	2.18
Other Indirect causes	43	45	38	39	41	50	50	49	72	38	1.90	1.91	1.64	1.77	1.93	2.50	2.37	2.14	3.03	1.62
Indirect neurological conditions	19	30	25	47	34	40	37	36	30	22	0.84	1.27	1.08	2.14	1.60	2.00	1.75	1.57	1.26	0.94
Psychiatric causes	†	†	†	9	15	16	18	13	13	18	†	†	†	0.41	0.71	0.80	0.85	0.57	0.55	0.77
Indirect malignancies	†	†	†	†	11	5	10	3	4	4	†	†	†	†	0.52	0.25	0.47	0.13	0.17	0.17
All Indirect	84	93	100	134	136	155	163	154	170	133	3.70	3.94	4.32	6.10	6.40	7.76	7.71	6.59	7.15	5.68
Coincidental	26	39	46	36	29	36	55	50	22	41	1.15	1.65	1.99	1.64	1.37	1.80	2.60	2.18	0.98	1.75

*Including early pregnancy deaths as a result of sepsis

‡Acute fatty liver and genital tract trauma; included with pre-eclampsia and eclampsia and haemorrhage respectively from 2009 onwards

†Deaths from these causes not included in reports from earlier years

Sources: CMACE, MBRRACE-UK

Table 2.5: Maternal mortality rates by cause using ICD-MM group classification, per 100,000 maternities, 2010to 2016

Cause of death	2010–12			2011–13			2012–14			2013–15			2014–16		
	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI	n	Rate	95% CI
Direct causes															
Group 1: Pregnancy with abortive outcome	8	0.33	0.14–0.66	6	0.25	0.09–0.55	7	0.29	0.12–0.62	4	0.17	0.05–0.44	3	0.13	0.03–0.38
Group 2: Hypertensive disorders	9	0.38	0.18–0.71	6	0.25	0.09–0.55	2	0.08	0.01–0.31	3	0.13	0.03–0.38	6	0.26	0.10–0.57
Group 3: Obstetric Haemorrhage	11	0.46	0.23–0.82	13	0.55	0.29–0.94	13	0.56	0.29–0.95	21	0.91	0.56–1.39	18	0.78	0.46–1.24
Group 4: Pregnancy-related infection	13	0.54	0.29–0.93	8	0.34	0.15–0.66	7	0.29	0.12–0.61	10	0.43	0.21–0.79	11	0.48	0.24–0.86
Group 5: Other obstetric complications	44	1.83	1.33–2.46	47	1.98	1.46–2.63	50	2.14	1.58–2.81	48	2.08	1.53–2.76	59	2.56	1.95–3.31
Group 6: Unanticipated complications of management	4	0.17	0.05–0.43	3	0.13	0.03–0.37	2	0.09	0.01–0.31	2	0.09	0.01–0.31	1	0.04	0.001–0.24
Indirect causes															
Group 7: Non-obstetric complications	154	6.41	5.44–7.51	131	5.52	4.62–6.55	119	5.08	4.21–6.08	114	4.94	4.08–5.94	127	5.52	4.60–6.57
Group 8: Unknown/undetermined	0	0	-	0	0	-	0	0	-	0	0	-	0	-	-
Coincidental causes															
Group 9: Coincidental causes	26	1.08	0.71–1.59	26	1.10	0.72–1.61	41	1.75	1.26–2.38	38	1.65	1.17–2.26	34	1.48	1.02–2.06

Source: MBRRACE-UK, Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency.

Direct deaths

There was no statistically significant change in the rate of direct maternal deaths from any cause between 2009 and 2016. Thrombosis and thromboembolism continue to be the leading cause of direct deaths occurring within 42 days of the end of pregnancy, followed by deaths due to obstetric haemorrhage and deaths by suicide (Figure 2.3). The maternal mortality rate from thrombosis and thromboembolism is now the same as it was in 1985-87, possibly reflecting the increased prevalence of risk factors for VTE in the UK maternity population, emphasising the importance of the messages outlined in chapter 4. Maternal death rates from suicide remain unchanged; these women's deaths are reviewed in detail in chapter 5. The rate of maternal mortality from haemorrhage is not significantly different from the rate in 2011-13 (RR 1.43, 95% CI 0.70-2.91), but in the absence of a decrease in rate the messages identified in chapter 3 for improving care for women with haemorrhage remain pertinent. The maternal death rate from pre-eclampsia and eclampsia continues to be low but there is no evidence of an ongoing decrease in the mortality rate.

Indirect deaths

Deaths due to indirect causes still remain the major proportion (56%) of maternal deaths in the UK. As in previous reports, cardiac disease remains the largest single cause of indirect maternal deaths (Figure 2.3). There has been no change in the maternal mortality rate from cardiac disease since enhanced case ascertainment was introduced (RR 1.05, 95% CI 0.71-1.55 when comparing 2003-05 with 2014-16). Cardiac disease will be a focus of the 2019 report.

Coincidental deaths

Most women's deaths from malignancy during or after pregnancy are classified as coincidental deaths, however, when all causes of malignancy are considered together, the overall pregnancy-related mortality rate is 4.4 per 100,000 maternities (95% CI 3.6-5.4; 102 women died between 2014-16 from malignancy). Many messages for improving their care have been identified and these are considered in chapter 7. Women who are murdered are also considered within the group of coincidental deaths. Ten women were murdered during or up to six weeks after pregnancy in the UK in 2014-16, all by a partner or former partner. This equates to a mortality rate of 0.43 per 100,000 maternities (95% CI 0.21-0.80), which is very similar to the mortality rate from direct causes of maternal sepsis. Identifying and preventing domestic violence, as discussed in chapter 6, is essential to prevent these women's deaths.

International comparison

For international comparison, data from the 2016 report is presented in Table 2.6 to highlight the maternal mortality ratios estimated for the UK using routinely reported data. The rate estimate from routine sources of data is much lower (about half) than the actual rates as identified through the UK CEMD, which uses multiple sources of death identification. New figures are not presented, as there has not been a complete triennium since these ratios were calculated.

Table 2.6: Maternal mortality ratios* per 100,000 live births, UK: 1985–2014

Triennium	No. of deaths identified through death certificates	Maternal mortality ratio	95% CI	Denominator number of live births
1985–87	174	7.67	6.61–8.90	2,268,766
1988–90	171	7.24	6.24–8.42	2,360,309
1991–93	150	6.48	5.52–7.60	2,315,204
1994–96	158	7.19	6.15–8.40	2,197,640
1997–99	128	6.03	5.70–7.17	2,123,614
2000–02	136	6.81	5.76–8.05	1,997,472
2003–05	149	7.05	6.00–8.27	2,114,004
2006–08	155	6.76	5.78–7.92	2,291,493
2009–11	134	5.57	4.67–6.60	2,405,251
2012–14	110	4.65	3.82–5.60	2,368,125

Source: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency

*Note that this table reports the Maternal Mortality Ratio and not the rate as elsewhere in the report

Women who died between six weeks and one year after the end of pregnancy

In the triennium 2014-16, 286 women died between six weeks and one year after the end of pregnancy, representing a mortality rate of 12.4 per 100,000 maternities (95% CI 11.0 – 14.0). This represents a non-significant 12% reduction compared with 2011-13 (RR 0.88, 95% CI 0.75-1.03). Rolling rates of late deaths are shown in figure 2.4 and causes of late death in Figure 2.5. Maternal suicides continue to be the leading cause of direct deaths occurring between six weeks and one year after the end of pregnancy.

Figure 2.4: Pregnancy-related maternal mortality rates six weeks to one year after the end of pregnancy, UK, 2009-2016

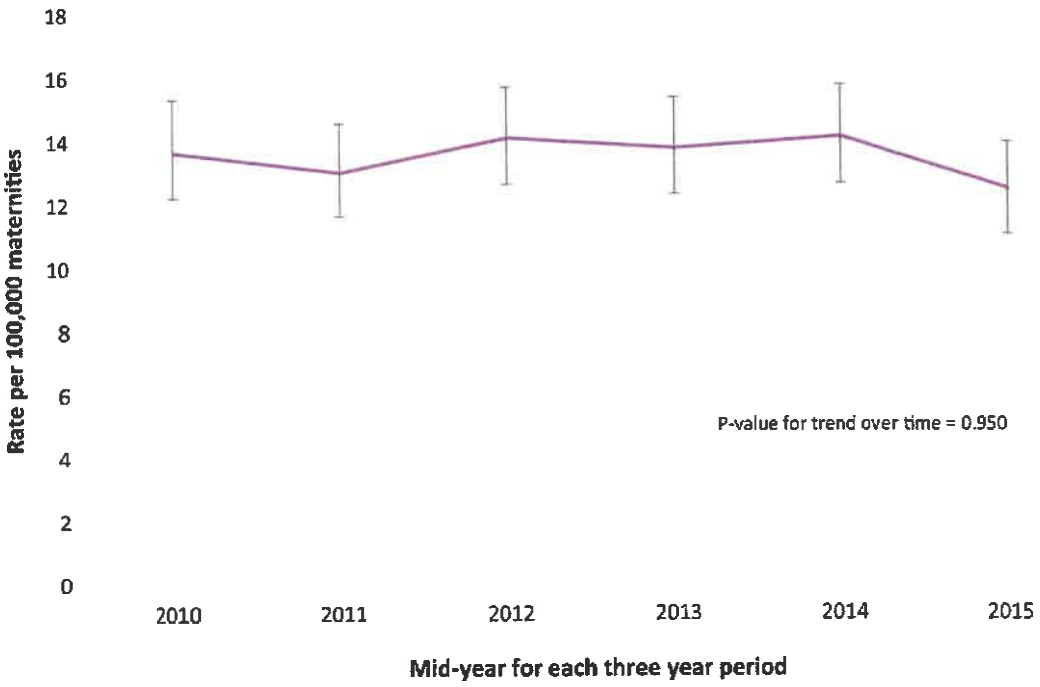
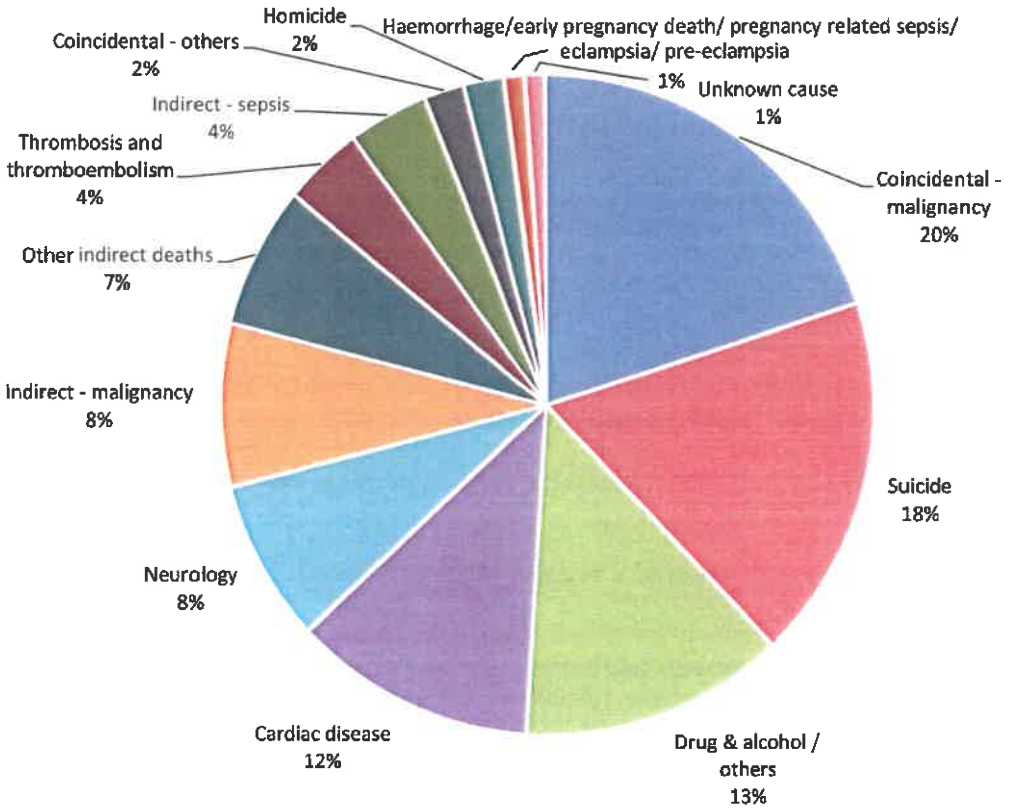


Figure 2.5: Causes of death amongst women who died between six weeks and one year after the end of pregnancy, UK 2014-16



2.3 The characteristics of women who died 2014-16

The women and babies

Of the 225 women who died from direct and indirect causes during or up to 42 days after the end of their pregnancy in 2014-16, 28% (64 women) were still pregnant at the time of their death and of these women 63% were ≤20 weeks' gestation (Table 2.7). Twelve (5%) women had a pregnancy loss at ≤20 weeks' gestation. The remaining 149 women gave birth to a total of 158 infants, 114 (72%) survived, 44 died (31 babies were stillborn and 13 died in the neonatal period). The 225 women who died left behind a further 254 children, thus a total of 368 motherless children remain. The majority of women who gave birth did so in hospital (81%); 16% of women gave birth in an emergency department or an ambulance, and 3% at home (Table 2.8). In this triennium 106 of the women who died were delivered by caesarean section, 42% of these were performed perimortem as part of attempted resuscitation. A total of 46 babies were born by perimortem caesarean section of which 21 (46%) were born after 32 weeks of gestation. Nine out of the 21 babies born after 32 weeks' gestation survived (8 were stillborn and 4 died in the neonatal period) and three out of the remaining 25 born at 32 weeks or less survived (16 were stillborn and 6 died in the neonatal period). Thus 26% of the total 46 babies delivered by perimortem caesarean section survived (52% were stillborn and 22% died in the neonatal period).

Table 2.7: Timing of maternal deaths in relation to pregnancy 2014-16

Time period of deaths in the pregnancy care pathway	Direct (n=98) Frequency (%)	Indirect (n=127) Frequency (%)	Total (n=225) Frequency (%)
Antenatal period			
≤20 weeks	15 (15)	25 (20)	40 (18)
>20 weeks	7 (7)	17 (13)	24 (11)
Postnatal on day of delivery	29 (30)	28 (22)	57 (25)
Postnatal 1–41 days after delivery	47 (48)	57 (45)	104 (46)

Table 2.8: Place of birth amongst women >20 weeks' gestation who died after birth 2014-16

Place of birth (for women who had a childbirth)	Direct (n=68) Frequency (%)	Indirect (n=81) Frequency (%)	Total (n=149) Frequency (%)
Home	2(3)	2 (2)	4 (3)
Hospital (except Emergency Department)	58 (85)	62 (77)	120 (81)
Emergency Department or ambulance	8 (12)	16 (20)	24 (16)
Not known	0 (0)	1 (1)	1 (1)

Socio-demographic characteristics

The socio-demographic characteristics of women who died in 2014-16 are shown in Table 2.9. The proportion of women who did not have information on whether they were subject to domestic abuse before or during pregnancy was 36%. Domestic abuse is considered further in chapter 6.

The rates of maternal mortality varied by age, socioeconomic status and ethnic background of the women, which are known to be independently associated with an increased risk of maternal death in the UK (Nair, Kurinczuk et al. 2015, Nair, Knight et al. 2016). The rate of maternal mortality was higher amongst older women, those living in the most deprived areas and amongst women from particular ethnic minority groups (Table 2.10). There remain statistically significant differences in the maternal mortality rates between women living in the most deprived areas and those living in the least deprived areas. As noted in the 2016 report, we are no longer able to obtain denominator figures for the specific ethnic groups, instead aggregate rates using larger ethnicity groupings are presented in Tables 2.10 and 2.11. The risk of maternal death in 2014-16 is yet again significantly almost five-fold higher among women from black ethnic minority backgrounds compared with white women (RR 4.93; 95% CI 3.27 to 7.26). Women from Asian backgrounds are also at higher risk than white women (RR 1.81, 95% CI 1.16 to 2.73). There were significant increases in the relative risk of maternal death in the third and fourth IMD quintiles in this triennium compared with 2011-13, otherwise the estimated ratios of relative risk (RRR) of maternal death in the different age, socioeconomic and ethnic groups did not show any statistically significant differences (Table 2.11). This suggests that the inequality gaps remain. Further research is needed to fully understand the reasons for these disparities and hence to develop actions to address them.

A quarter of women who died in 2014-16 (24%) were born outside the UK; 42% of these women were not UK citizens. Overall 11% of the women who died were not UK citizens. Women who died who were born abroad and who were not UK citizens had arrived in the UK a median of 3.5 years before they died (range 3 months to 18 years). Women who died who were born abroad were from Asia (32%, mainly Pakistan and India) and Africa (37%, mainly Nigeria, Eritrea, Sierra Leone and South Africa), Eastern Europe (16%, mostly from the Czech Republic, Poland and Romania) with the remainder from other parts of Europe, America and the Caribbean. Table 2.12 shows the rates of death amongst women born in selected countries with the highest number of deaths. Similar to the previous triennium, there was no statistically significant difference in maternal death rate between women born in the UK and those born outside the UK in 2014-16. However, women born in certain specific countries had a significantly higher risk of death compared to women born in the UK (Table 2.12). Of the 24 women who were not UK citizens and were born outside the UK, 3 were refugees/asylum seekers (13%), 6 (25%) were recently arrived wives of UK residents, 6 were EU citizens (25%) and 9 (38%) had another or unknown status.

It is also of note that 16% of women who died were known to social services, highlighting further the vulnerability of many women who died.

Table 2.9: The socio-demographic characteristics of women who died 2014-16

Characteristics	Direct (n=98) Frequency (%)	Indirect (n=127) Frequency (%)	Total (n=225) Frequency (%)
Age (years)			
<20	3 (3)	6 (5)	9 (4)
20–24	9 (9)	17 (13)	26 (12)
25–29	20 (20)	33 (26)	53 (24)
30–34	25 (26)	35 (28)	60 (27)
35–39	29 (30)	27 (21)	56 (25)
≥ 40	12(12)	9 (7)	21 (9)
Parity			
0	35 (36)	44 (35)	79 (35)
1 to 2	42 (43)	56 (44)	98 (44)
≥3	14 (14)	18 (14)	32 (14)
Missing	7 (7)	9 (7)	16 (7)
UK citizen			
Yes	77 (79)	106 (83)	183 (81)
No	11 (11)	13 (10)	24 (11)
Missing	10 (10)	8 (6)	18 (8)
Ethnicity			
White European	63 (64)	83 (65)	146 (65)
Indian	3 (3)	7 (6)	10 (4)
Pakistani	6 (6)	8 (6)	14 (6)
Bangladeshi	1 (1)	2 (2)	3 (1)
Other Asian	4 (4)	0 (0)	4 (2)
Black Caribbean	6(6)	2 (2)	8 (4)
Black African	6 (6)	17 (13)	23 (10)
Others/ Mixed	5 (5)	6 (5)	11 (5)
Missing	4 (4)	2 (2)	6 (3)
Woman's region of birth			
United Kingdom	59 (60)	83 (65)	142 (63)
Eastern Europe	7 (7)	2 (2)	9 (4)
Western Europe	1 (1)	1 (1)	2 (1)
Asia	9 (9)	9 (7)	18 (8)
Africa	4 (4)	17 (13)	21 (9)
Australia and North America	0 (0)	1 (1)	1 (0)
Central & South America & Caribbean	5 (5)	1 (1)	6 (3)
Missing	13 (13)	13 (10)	26 (12)
Socioeconomic status (Index of Multiple Deprivation (IMD) of postcode of residence)			
First quintile (Least deprived)	4 (4)	6 (5)	10 (4)
Second quintile	5 (5)	15 (12)	20 (9)
Third quintile	15 (15)	23 (18)	38 (17)
Fourth quintile	25 (26)	29 (23)	54 (24)
Fifth quintile (Most deprived)	24 (24)	38 (30)	62 (28)
Missing	25 (26)	16 (13)	41 (18)
Socioeconomic status (Occupational classification)			
Employed (Either woman or partner)	58 (59)	67 (53)	125 (56)
Unemployed (Both)	20 (20)	24 (19)	44 (20)
Missing	20 (20)	36 (28)	56 (25)
Able to speak/understand English			
Yes	91 (93)	124 (98)	215 (96)
No	7 (7)	0 (0)	7 (3)
Missing	0 (0)	3 (2)	3 (1)
Living arrangements			
With partner	72 (73)	90 (71)	162 (72)
Living alone	9 (9)	19 (15)	28 (12)
With parents/extended family	9 (9)	11 (9)	20 (9)
Others	1 (1)	1 (1)	2 (1)
Missing	7 (7)	6 (5)	13 (6)
Domestic abuse (prior to pregnancy/ during pregnancy)			
Yes	10 (10)	8 (6)	18 (8)
No	52 (53)	73 (57)	125(56)
Missing	36 (37)	46 (36)	82 (36)
Known to social services			
Yes	16 (16)	21 (17)	37 (16)
No	78 (80)	101 (80)	179 (80)
Missing	4 (4)	5(4)	9 (4)

Table 2.10: Maternal mortality rates amongst different population groups 2014–16

	Total maternities 2014-16	Total deaths	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
Age (years)						
<20	81,185	9	11.1	5.07 to 21.04	1.53	0.63 to 3.36
20–24	357,941	26	7.26	4.74 to 10.64	1 (Ref)	-
25–29	651,355	53	8.14	6.10 to 10.64	1.12	0.69 to 1.87
30–34	720,962	60	8.32	6.35 to 10.71	1.15	0.71 to 1.89
35–39	395,374	56	14.16	10.70 to 18.39	1.95	1.20 to 3.24
≥ 40	94,723	21	22.17	13.72 to 33.89	3.05	1.63 to 5.64
IMD Quintiles (England only)						
*I (Least deprived/*highest 20%)	276162	9	3.26	1.49 to 6.19	1 (Ref)	-
II	306896	17	5.54	3.23 to 8.87	1.70	0.72 to 4.33
III	349005	35	10.03	6.99 to 13.95	3.08	1.45 to 7.28
IV	422310	50	11.84	8.79 to 15.61	3.63	1.77 to 8.40
*V (Most deprived/*lowest 20%)	510542	54	10.58	7.95 to 13.80	3.25	1.59 to 7.48
Ethnic group (England only)						
White (inc. not known)	1,529,881	123	8.04	6.68 to 9.59	1 (Ref)	-
Asian	199,661	29	14.52	9.73 to 20.86	1.81	1.16 to 2.73
Black	85,735	34	39.66	27.47 to 55.41	4.93	3.27 to 7.26
Chinese/ others	75,235	4	5.32	1.45 to 13.61	0.66	0.18 to 1.74
Mixed	30,639	5	16.32	5.30 to 38.08	2.03	0.65 to 4.87

Table 2.11: Comparing the relative risk of maternal death among different population groups between 2011-13 and 2014-16

	2011-13		2014-16		Ratio of the relative risks (RRR) (comparing 2014-16 with 2011-13)	95% CI	P-value
	Relative risk (RR)	95% CI	Relative risk (RR)	95% C			
Age (years)							
<20	1.33	0.51 to 3.08	1.53	0.63 to 3.36	1.15	0.34 to 3.93	0.823
20–24	1 (Ref)	-	1 (Ref)	-	-	-	-
25–29	1.40	0.84 to 2.41	1.12	0.69 to 1.87	0.80	0.39 to 1.65	0.547
30–34	1.67	1.02 to 2.82	1.15	0.71 to 1.89	0.69	0.34 to 1.39	0.301
35–39	2.53	1.52 to 4.33	1.95	1.20 to 3.24	0.77	0.37 to 1.59	0.480
≥ 40	3.69	1.90 to 7.09	3.05	1.63 to 5.64	0.83	0.33 to 2.04	0.680
IMD Quintiles (England only)							
I (Least deprived/ highest 20%)	1 (Ref)	-	1 (Ref)	-	-	-	-
II	0.89	0.47 to 1.71	1.70	0.72 to 4.33	1.91	0.63 to 5.77	0.251
III	0.77	0.40 to 1.47	3.08	1.45 to 7.28	4.00	1.42 to 11.28	0.009
IV	1.35	0.79 to 2.35	3.63	1.77 to 8.40	2.69	1.04 to 6.96	0.041
V (Most deprived/ lowest 20%)	1.44	0.87 to 2.46	3.25	1.59 to 7.48	2.26	0.89 to 5.73	0.087
Ethnic group (England only)							
White (inc. not known)	1 (Ref)	-	1 (Ref)	-	-	-	-
Asian	1.64	1.04 to 2.50	1.81	1.16 to 2.73	1.10	0.60 to 2.04	0.752
Black	3.46	2.17 to 5.31	4.93	3.27 to 7.26	1.42	0.78 to 2.59	0.247
Chinese/ others	0.55	0.11 to 1.65	0.66	0.18 to 1.74	1.20	0.21 to 7.02	0.840
Mixed	0.43	0.01 to 2.43	2.03	0.65 to 4.87	4.72	0.25 to 88.00	0.298

Table 2.12: Maternal mortality rates according to mother's country of birth (selected countries)

Woman's country of birth	Maternities 2014-16	Total Deaths	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
UK	1,695,266*	142	8.38	7.06 to 9.87	1 (Ref)	-
Outside UK	606,362*	57	9.40	7.12 to 12.18	1.12	0.81 to 1.54
Specific countries						
Eritrea	3241‡	3	92.56	19.09 to 270.27	11.05	2.25 to 32.96
India	42687‡	3	7.03	1.45 to 20.54	0.84	0.17 to 2.50
Jamaica	5300‡	3	56.60	11.67 to 165.33	6.76	1.38 to 20.15
Nigeria	21476‡	7	32.59	13.11 to 67.15	3.89	1.54 to 8.22
Pakistan	54379‡	8	14.71	6.35 to 28.99	1.76	0.74 to 3.56

*Country of birth not recorded for 26 women who died

*Estimates based on proportions of births to UK and non-UK born mothers applied to number of maternities

‡Estimates based on ratio of maternities to births applied to number of births recorded to mothers born in stated country

Medical and pregnancy-related characteristics

Studies have shown that 66% of the increased risk of maternal death in the UK could be attributed to medical comorbidities (Nair, Knight et al. 2016). More than two-thirds (68%) of the women who died in 2014-16 were known to have pre-existing medical problems (Table 2.13), 24% were known to have pre-existing mental health problems and 8% had pre-existing cardiac problems. Notably, however, for women who died in 2016, for 19% it was reported to be unknown whether they had previous or pre-existing mental health problems, despite the identification of this being a key recommendation in 2015 (Knight, Tuffnell et al. 2015), reiterated again in chapter 5. More than a third (37%) of the women who died in this triennium were obese and 20% were overweight (Table 2.13).

The pregnancy-related characteristics of the women who died in 2014-16 are shown in Table 2.14.

Table 2.13: Selected medical conditions and characteristics identified amongst women who died 2014-16

Medical condition/characteristic	Direct (n=98) Frequency (%)	Indirect (n=127) Frequency (%)	Total (n=225) Frequency (%)
Body mass index (BMI) (Kg/m²)			
<18	0 (0)	3 (2)	3 (1)
18–24	28 (29)	38 (30)	66 (29)
25–29	26 (27)	19 (15)	45 (20)
≥ 30	34 (35)	50 (39)	84 (37)
Missing	10 (10)	17 (13)	27 (12)
Mental health problems or psychiatric disorders			
Yes	24 (24)	31 (24)	55 (24)
No	67 (68)	83 (65)	150 (67)
Missing	7 (7)	13 (10)	20 (9)
Pre-existing cardiac problems			
Yes	4 (4)	13 (10)	17 (8)
No	90 (92)	112 (88)	202 (90)
Missing	4 (4)	2 (2)	6 (3)
Any pre-existing medical problem (excluding obesity)			
Yes	60 (61)	94 (74)	154 (68)
No	34 (35)	31 (24)	65 (29)
Missing	4 (4)	2 (2)	6 (3)

Table 2.14: Pregnancy-related characteristics of the women who died 2014-16

Characteristics	Direct (n=98) Frequency (%)	Indirect (n=127) Frequency (%)	Total (n=225) Frequency (%)
Pregnancy known to be as a result of assisted reproductive techniques			
Yes	4 (4)	4 (3)	8 (4)
No	92 (94)	120 (94)	212 (94)
Missing	2 (2)	3 (2)	5 (2)
Multiple pregnancy			
Yes	6 (6)	4 (3)	10 (4)
No	92 (94)	123 (97)	215 (93)
Previous caesarean section			
Yes	25 (26)	20 (16)	45 (20)
No	69 (70)	102 (80)	171 (76)
Missing	4 (4)	5 (4)	9 (4)
Previous caesarean numbers (among women who had a previous caesarean section)			
1	15 (60)	18 (90)	33 (73)
≥2	10 (40)	2 (10)	12 (27)

Other characteristics of women who died

Inadequate utilisation of antenatal care services and substance misuse have been shown to be associated with increased risk of maternal death in the UK (Nair, Kurinczuk et al. 2015, Nair, Knight et al. 2016). The prevalence of these risk factors among women who died in 2014-16 did not differ from that noted in the previous reports (Table 2.15) and use of recommended antenatal care still remains low. Just over a quarter (26%) of women who received antenatal care, received the recommended level of care according to NICE antenatal care guidelines (booking at 10 weeks or less and no routine antenatal visits missed) (National Institute for Health and Care Excellence 2017).

Table 2.15: Other characteristics of women who died in 2014-16

Characteristics	Direct (n=98) Frequency (%)	Indirect (n=127) Frequency (%)	Total (n=225) Frequency (%)
Smoking			
Smoker	25 (26)	34 (27)	59 (26)
Non-smoker	62 (63)	80 (63)	142(63)
Missing	11 11)	13 (10)	24 (11)
Substance user			
Yes	11 (11)	16 (13)	27 (12)
No	85 (87)	108 (85)	193 (86)
Missing	2 (2)	3 (2)	5 (2)
Received any antenatal care*			
Yes	86 (88)	112 (88)	198 (88)
No	12 (12)	15 (12)	27 (12)
Gestational age at booking (among women who received any antenatal care)			
≤10	28 (33)	45 (40)	73 (37)
11–12	35 (41)	41 (37)	76 (38)
>12	22 (26)	23 (21)	45 (23)
Missing	1 (1)	3 (3)	4 (2)
Received *recommended* antenatal care† (among women who received any antenatal care)			
Yes	19 (22)	33 (29)	52 (26)
No	65 (76)	75 (67)	140 (71)
Missing	2 (2)	4 (4)	6 (3)
Received a minimum level of antenatal care† (among women who received any antenatal care)			
Yes	61 (71)	78 (70)	139 (70)
No	22 (26)	26 (23)	48 (24)
Missing	3 (3)	8 (7)	11 (6)

*Includes 3 women who died in early pregnancy.

†NICE recommended antenatal care: booked at 10 weeks or less and no antenatal visits missed. Minimum level of care: booked at less than 13 weeks and 3 or fewer antenatal visits missed.

Classification of quality of care

This section includes information on women who died between 2014 and 2016 and are included in the confidential enquiry chapters of this report (including 128 women who died between six weeks and a year after the end of pregnancy and women from the Republic of Ireland). Table 2.16 shows the classification of care as agreed by the assessors for 233 women whose case notes were available with sufficient information for an in-depth review. Among these women 28% were assessed to have received good care, but detailed assessment showed that for another 38% improvements in care may have made a difference to their outcome.

Table 2.16: Classification of care received by women who died and for whom case notes were available for an in-depth review and are included in the confidential enquiry chapters, UK and Ireland (2014-16)

Classification of care received	(n=225)* Number (%)
Good care	63 (28)
Improvements to care which would have made no difference to outcome	77 (34)
Improvements to care which may have made a difference to outcome	85 (38)

*includes only women whose case notes were available with sufficient information for an in-depth review

Local clinicians' reports

There was an increase in the proportion of reports received from local clinicians of those requested for the confidential enquiry from 18% in 2012 to 68% in 2015. There has been an encouraging further increase to 77% in 2016, with GPs showing the highest proportionate return rate at 87% (Table 2.17). Local clinicians' reports are absolutely essential to allow MBRRACE-UK assessors to fully take account of any local factors impacting on care, and we urge clinicians to return these in a timely manner.

Table 2.17: Percentages of local clinicians' reports received for women who died in 2016

Specialty group	Percentage of reports requested that were received
Obstetricians	73
Anaesthetists	76
Midwives	72
Critical Care Clinicians	81
Emergency Medicine Specialists	65
GPs	87
Physicians	78
Psychiatrists	77
Total	77

2.4 The women who survived

Women who survived after major obstetric haemorrhage and massive transfusion

A national cohort study was undertaken through the UK Obstetric Surveillance System between July 2012 and June 2013, identifying all pregnant women at ≥20 weeks of gestation receiving ≥8 units of red blood cells within 24 hours of giving birth (Green, Knight et al. 2016). As described in section 1.4, 34 women were included in the morbidity Confidential Enquiry. The characteristics of the women who survived and were selected for inclusion in the Confidential Enquiry into Maternal Morbidity are shown in Table 2.18. It is worth noting that, in contrast to the women who died, fewer of these women were overweight or obese and only a minority had pre-existing medical or mental health problems.

Table 2.18: Characteristics of women who survived after major obstetric haemorrhage

Characteristics	Total (n=34) Frequency (%)
Age	
<25	3 (9)
25–34	16(47)
≥35	15 (44)
Parity	
0	14(41)
≥1	20 (59)
Previous caesarean section	
Yes	16 (47)
No	18 (53)
Previous caesarean numbers (among women who had a previous caesarean section)	
1	5 (31)
≥2	11 (69)
Ethnicity	
White European	20 (59)
Other	14 (41)
Socioeconomic status (Occupational classification)	
Employed (Either woman or partner)	30 (88)
Unemployed (Both)	3 (9)
Missing	1 (3)
Smoking	
Smoker	4 (12)
Non-smoker	30 (88)
Body mass index (BMI) (kg/m^2)	
<18	2 (6)
18–24	19 (56)
25–29	7 (21)
≥30	6 (18)
Any pre-existing medical or mental health problem (excluding obesity)	
Yes	5 (15)
No	29 (85)

3. Messages for prevention and treatment of morbidity from major obstetric haemorrhage

Marian Knight, Jim Bamber, Sebastian Lucas, Sara Paterson-Brown and Derek Tuffnell on behalf of the MBRRACE-UK haemorrhage chapter-writing group

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3.1 Key messages

Recognition of bleeding remains important. Caesarean section in advanced labour is associated with a risk of uterine angle extensions which can be difficult to control and which can cause concealed bleeding post operatively. **ACTION: Health professionals.**

Always exclude each of the four Ts (tone, tissue, trauma and thrombin) when assessing any woman with ongoing bleeding. **ACTION: Health professionals.**

Women who have had a previous caesarean section who also have either placenta praevia or an anterior placenta underlying the old caesarean section scar at 32 weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations for surgery made. **ACTION: Service planners/commissioners, service managers, health professionals.**

Any woman with suspected placenta praevia accreta should be reviewed by a consultant obstetrician and consultant anaesthetist in the antenatal period. The different risks and treatment options should have been discussed and a plan agreed. **ACTION: Service planners/commissioners, service managers, health professionals.**

Any woman going to theatre electively with suspected placenta praevia accreta should be attended by a consultant obstetrician and anaesthetist. If the delivery is unexpected, out-of-hours consultant obstetric and anaesthetic staff should be alerted and attend as soon as possible. **ACTION: Service managers, health professionals.**

Documentation of fluid balance is part of the protocol for monitoring and investigation in major PPH; care must be taken to avoid over-replacement as well as under-replacement. **ACTION: Health professionals.**

Young women are vulnerable to pressure sores and care should be taken of pressure points in the obstetric population as well as other populations. **ACTION: Service managers, health professionals.**

3.2 Background

Rates of postpartum haemorrhage are known to be increasing in high resource settings (Knight, Callaghan et al. 2009), and alongside this a near-doubling of the maternal death rate from haemorrhage was identified in 2013-15 (Knight, Nair et al. 2017). This was almost entirely due to an increase in the numbers of women dying from haemorrhage in association with abnormally invasive/morbidly adherent placentation (AIP) – placenta accreta, increta or percreta. There is no evidence of any change in this trend from the figures identified in this report; the maternal mortality rate from haemorrhage in the UK remains at 0.78 per 100,000 maternities. As noted in chapter 1, the women whose care was examined here were a stratified random sample of all women of 20 weeks or more gestation who were transfused 8 or more

units of red cells in the UK between July 2012 and June 2013 (Green, Knight et al. 2016). They are thus representative of all women who survived following a massive transfusion in association with obstetric haemorrhage in the UK.

3.3 The women who survived

The care of thirty-four women was reviewed for the purposes of this chapter. The causes of these women's haemorrhages exhibit two clear themes: abnormally invasive placentation (13 women) and trauma (uterine and vaginal tears in 11 women) (Table 3.1). Haemorrhage in relation to infection or atony was also identified in 8 women whose care was examined for the purposes of this chapter. It is striking how similar the causes of these women's haemorrhage are to the causes of women's deaths from haemorrhage as described in chapter 8 of the 2017 report (Knight, Nair et al. 2017), with the exception that trauma – uterine or vaginal tears – appears to be associated with a greater proportion of haemorrhage morbidity.

Table 3.1: Direct deaths by type of obstetric haemorrhage 2013-15 and causes of haemorrhage morbidity 2012-13

Cause of death/haemorrhage	Women who died UK and Ireland 2013-15	Women who survived UK 2012-13
Placental Abruption	3	0
Placenta Praevia/accreta	9 (8 with accreta/increta/percreta)	13** (13 with accreta/increta/percreta)
Atony alone	7 (5 post caesarean birth)	4 (4 post caesarean birth)
Delayed manual removal of placenta	2	1
Genital Tract Trauma	1	11
AFE	9	1
Infection	0*	4
TOTAL	31	34

*Note that the deaths of women which were thought to be due primarily due to infection are considered in the sepsis chapter

**One women with AIP had a uterine rupture as a consequence

Although only four women had solely atonic haemorrhage, atony was also a feature in six of the women who had genital tract trauma, three of whom gave birth by caesarean section. Amongst the women with genital tract trauma, six of the tears occurred at caesarean section, of which four were diagnosed late, four followed spontaneous vaginal birth, of which one was associated with excessive misoprostol, and one followed forceps birth. Of note the woman who survived an amniotic fluid embolism also had excessive uterotonic doses.

3.4 Overview of care and lessons to be learned

Recognition of haemorrhage

A woman underwent a caesarean section in the late evening at 9cm dilation for failure to progress following spontaneous onset of labour. Immediately after giving birth she had a large postpartum haemorrhage which was recognised to be due to complex broad ligament trauma and atony. The major haemorrhage protocol was immediately activated and general anaesthesia was induced. A consultant obstetrician arrived 8 minutes after the major haemorrhage call was made. The women bled three litres within the first hour after her caesarean and a further consultant was called and arrived to assist 50 minutes after the major haemorrhage call. Her haemorrhage was eventually controlled with the assistance of a third obstetrician/gynaecologist and a vascular surgeon who repaired a torn uterine artery. Her uterus was preserved. She bled in total 6 litres and was transfused 10 units of red cells as well as FFP and platelets, all of which arrived promptly on request. She made an uneventful recovery.

This woman's haemorrhage was recognised early, the major haemorrhage protocol was appropriately followed and early involvement of senior staff from different specialties led to control of her bleeding and her eventual uneventful recovery. It was encouraging to note that amongst all the women examined, in contrast to the women who died and whose care was reviewed in the 2017 report (Knight, Nair et al. 2017), the haemorrhage was generally recognised at an earlier stage. There were thus less profound delays in their management and this was clearly a factor in their ultimate recovery. Note, however, that all women whose care was examined for the purposes of this chapter had been transfused at least eight units of red cells, and there were many opportunities where management could have been different or more timely, leading to earlier resolution of their bleeding.

In eight women, staff were slow to recognise the significant haemorrhage. This was particularly evident when women were being cared for on postnatal wards or in recovery; in theatre haemorrhage was generally better recognised and acted on more quickly.

A woman undergoing a trial of labour after caesarean section progressed slowly and her labour was augmented with syntocinon. She failed to progress and underwent caesarean section. At operation she bled 2 litres and was noted to have an abnormal thin and vascular lower segment. She re-bled in recovery, became hypotensive, and after a 15 minute delay was returned to theatre for an examination under anaesthesia and insertion of an intrauterine balloon. Her blood loss was now over 4 litres and she was transferred to intensive care. She lost a further 600ml via an abdominal drain and therefore returned to theatre a second time at which time a broad ligament haematoma was identified and she had diathermy to bleeding points. Her estimated blood loss was now 6 litres. She had a further bleed in intensive care and following a CT scan which showed intra-abdominal bleeding returned to theatre for a second relaparotomy at which time her damaged uterine artery was identified by a non-obstetric surgeon and ligated.

Assessors felt that a laparotomy on first return to theatre may have identified this woman's intra-abdominal bleeding earlier, but particularly that the significance of her hypotension in recovery was not recognised. The following recommendation was made in both 2014 and 2017 and remains relevant here.

Whilst significant haemorrhage may be apparent from observed physiological disturbances young fit pregnant women compensate remarkably well. Whilst a tachycardia commonly develops there can be a paradoxical bradycardia and hypotension is always a very late sign, therefore ongoing bleeding should be acted upon quickly (Thomas and Dixon 2004) (Recommendation in both 2014 and 2017).

Identification of trauma

In eight of the women whose care was reviewed, haemorrhage was caused by either a uterine or cervical/vaginal tear which was not initially recognised. Examination under anaesthetic plays an important role in excluding both trauma and retained tissue as the cause in any women with a major haemorrhage – but both causes should always be looked for.

A woman underwent induction of labour after a spontaneous rupture of membranes with meconium staining at term. She gave birth after a 12 hour labour with an apparent delay between delivery of the baby's head and body, although it is unclear whether any manoeuvres were performed. Thirty minutes after she gave birth, she had a two litre postpartum haemorrhage presumed to be due to uterine atony. A massive obstetric haemorrhage call was made, she received uterotonics and was taken to theatre within 20 minutes for examination under anaesthetic. The consultant obstetrician was alerted but did not attend. The woman left theatre after two hours, but within 30 minutes had a further bleed of one litre. She returned to theatre and the consultant attended and identified high vaginal and cervical tears which took a further two hours to repair. She was transferred by ambulance to a level 2 critical care unit.

In this instance it is unclear whether a systematic assessment of each of the four main causes of bleeding (Box 3.1) were undertaken during the woman's initial two hour theatre episode.

Box 3.1: Causes of postpartum haemorrhage (Royal College of Obstetricians and Gynaecologists 2016)

Tone - abnormalities of uterine contraction

Tissue - retained products of conception, abnormally invasive placenta

Trauma - genital tract injury

Thrombin - abnormalities of coagulation

High vaginal and cervical tears can occur after spontaneous as well as assisted vaginal birth, as the above vignette shows. The other frequent trauma seen in the cases reviewed related to angle tears at caesarean sections especially when carried out in the late first or second stage.

A woman underwent a post-dates induction of labour. A caesarean section for fetal distress was carried out when she was 9cm dilated. In recovery she was noted to be bleeding. The consultant attended immediately; at relaparotomy the bleeding left angle tear to the uterus was repaired. The woman recovered uneventfully after her 8 unit transfusion and level 2 critical care.

Even though this woman's angle tear was not diagnosed at the initial caesarean section, her postpartum haemorrhage was diagnosed promptly in recovery, the consultant attended promptly, examined the woman appropriately and her haemorrhage was rapidly treated.

At caesarean section in advanced labour the lower segment is ballooned out and the tissues are oedematous and friable. This, combined with sometimes difficult manipulation to deliver the impacted fetal head makes the risk of a tear greater, and if rotation of the uterus has not been recognised or corrected the angle tear can extend into the broad ligament. Four of five women who had caesarean sections in advanced labour had troublesome angle extensions and broad ligament haematomas.

Caesarean section in advanced labour is associated with a risk of uterine angle extensions which can cause concealed bleeding post operatively and bleeding which can be difficult to control.

Always exclude each of the four Ts (tone, tissue, trauma and thrombin) when assessing any woman with ongoing bleeding.

Consultants should attend second stage caesarean sections until trainees have been signed off with OSATS (Royal College of Obstetricians and Gynaecologists 2009).

A multidisciplinary team involving senior members of staff should be summoned to attend to women with major PPH (blood loss of more than 1000 ml) and ongoing bleeding or clinical shock. (Royal College of Obstetricians and Gynaecologists 2016).

The consultant obstetrician should attend in person when there is a PPH of more than 1500 ml where the haemorrhage is continuing (Royal College of Obstetricians and Gynaecologists 2009).

Some women with bleeding due to trauma were managed inappropriately with intrauterine balloons.

> A woman undergoing a trial of labour after caesarean section underwent an unsuccessful trial of operative vaginal delivery in theatre after delay in second stage. A right angle extension was noted at caesarean section. The registrar made an appropriately early call for help. The consultant attended after a recorded 1200ml of blood loss, repaired the tear and placed an intrauterine balloon. Signs of the woman's ongoing concealed haemorrhage were not noticed until several hours later, when she returned to theatre. She underwent interventional radiological management of an inaccessible bleeding vessel. In total she lost over 15 litres of blood and received more than 20 units of red cells along with other blood products.

It was unclear that this woman was ever truly haemodynamically stable after her initial tear was repaired. In this instance the insertion of the intrauterine balloon provided false reassurance that her haemorrhage was under control as she was not bleeding vaginally. Signs of her ongoing bleeding were missed.

Intrauterine balloon tamponade is an appropriate first-line 'surgical' intervention for most women where uterine atony is the only or main cause of haemorrhage (Royal College of Obstetricians and Gynaecologists 2016).

Abnormally invasive placentation

Thirteen of the women whose care was reviewed for the purposes of this chapter had morbidly adherent placentae – placenta accreta, increta or percreta. There are two aspects to caring for women at risk of accreta: the first requires antenatal diagnosis, the second relates to the care peri-delivery, and both are particularly important given the observed increase in the number of women dying from haemorrhage associated with abnormally invasive placenta (Knight, Nair et al. 2017), and current trends in caesarean birth (Betran, Ye et al. 2016), a recognised risk factor for abnormal placentation. Assessors noted huge variation in diagnosis and planning of care, from no recognition or anticipation of accreta, to late recognition. Some women, despite placenta accreta being anticipated, had no imaging.

Diagnosis

A woman with three previous caesarean births was noted to have a major placenta praevia at 24 weeks. At the same scan a fetal anomaly was noted and thereafter attention focussed solely on care and delivery planning for the fetus. The woman's very high risk of placenta accreta was never considered. At delivery, the placenta was adherent and the baby was delivered with difficulty after 20 minutes and following conversion to general anaesthesia. The placenta was eventually removed piecemeal, but the woman had further bleeding in recovery and returned to theatre. Brace sutures did not control the haemorrhage and she had a hysterectomy. She was cared for overnight in intensive care. She recovered physically but continued to have mental health problems after her traumatic delivery.

The risk factors for abnormally invasive placentation, most notably previous caesarean section, but also including IVF pregnancy, other uterine surgery and endometrial ablation, are well known (Fitzpatrick, Sellers et al. 2012). In four women the diagnosis of placenta accreta was not considered despite clear risk factors. The proportion of women with risk factors continues to grow and awareness of these factors will become increasingly important. Risk recognition allows for full multidisciplinary planning.

All women require follow-up imaging if the placenta covers or overlaps the cervical os at 20 weeks of gestation.

Women with a previous caesarean section require a higher index of suspicion as there are two problems to exclude: placenta praevia and placenta accreta. If the placenta lies anteriorly and reaches the cervical os at 20 weeks, a follow-up scan can help identify if it is implanted into the caesarean section scar.

Women who have had a previous caesarean section who also have either placenta praevia or an anterior placenta underlying the old caesarean section scar at 32 weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations for surgery made.

(Royal College of Obstetricians and Gynaecologists 2011a)

Planning of care for women with suspected placenta accreta

A woman with a major placenta praevia accreta had a large antepartum haemorrhage in the second trimester. She was managed conservatively and a multidisciplinary team made detailed plans for her delivery in the event of a future bleed in line with the suspected placenta accreta care bundle. However, when she had a further bleed in the early third trimester she was delivered by caesarean section without any of the plans being followed and with little preparation. She was tachycardic at the start of the procedure but the significance of this was not recognised and the procedure commenced with a junior anaesthetist under epidural anaesthesia with one small intravenous line. The procedure was converted to general anaesthesia after difficult surgery. She lost over 12 litres of blood in less than two hours.

Some women at high risk of accreta underwent appropriate imaging and delivery was planned well. However, in some instances, as this woman's care illustrates, the need for an emergency delivery had been anticipated and detailed and appropriate plans made which were not followed in the acute situation.

Any woman with suspected placenta praevia accreta should be reviewed by a consultant obstetrician in the antenatal period. The different risks and treatment options should have been discussed and a plan agreed, which should be reflected clearly in the consent form. This should include the anticipated skin and uterine incisions and whether conservative management of the placenta or proceeding straight to hysterectomy is preferred in the situation where accreta is confirmed at surgery. Additional possible interventions in the case of massive haemorrhage should also be discussed, including cell salvage and interventional radiology when available.

The care bundle for suspected placenta accreta should be applied in all cases where there is a placenta praevia and a previous caesarean section or an anterior placenta underlying the old caesarean scar.

Any woman going to theatre electively with suspected placenta praevia accreta should be attended by a consultant obstetrician and anaesthetist. If the delivery is unexpected, out-of-hours consultant obstetric and anaesthetic staff should be alerted and attend as soon as possible.

(Royal College of Obstetricians and Gynaecologists 2011a)

Whilst there was anaesthetist involvement in the planning of some women's care, reviewers noted in particular that where plans were made antenatally, anaesthetists were often not involved. RCOG guidance states that "The choice of anaesthetic technique for caesarean sections for placenta praevia and suspected placenta accreta must be made by the anaesthetist conducting the procedure. There is insufficient evidence to support one technique over another", and, as noted above, that consultant anaesthetists should be present when any woman with suspected placenta praevia accreta goes to theatre (Royal College of Obstetricians and Gynaecologists 2011a). It follows therefore that consultant anaesthetist review should always take place in the antenatal period as part of multidisciplinary planning.

The following are the basic elements of the care bundle for women where placenta praevia accreta is suspected following antenatal imaging and MDT discussion (Paterson-Brown and Singh 2010):

- Consultant obstetrician planned and directly supervising delivery
- Consultant obstetric anaesthetist planned and directly supervising anaesthetic at delivery
- Blood and blood products available on site
- Multidisciplinary involvement in pre-op planning
- Discussion and consent includes possible intervention (such as hysterectomy, leaving placenta in situ, cell salvage and interventional radiology)
- Local availability of level 2 critical care bed

Following the plans made, particularly ensuring consultant presence, is even more important when a woman presents out of hours with bleeding and is therefore at higher risk of complications.

Hysterectomy

A woman with multiple previous caesarean births was noted to have a placenta which covered the cervical os at her 20 week scan and was booked for a scan at 32 weeks. She was admitted with a major haemorrhage at 31 weeks and after a 2 litre blood loss the decision was made by her consultant to deliver her. At caesarean section her placenta was removed piecemeal with the assistance of a second consultant. An intrauterine balloon was inserted and she left theatre after an estimated 6 litre blood loss. One hour later her estimated blood loss was 11 litres and therefore she returned to theatre for a hysterectomy. She recovered after 5 days in intensive care.

The placenta accreta bundle clearly describes the importance of advance discussion of possible hysterectomy. The majority of women with abnormally invasive placentation whose care was reviewed here underwent hysterectomy. It was difficult for the assessors to comment on the timing of proceeding to hysterectomy in ten of these women, without more information about the woman's wishes, and consent

issues, but clinically it was often, as illustrated in the vignette above, a decision taken late after litres of blood loss, massive transfusions, and returns to theatre. In two women who had cardiac arrests, the decision to perform a hysterectomy was taken promptly.

Uterine hyperstimulation

Three women had major haemorrhage in the context of hyperstimulation. One woman who was undergoing induction of labour after an intrauterine death received an inappropriate dose of misoprostol, another woman had a precipitate labour after induction with a long-acting Dinoprostone and the third had her labour augmented with oxytocin after an antepartum haemorrhage and laboured very rapidly with hyperstimulation. Antepartum haemorrhage alone is a known risk factor for rapid labour and any stimulation should be done extremely carefully.

Stimulating or augmenting uterine contractions should be done in accordance with current guidance and paying particular attention to avoiding uterine tachysystole or hyperstimulation (Knight, Kenyon et al. 2014).

Units must be clear that they are using the appropriate dosage of agents for induction of labour. These differ according to gestation and are lower for women with a uterine scar (Knight, Nair et al. 2017).

Recommended doses of misoprostol for women with late intrauterine fetal death:

- 100 micrograms 6-hourly before 26+6 weeks, for up to 24 hours

- 25–50 micrograms 4-hourly at 27+0 weeks or more, for up to 24 hours

The lower dose should be used for women with a previous caesarean section

RCOG Green top guideline 55 Late intrauterine fetal death and stillbirth (Royal College of Obstetricians and Gynaecologists 2010).

Delayed removal of placenta

Two women, whose care was reviewed in the 2017 report (Knight, Nair et al. 2017) died from concealed haemorrhage when removal of a retained placenta was delayed. This theme was also evident amongst the women who survived.

A woman was induced following an intrauterine death in association with infection. She gave birth rapidly but her placenta was retained. Despite revealed bleeding, she was not taken to theatre for a manual placental removal until four hours later. The consultant obstetrician was not called until she had lost an estimated three litres of blood. Conservative measures to control her haemorrhage with prostaglandins and tranexamic acid were successful and she was discharged six days later.

Once a retained placenta is diagnosed obstetric review and transfer to theatre should be expedited and careful recording of observations should be performed, with consideration that a persistent loss can become significant, concealed bleeding can be marked and deterioration is likely (Knight, Nair et al. 2017).

This woman's care also illustrates another recurrent theme identified by reviewers, who noted that junior staff were sometimes slow to call for help when women were deteriorating in the context of severe bleeding which failed to respond to first-line measures.

Concerns should be escalated to a senior doctor or midwife if a woman deteriorates, and there should be a named senior doctor in charge of ongoing care (Knight, Kenyon et al. 2014).

Deterioration includes adverse changes in physiological vital signs even in the absence of change in the woman's clinical demeanor or obvious revealed blood loss.

The tamponade test

A woman in spontaneous labour underwent an emergency caesarean birth for fetal distress. In recovery 50 minutes later she was noted to have a PPH which was managed with uterotonics, but after a further 30 minutes blood loss had reached 2 litres. She was taken to theatre for an examination under anaesthesia and a small piece of retained placenta was removed. An intrauterine balloon was inserted and she went to recovery at which point the consultant was informed about her 3 litre blood loss. She continued to bleed so returned to theatre for a second time. The consultant obstetrician performed a laparotomy and inserted a brace suture. She was admitted to the intensive care unit overnight but made a full recovery and was discharged home.

In this instance the woman was managed appropriately up until the insertion of the intrauterine balloon. At this stage, a 'Tamponade test' could have revealed whether the intrauterine balloon was effectively controlling her haemorrhage, and indicated the need for immediate laparotomy. This would have led to earlier cessation of her haemorrhage and potentially prevented her intensive care unit admission.

If pharmacological measures fail to control the haemorrhage, initiate surgical haemostasis sooner rather than later. Intrauterine balloon tamponade is an appropriate first- line 'surgical' intervention for most women where uterine atony is the only or main cause of haemorrhage. A 'positive test' (control of PPH following inflation of the balloon) indicates that laparotomy is not required, whereas a 'negative test' (continued PPH following inflation of the balloon) is an indication to proceed to laparotomy. ...Hysterectomy should not be delayed until the woman is in extremis.

RCOG Green-top guideline 52 (Royal College of Obstetricians and Gynaecologists 2011b).

Infection and bleeding risk

Four women had major haemorrhage when they were clearly septic. In all these women, the sepsis was thought to be a contributing factor to the severity of their haemorrhage, and the importance of sepsis as a risk factor for haemorrhage should not be forgotten – it may lead either to uterine atony or to disseminated intravascular coagulation (Royal College of Obstetricians and Gynaecologists 2016).

A woman presented in labour 48 hours after spontaneous rupture of membranes clearly septic. A sepsis bundle was started and she was rapidly delivered by caesarean section, at which she lost 1.5 litres of blood. She bled a further 1000ml over the next 12 hours but her coagulopathy was appropriately managed by a multidisciplinary senior team and she made an uneventful recovery.

This woman's care illustrates the benefit of early recognition of the sepsis underlying her haemorrhage and careful management of the resulting coagulopathy by an experienced senior multidisciplinary team.

Fluid balance

Careful attention to fluid balance in women with pre-eclampsia has eliminated pulmonary oedema as a cause of maternal death in women with hypertensive disorders in the UK and Ireland over recent years. It is therefore concerning that several of the women whose care was examined in this chapter developed pulmonary oedema as a consequence of the fluids they received to manage their haemorrhage. Consideration of over-replacement is as important as consideration of under-replacement. Over replacement with crystalloid and/or colloid could worsen any developing coagulopathy and be counter-productive. Fluid management requires skilled senior input. If fluid replacement is needed blood and blood products should be sourced with speed to avoid over reliance on crystalloids to support the cardiovascular system. It is important to continually reassess the signs of the woman's intravascular volume status during intravenous fluid resuscitation and to frequently monitor fluid balance.

A woman with a BMI of 21kg/m^2 gave birth rapidly after an antepartum haemorrhage and hyperstimulation after augmentation. She bled a total of 4 litres following a third degree tear. She received 10 units of red cells, 10 units of FFP, 2 units of cryoprecipitate and a unit of platelets. Her fluid balance was poorly recorded and although she also received crystalloids, the volumes are unclear. She developed pulmonary oedema, requiring CPAP followed by a two day stay in intensive care.

Documentation of fluid balance is part of the protocol for monitoring and investigation in major PPH (Royal College of Obstetricians and Gynaecologists 2016).

Pressure sores

A young woman with a major placenta praevia percreta had an unplanned early delivery after an antepartum haemorrhage. Difficult surgery involving the bladder took several hours – it was more than two hours before a consultant gynaecologist and urologist were called to assist. She subsequently developed pressure sores on both buttocks.

Two women whose care was examined here developed pressure sores. It is disappointing that in this instance despite there being multiple points where improvements could have been made in this woman's care these were not recognised by the obstetric team.

Young women are vulnerable to pressure sores and care should be taken of pressure points in the obstetric population as well as other populations.

3.5 Pathological review

Fifteen of the women reviewed for the purposes of this chapter had an emergency hysterectomy, total or subtotal. Although it is assumed that all the resected uteri were submitted to histopathology laboratories for analysis, only nine pathology reports were available for this qualitative review of their pathology and correlation with the clinical circumstances.

The quality features assessed included: the clinical information presented to the pathologist on the request form, the extent of sampling of the uterus, the microscopic data and the diagnostic conclusions in the reports. These were compared with the full medical records as supplied to MBRRACE.

The positive pathologies found in the hysterectomies were placenta praevia, placenta accreta/percreta, retained placenta, thrombosed vessels, and uterine rupture. No cases had had uterine artery embolisation with PVA particles. There was only one placental pathology report.

Most of the reports were of good quality and addressed the clinically known or suspected pathologies, mainly to confirm them. Uterine atony has no specific histopathological features, so unsurprisingly the reports in these instances were non-specific, yet they usefully included significant 'negatives' such as absence of amniotic squames in the uterine vessels and absence of retained placental material.

The detail of clinical information presented varied from complete (i.e. number of previous caesarean sections, known placenta praevia or accreta etc) to merely 'massive obstetric haemorrhage' with no clinical clues. Placenta accreta was identified pathologically in one case where there was no clinical mention of it. However, in another, where placenta praevia and percreta were both evident at surgery, only the praevia was stated on the request form, and the pathologist therefore did not address the percreta aspect. Finally, in one case of clinical placenta praevia and previous Caesarean section, neither facts were mentioned on the request form, and the pathology report was therefore unfocussed and non-specific as the pathologist had no pertinent information to guide examination.

To assist the pathologist to obtain the maximum useful information, inclusion of the following information concerning significant features with the pathology request is essential: present and previous caesarean sections and their number, location of the placenta in the uterus, suspected placenta accreta/percreta or retained placenta, uterine rupture, uterine artery embolisation.

Where possible, the placenta should accompany the uterus to the laboratory to enable the most complete report possible.

While the (usually subtotal) hysterectomy will have been for uncontrolled obstetric haemorrhage and so should concentrate on finding reasons for the haemorrhage, it is also important to remember the need, if the patient survives, of reporting the nature of the mucosa at the inferior margin; if this is endometrial, then there is a risk of endometrial neoplasia at the top of the cervical stump. This information will be particularly pertinent to women's future care.

3.6 Conclusions

This confidential enquiry into maternal morbidity from haemorrhage identified improvements in care for almost 90% of women; in 74% this would have made a difference to their outcome (Table 3.2). The enquiry has highlighted several themes which were also recognised in the reviews of maternal deaths, but importantly has identified new messages relating to the care of women with abnormal placentation and genital tract trauma. There is a clear need to recognise women who are at risk of abnormal placentation and plan appropriately for their delivery care, ensuring that plans are enacted when women are admitted in an emergency. The risk of uterine angle tears following caesarean section in advanced labour needs to be recognised, and there should be greater awareness of the possibility of concealed haemorrhage in relation to genital tract trauma in all its forms. In the context of rising caesarean section rates, taking forward these messages for care is essential to prevent escalating frequency of both major obstetric haemorrhage and maternal death.

Table 3.2: Classification of care received by women who survived major obstetric haemorrhage, UK, 2012-13

Classification of care received	Women with major obstetric haemorrhage Number (%) N=34
Good care	4 (12)
Improvements to care which would have made no difference to outcome	5 (15)
Improvements to care which may have made a difference to outcome	25 (74)

4. Lessons for prevention and treatment of thrombosis and thromboembolism

Derek Tuffnell, Marian Knight and Lucy Mackillop on behalf of the MBRRACE-UK VTE chapter-writing group

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Peer review: Cathy Nelson-Piercy

4.1 Key messages

There is clear evidence that doctors and midwives find existing risk scoring systems difficult to apply in practice. There is a need for development of a tool to make the current risk assessment system simpler and more reproducible. **ACTION: Professional organisations, service planners/commissioners, service managers, health professionals.**

Audits should be conducted not only to assess whether thromboembolism risk assessment was performed, but also whether the calculated risk score was correct. **ACTION: Service managers, health professionals.**

All women should undergo a documented assessment of risk factors for venous thromboembolism in early pregnancy or pre-pregnancy. Risk assessment should be repeated if the woman is admitted to hospital for any reason or develops other intercurrent problems. Risk assessment should be repeated again intrapartum or immediately postpartum. **ACTION: Service managers, health professionals.**

Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth. **ACTION: Service managers, health professionals.**

If women need thromboprophylaxis as soon as they become pregnant there should be clear pathways for them to access prescriptions and support to ensure compliance. **ACTION: Service planners/commissioners, service managers, health professionals.**

Women with a high BMI should be given information about the symptoms of VTE. **ACTION: Service planners/commissioners, service managers, health professionals.**

Women with a BMI ≥40kg/m2 score 2 points on the RCOG guideline for thromboprophylaxis in pregnancy and therefore all need postnatal thromboprophylaxis regardless of mode of delivery. **ACTION: Service managers, health professionals.**

Prescriptions for the entire postnatal course of low molecular weight heparin should be issued in secondary care. This will help ensure that women receive the full course without the need to visit their GP to obtain another prescription. **ACTION: Service planners/commissioners, service managers, health professionals.**

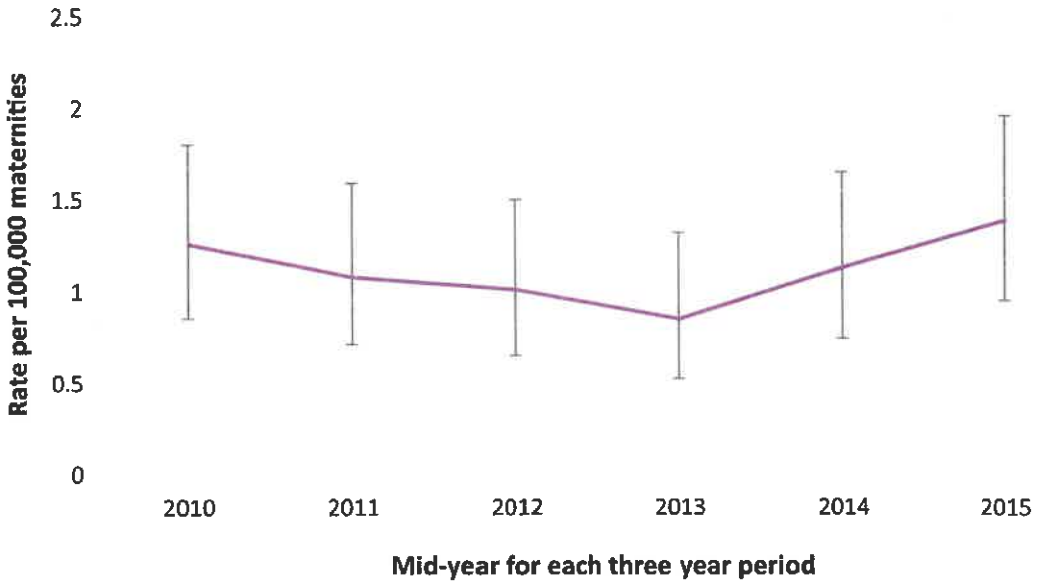
4.2 Background

Venous thromboembolism (VTE) remains the leading cause of direct maternal death, with no evidence of a consistent decrease in mortality over the past 20 years. This is despite detailed guidance for both prevention and treatment of thromboembolic disease from the Royal College of Obstetricians and Gynaecologists, most recently updated in 2015, and the Institute of Obstetricians and Gynaecologists, updated in 2016, leading to the wider use of thromboprophylaxis (Royal College of Obstetricians and Gynaecologists 2015a, Royal College of Obstetricians and Gynaecologists 2015b, Institute of Obstetricians and Gynaecologists Royal College of Physicians of Ireland, HSE Clinical Care Programme in Obstetrics and Gynaecology et al. 2016). Alongside the changes in guidelines, the maternity population as well as interventions are changing. Women giving birth are now older, with more risk factors for thromboembolic disease such as obesity. More interventions such as caesarean section are undertaken, also placing women at higher risk of VTE. Thus it is likely that VTE in association with pregnancy will become an even greater problem without careful attention to prevention.

4.3 The women who died

There were 39 women who died from venous thromboembolism in the UK and Ireland between 2014 and 2016. Thirty women died from pulmonary embolism and two women died from venous sinus thrombosis during pregnancy or up to 6 weeks after pregnancy. The care of five women who died between six weeks and six months after pregnancy were reviewed for the purposes of this chapter, but the deaths of two women which occurred more than 6 months after they gave birth were thought to be unlikely to be related to pregnancy, thus the care of 37 women was reviewed for the purposes of this chapter. The maternal mortality from venous thromboembolism during pregnancy or up to six weeks after the end of pregnancy in the UK was 1.39 per 100,000 maternities in 2014-2016 (95% CI 0.95-1.96) compared to 1.01 per 100,000 in 2011-2013 (95% CI 0.65-1.50). There has been no significant change in mortality due to venous thromboembolic disease since 2009 (p=0.664) (Figure 4.1).

Figure 4.1: Maternal mortality from venous thromboembolism, 3 year rolling rates UK 2009-16



Of the 35 women who died from pulmonary embolism 12 collapsed antenatally, three following a first trimester pregnancy loss, and 20 postnatally. Of the 20 women who collapsed postnatally 14 had been delivered by caesarean section and 6 had vaginal births. Of the 12 who collapsed antenatally 6 deaths were in the first trimester, 2 were in the second trimester and 4 were in the third trimester.

Overall, of the 37 women who died and whose care was reviewed for the purposes of this chapter, 21 women (57%) had a BMI ≥ 30kg/m², a further 6 (16%) had a BMI ≥ 25kg/m² but <30kg/m². BMI was missing for 3 (8%) women. Nine women (24%) smoked, 25 (68%) had either never smoked or given up before pregnancy and smoking status was unknown for 3 (8%). Seven of the 9 women who smoked (78%) were obese (BMI ≥ 30kg/m²). Twenty-six (70%) women were aged under 35 when they died, 7 (19%) were aged 35-39 and 4 were aged 40 or over.

In 69% (22) of the 32 women who died during pregnancy or up to 6 weeks following pregnancy improvements in care may have made a difference to the outcome.

4.4 Overview of care and lessons to be learned

Women at risk in early pregnancy

A worryingly high proportion of women died in the first trimester; seven women died whilst still pregnant and three following a first trimester pregnancy loss. Although three women had a BMI of over 40kg/m², with the highest BMI among the women who died in the first trimester being 56kg/m², none had other or sufficient risk factors for antenatal prophylaxis to be started at diagnosis of pregnancy. Two women were known to have sickle cell trait, but while sickle cell anaemia is a known risk factor for thromboembolism, the evidence is less clear for sickle cell trait, and guidelines vary as to whether it should be considered (Scottish Intercollegiate Guidelines Network 2014, Royal College of Obstetricians and Gynaecologists 2015a). Nevertheless sickle cell trait alone would not have led to antenatal prophylaxis in any guidance.

Importantly risk assessment and thromboprophylaxis (low molecular weight heparin, LMWH) prescription should take place as early as possible. To enable this, service designer/commissioners and local primary and secondary care providers need to work together to ensure efficient and effective care pathways allowing women to receive their LMWH prescription in a timely fashion.

In three women, the importance of other early pregnancy complications and their association with risk of VTE was not recognised.

> A woman died after a septic miscarriage. There were delays in emptying her uterus and delays in further surgery despite ongoing sepsis. Thromboprophylaxis was not initiated and she died from a pulmonary embolism, although a number of improvements were also identified in her sepsis care, in particular the need for earlier source control.

This woman's death emphasises the significance of the relationship between sepsis and VTE. Current systemic infection (requiring intravenous antibiotics or admission to hospital) is a recognised risk factor for VTE and guidelines emphasise the importance of ongoing reassessment of risk to take these factors into account

> After a woman with known substance dependence had surgical management of an ectopic pregnancy no risk assessment for VTE was carried out. When she presented with shortness of breath and tachycardia the focus was on concern about possible withdrawal symptoms though the cause of her symptoms was the pulmonary embolism from which she died.

Although it is unclear whether women undergoing surgical management of miscarriage and surgical termination of pregnancy are at increased risk of VTE, assessment of VTE risk after any surgical procedure ending pregnancy is as important as assessment postnatally. Any surgical procedure in pregnancy or the puerperium gives a score of 3 in the RCOG guidance (Royal College of Obstetricians and Gynaecologists 2015a), therefore postnatal thromboprophylaxis is indicated. In this instance, this woman should have received 10 days of thromboprophylaxis. In addition, when she presented with her respiratory symptoms and tachycardia, her co-morbid substance misuse distracted from a proper assessment which would have led to diagnosis of her VTE.

If women need thromboprophylaxis as soon as they become pregnant there should be clear pathways for them to access prescriptions and support to ensure compliance.

Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth.

Any surgical procedure in pregnancy or the puerperium gives a score of 3 in the RCOG thromboprophylaxis guidance, indicating that 10 days of postnatal thromboprophylaxis should be considered (Royal College of Obstetricians and Gynaecologists 2015a).

Risk assessment and prescribing thromboprophylaxis

Consistency of risk assessment

It was apparent from the reviews undertaken that risk assessment is not interpreted consistently. In a number of instances assessors noted that local, simplified versions of national risk assessment scoring frameworks had been produced. These appeared to have significant deviation from national guidance and it was not clear on what basis the simplifications had been made. This inconsistency in risk assessment was noted between units and between clinicians caring for the women who died, but also between MBRRACE assessors reviewing the same woman's care. This shows that there is considerable confusion as to how best to perform risk assessment for whether thromboprophylaxis is required and about the duration of thromboprophylaxis. Although measures are in place to ensure that risk assessment takes place, there is no assessment of the quality and consistency of that assessment. There is a need for ongoing audit of whether that assessment is consistent with guidance as well as whether it is carried out.

Audits should be conducted not only to assess whether thromboembolism risk assessment was performed, but also whether the calculated risk score was correct.

A simpler form of risk assessment could also ensure consistency. There seems to be variation as to who performs risk assessment from anaesthetists after a caesarean section to obstetricians and midwives. Whichever professional performs the risk assessment there needs to be consideration of all relevant factors and a clear plan as to the duration of treatment.

A feature assessors noted was that several morbidly obese women did not meet the criteria for antenatal thromboprophylaxis as this was their only risk factor. 8 of the 37 women had a BMI ≥40kg/m2. Whilst this should lead to postnatal thromboprophylaxis four women were undelivered when they died and not receiving thromboprophylaxis. The RCOG guideline (Royal College of Obstetricians and Gynaecologists 2015a) states that risk is higher with increasing obesity so some degree of individual assessment is required for women with extreme obesity, taking into account other factors such as their mobility status to judge whether they qualify for LMWH. It was not clear that any of these women had been given information about the symptoms of VTE in pregnancy.

There is clear evidence that doctors and midwives find existing risk scoring systems difficult to apply consistently in practice. There is a need for development of a tool to make the current risk assessment system simpler and more reproducible.

Women with a high BMI should be given information about the symptoms of VTE.

Women with a BMI ≥40kg/m² score 2 points on the RCOG guideline for thromboprophylaxis in pregnancy and therefore all need postnatal thromboprophylaxis regardless of mode of delivery (Knight, Tuffnell et al. 2015).

Electronic records

As highlighted above, risk assessment in the first trimester is also important and assessors noted that in some instances where units are using electronic records the GP did not have access to the antenatal records. This makes accurate risk assessment in primary care more difficult.

Difficulty with electronic record systems was reflected in the assessments undertaken for the enquiry as the multiple electronic record systems made reviewing women's care more difficult. Some of the records when converted to documents outside the system became unintelligible. This is likely to generate challenges for external review in many similar situations and is an important consideration which needs to be taken forward as electronic patient records develop and supersede paper records.

As electronic patient records systems develop, issues of access from outside individual units need to be taken into account, not only for direct patient care but also for external review processes such as the Confidential Enquiries.

Reassessment of risk

> An older woman with a pregnancy as the result of assisted reproductive techniques collapsed immediately after a caesarean section. She had been an inpatient for 10 days prior to the caesarean section with pre-eclampsia but had not been given thromboprophylaxis.

As was highlighted in the care of women who died after first trimester pregnancy losses, risk factors change throughout pregnancy and ongoing risk assessment must continue throughout pregnancy. In this instance, the woman's admission to hospital alone placed her at intermediate risk and antenatal thromboprophylaxis should have been considered. Admission alone increases VTE risk 12 fold (Royal College of Obstetricians and Gynaecologists 2015a). Her pre-eclampsia was a further risk factor which indicated she should have antenatal thromboprophylaxis from 28 weeks gestation.

Risk assessment for venous thrombosis (VTE) should be undertaken at booking and repeated at any hospital admission, intrapartum or immediately postpartum and before discharge from hospital. (Knight, Tuffnell et al. 2015)

Antenatal admission places a woman at intermediate risk or VTE and she should be considered for antenatal thromboprophylaxis (Royal College of Obstetricians and Gynaecologists 2015a).

Symptoms/signs of VTE

Four women who died antenatally and two who died postnatally presented with symptoms and signs that were potentially indicative of VTE but appropriate investigation did not happen. In one woman repeated episodes of tachycardia and breathlessness were attributed to anxiety and she had a cardiac arrest a few days later. Two women with leg pain in the first trimester either did not have investigations or were not followed up.

> A woman with a BMI of 46kg/m^2 had calf pain and breathlessness at 8 weeks gestation. She attended the emergency department and was given one dose of low molecular weight heparin. However no investigation or follow up of treatment took place. She was seen in primary care with 'anxiety' and managed for a presumed pulled muscle for two weeks. She died a week later from a pulmonary embolism.

The pathway for women with potential signs of VTE to seek medical attention needs to be clear. Midwives seem to tell women to go to the GP, but it is not clear whether women are always aware of the urgency with which they need to be seen and assessed by a medical professional. Women should be advised not to delay and/or local systems should ensure that the pathways for referral are appropriate and rapid. Clinicians also need to be aware that with pulmonary embolism in pregnancy there may be no signs in the legs. This can mean a leg Doppler can be negative, and if clinical suspicion of PE is high, V/Q or CTPA should be undertaken.

> A woman was admitted in the third trimester and had leg pain and shortness of breath. She smoked and had a high platelet count. She was seen by a student midwife and junior doctor. The student's midwifery mentor was not present. No investigation of these symptoms and no escalation to senior staff took place. She died from a subsequent massive pulmonary embolism.

If, after review, there is uncertainty about a diagnosis or management plan, then senior review should be sought. In this instance escalation to a senior may have led to detection and treatment of this woman's VTE and prevented her eventual death.

Individual hospitals should have an agreed protocol for the objective diagnosis of suspected VTE during pregnancy (Royal College of Obstetricians and Gynaecologists 2015b).

Management [of life-threatening PE] should involve a multidisciplinary team including senior physicians, obstetricians and radiologists.(Royal College of Obstetricians and Gynaecologists 2015b).

Commencing treatment, dose and compliance

> A woman with a BMI over 35kg/m^2 was in lithotomy for 90 minutes for suturing of vaginal and cervical tears. She had multiple 'fainting' episodes postnatally that were not investigated until day 44. She was admitted to a medical unit where the diagnosis was considered but they delayed LMWH because of concerns over breastfeeding. A few hours later she collapsed and died.

Thromboprophylaxis should be started as soon as is clinically appropriate after birth. In very high risk women it is possible to give unfractionated heparin around the time of labour and birth as its effect can be reversed quickly. Women who have had a major haemorrhage or surgery for morbidly adherent placenta or with signs of sepsis are at risk for VTE, therefore prolonged delays before thromboprophylaxis is started should be avoided. Physicians need to be aware that breast feeding is not a contraindication to commencing treatment.

Ensuring the appropriate dosage is prescribed is important once the need for thromboprophylaxis has been determined. This enquiry has previously noted that a woman's weight needs to be rechecked in the third trimester but it also needs to be checked postnatally. Women will need to be weighed again to risk assess and ensure the correct dosage is advised.

> A woman with a BMI over 40kg/m² who smoked heavily needed a six week supply of postnatal thromboprophylaxis. She was only given sufficient for two weeks. She developed a DVT in the postnatal period and was treated with rivaroxaban but died two weeks later. While review of her care shows compliance may have played a role in the failure of treatment, the complete course of LMWH was not supplied from secondary care leading to an interruption of her prophylaxis which should have continued for six weeks.

This was the only instance amongst the women who died of a woman being discharged with an insufficient course of thromboprophylaxis so it does appear that units are now ensuring a full course is provided. However issues with risk assessment meant that in some instances the duration of treatment was shorter than it should have been. Some women also received an inadequate dose for their weight.

Prescriptions for the entire postnatal course of LMWH should be issued in secondary care. This will help ensure that women receive the full course without the need to visit their GP to obtain another prescription. This also provides a double safety net since the prescription will be checked by a hospital pharmacist, who ensures the correct weight-appropriate dose is dispensed. (Knight, Tuffnell et al. 2015)

It was difficult in a number of women's records to confirm that there was compliance with thromboprophylaxis or treatment after discharge from hospital. Rivaroxaban was prescribed, as described above, in this woman who required postnatal treatment for at least three months. Use of rivaroxaban is not in current guidance and data about rivoxaban and breastfeeding are lacking, however, it can be used where women decline LMWH injections. Ensuring women are aware of the importance of postnatal injections or tablets is imperative. This may be assisted by regular enquiries by any health care professional, including community midwives or maternity care assistants as to whether women have any concerns over self-administering their treatment.

Management of the acute event

> A woman with a BMI of over 40kg/m² had an emergency caesarean section. She had not had an antenatal VTE risk assessment. Postnatally her risk was incorrectly scored so she had a shortened duration of treatment. She collapsed three weeks postnatally at home and the ambulance crew persisted with resuscitation in the home so she did not leave her home until 53 minutes after the ambulance arrived. At hospital she was given thrombolysis but resuscitation was discontinued after 39 minutes.

If the acute event occurs in the community then early transfer to an acute setting is appropriate as this may allow thrombolysis. From review of the cases there was an impression that more thrombolysis was being performed in the acute setting which is encouraging. However, it is important to remember that after thrombolysis more prolonged resuscitation is appropriate before determining that treatment has not been successful. Nevertheless, there were still instances where thrombolysis was not considered or was inappropriately considered to be contraindicated. Echocardiography can be helpful in the acute phase to assess whether a pulmonary embolus is the diagnosis.

A woman with a BMI of over 40kg/m² had some calf pain antenatally that was not investigated. She had a caesarean section. She felt unwell in the hours immediately after surgery but this was not escalated to medical staff. She collapsed five hours later. There were further delays in diagnosis and initiating treatment as senior staff were busy with another woman. However once senior staff were available, bedside echocardiography supported the diagnosis of PE, following which she received thrombolysis. Unfortunately she could not be resuscitated.

Neither pregnancy, caesarean section delivery or the immediate postpartum state are absolute contraindications to thrombolysis. (Knight, Kenyon et al. 2014)

Venous sinus thrombosis

There were two women who died from venous sinus thrombosis (VST), one postnatal and one antenatal. The symptoms of headache were ascribed to other illness despite no real features to support that and the diagnosis of VST was not considered. Neither woman underwent appropriate imaging. Atypical severe headache in pregnancy or postpartum should prompt the involvement of the obstetric medical team and appropriate investigation.

Brain CT may not diagnose venous sinus thrombosis. CT venography or MR venography is required.

4.5 Conclusions

The overwhelming theme identified in the reviews of the care of the women who died from VTE was inconsistency of risk assessment. This is reflected in the assessment that for two thirds of women, improvements in care were noted that may have made a difference to their outcome (Table 4.1). The inconsistency stemmed from confusion over interpretation of national guidance, local interpretation of national guidance, and a lack of reassessment at points when women's risk changed during pregnancy. There is a need for action to address this. Coupled with this is a need to consider the pathways of care for women in the first trimester who have risk factors for VTE and to ensure that they receive thromboprophylaxis early in pregnancy where appropriate. Raising awareness of the symptoms of VTE among women with a high BMI, in particular, may be needed to prevent women from dying from VTE in early pregnancy.

Table 4.1: Classification of care received by women who died from thrombosis and thromboembolism, UK and Ireland, 2014-16

Classification of care received	Women who died from VTE Number (%) N= 37 (including 5 late)
Good care	6 (16)
Improvements to care which would have made no difference to outcome	6 (inc. 2 late)(16)
Improvements to care which may have made a difference to outcome	25 (inc. 3 late)(68)

5. Messages for mental health

Roch Cantwell, Esther Youd and Marian Knight on behalf of the MBRRACE-UK mental health chapter-writing group

Chapter writing group members: Kathryn Bunch, Roch Cantwell, Philippa Cox, Bill Fawcett, Linda Ibbetson, Hemali Jayakody, Sara Kenyon, Marian Knight, Rohit Kotnis, Jenny Kurinczuk, Kim Morley, Judy Shakespeare, Derek Tuffnell, Esther Youd

5.1 Key messages

There is an urgent need to establish pathways for release of mental health records with the Chief Medical Officers and Departments of Health of Ireland and the four UK nations to MBRRACE-UK. **ACTION: Policy makers**

Liaison, crisis and home treatment staff should have specific training, at induction and continuing professional development, in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out-of-hours care for pregnant and postnatal women. Formal links should be made with local specialist perinatal mental health services to facilitate training. **ACTION: Service planners/commissioners, service managers, health professionals**

Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour. **ACTION: Service managers, health professionals**

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant. **ACTION: Professional organisations, all health professionals**

Women should receive continuity of mental health care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care. **ACTION: Service planners/commissioners, service managers, health professionals**

In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination. **ACTION: Service managers, health professionals**

New expressions or acts of violent self-harm, or new and persistent expressions of incompetency as a mother or estrangement from the infant are 'red flag' symptoms and should always be regarded seriously. **ACTION: Health professionals**

Self-harm in pregnancy or the early postpartum period is an unusual event, and should always prompt referral for continuing evaluation, ideally by specialist perinatal mental health services. **ACTION: Service planners/commissioners, service managers, health professionals**

Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lowered thresholds and direct access for maternity and primary care professionals. **ACTION: Service planners/commissioners, service managers, health professionals**

5.2 Background

The 2015 report was the first to review the care of all women who died by suicide in pregnancy or up to one year postpartum (Knight, Tuffnell et al. 2015); prior to MBRRACE-UK only deaths after 42 days were reviewed if they were notified to the confidential enquiry, whereas the MBRRACE-UK team seeks to identify and review all deaths by suicide up to one year after the end of the pregnancy. Since then, the importance of maternal mental health continues to be increasingly recognised, with announcements of new funding for perinatal mental health services, new perinatal mental health networks (The Scottish Government 2017), and a new model of care for Ireland with respect to specialist perinatal mental health services (Health Service Executive 2017). However, the latest mapping from the Maternal Mental Health Alliance still identifies large gaps in quality perinatal mental health care (Maternal Mental Health Alliance

2017), and women in large parts of both the UK and Ireland have no access to inpatient mother and baby unit care in their area and close to support from family and friends. These gaps in service provision exist despite an estimated 10% of women experiencing a mental health problem during pregnancy or postpartum (National Institute for Health and Care Excellence 2014a). The care of all women who died by suicide during pregnancy or up to one year after pregnancy in 2014-16 in the UK and Ireland was reviewed for the purposes of this chapter, thus the care of all women who died by suicide up to one year after pregnancy has now been reviewed for a continuous period of 8 years.

Table 5.1: The socio-demographic characteristics of women who died by suicide 2014-16 in the UK and Ireland

Characteristics	Suicide (n=71) Frequency (%)
Age	
<20	2 (3)
20 – 24	8 (11)
25 – 29	22 (31)
30 – 34	18 (25)
35 – 39	17 (24)
≥ 40	4 (6)
Parity	
Nulliparous	15 (21)
Multiparous	51 (72)
Missing	5 (7)
UK or Irish citizen	
UK or Irish citizen	
Yes	65 (92)
No	2 (3)
Missing	4 (6)
Ethnicity	
White	61 (86)
Black or other minority ethnic group	7 (10)
Missing	3 (4)
Woman's region of birth	
United Kingdom or Ireland	53 (75)
Remainder of Europe	4 (6)
Outside Europe	4 (6)
Missing	10 (14)
Socioeconomic status (Index of Multiple Deprivation (IMD) of postcode of residence)	8 (11)
First quintile (Least deprived)	6 (9)
Second quintile	8 (11)
Third quintile	13 (18)
Fourth quintile	13 (18)
Fifth quintile (Most deprived)	15 (21)
Missing	16 (23)
Socioeconomic status (Occupational classification)	
Employed (Either woman or partner)	35 (49)
Unemployed (Both)	21 (30)
Missing	15 (21)
Able to speak/understand English	
Yes	68 (96)
No	1 (1)
Missing	2 (3)
Living arrangements	
With partner	49 (69)
Living alone	13 (18)
With parents/extended family	2 (3)
Others	1 (1)
Missing	6 (8)
Domestic abuse (prior to pregnancy/ during pregnancy)	
Yes	17 (24)
No	12 (17)
Missing	42 (59)
Known to social services	
Yes	28 (39)
No	35 (49)
Missing	8 (11)

5.3 The women who died

Seventy-one women died by suicide during pregnancy or up to one year after pregnancy in 2014-16 in the UK and Ireland, a mortality rate of 2.9 per 100,000 maternities (95% CI 2.2-3.6). This compares to a rate of 2.3 per 100,000 maternities (95% CI 1.9-2.8) in 2009-13 (p=0.210), and a suicide rate of 4.2 per 100,000 (95% CI 3.4-5.1) amongst the general population of women (including pregnant and postpartum women) aged 25-29 in 2016 in the UK (Office for National Statistics 2017). Overall, including the 43 women whose deaths were related to drug and alcohol misuse and who are further discussed in chapter 6, 114 women died from mental health-related causes during or up to one year after pregnancy in the UK and Ireland, a mortality rate of 4.57 per 100,000 maternities (95% CI 3.77-5.48).

Characteristics

The women who died by suicide had a median age of 30 years, 86% were of white ethnicity and 91% were UK or Irish citizens (Table 5.1). Over two thirds (71%) were multiparous. Twenty-eight women (39%) were known to social services. Almost a quarter (24%) had a known history of domestic abuse, but for 59% complete information was missing. This compares to a known history of domestic abuse for 9% of women who died from other causes, with a similar level of missing information. Eighty-six percent of women who died by suicide received some antenatal care but only 31% of those who received antenatal care received the recommended level of care. One in five (21%) booked at greater than 12 weeks' gestation.

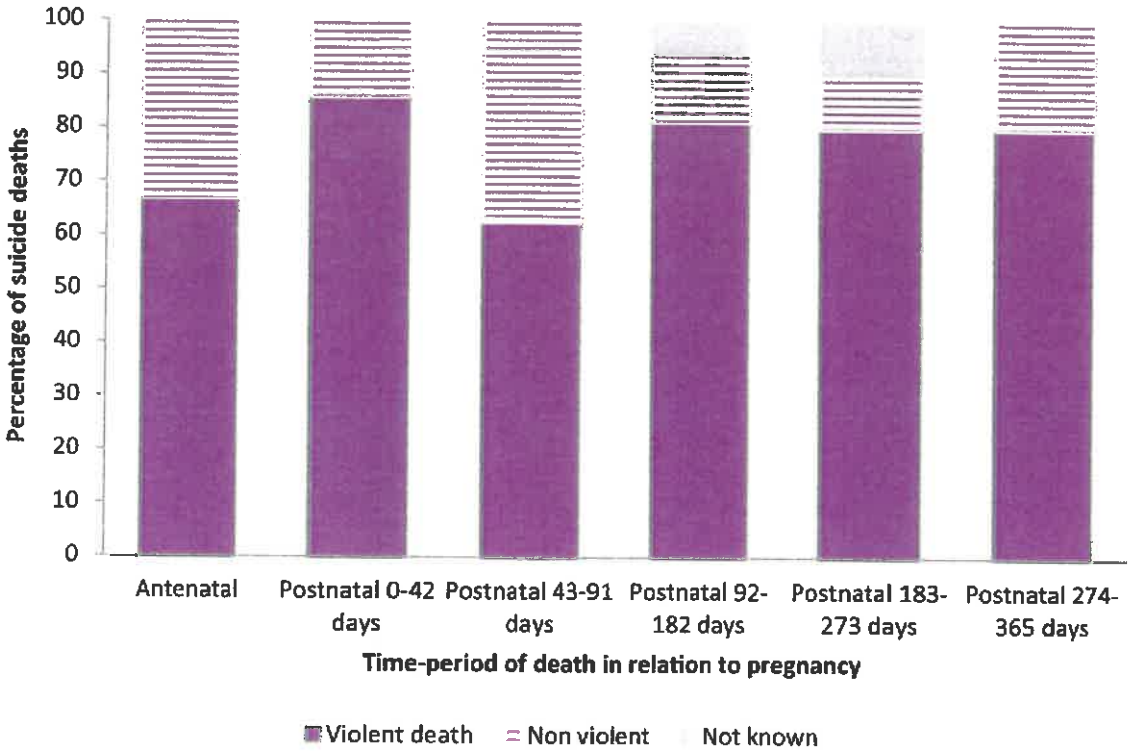
Timing

Women's deaths were distributed almost evenly across the postnatal period, with only one in eight occurring antenatally (Table 5.2). As reported in previous Enquiry reports, most women died by violent means (Figure 5.1).

Table 5.2: Timing of the deaths of women who died by suicide in relation to pregnancy, UK and Ireland 2014-16

Time period of deaths in the pregnancy care pathway	Suicide (n=71) Frequency (%)
Antenatal period	9 (13)
Postnatal 0 to 6 weeks after delivery (0-42 days)	7 (10)
Postnatal more than 6 weeks but less than 3 months after delivery (43-91 days)	8 (11)
Postnatal 3 months or more but less than 6 months after delivery (92-182 days)	17 (24)
Postnatal 6 months or more but less than 9 months after delivery (183-273 days)	20 (28)
Postnatal 9 months or more but less than 12 months after delivery (74-365 days)	10 (14)

Figure 5.1: Timing of violent suicide deaths in relation to pregnancy, UK and Ireland 2014-16



P-value for chi-square test for difference in proportion of violent and non-violent deaths across the time period=0.546

Diagnosis

Attribution of diagnosis presents a challenge for the enquiry, not least because of the almost complete absence of mental health records made available for review. For most women, diagnosis has been inferred indirectly from those given in maternity or primary care records, and/or based on symptom patterns described. Nevertheless, as in the previous report, the most common diagnosis was of recurrent depressive disorder and the majority of women had a prior history of mental ill health at some point in their lives. Notably, very few women had previous psychotic disorder, whether bipolar, postpartum or non-affective.

5.4 Overview of care and lessons to be learned

Maternity care and/or primary care records, together with some mental health records, were available for detailed review for 68 of the 71 women who died by suicide.

Good care

A woman with no past history of mental health contact died by violent means a few weeks after the birth of her first child. She was asked all appropriate questions about her mental health in pregnancy and received good antenatal and postnatal care. She left a suicide note but gave no indication at any point before her death of any mental health concerns.

While there continue to be important lessons to learn, old and new, there were a few women, including the woman described above, who died in the absence of any prior indication of ill health. There were also examples of good care by staff who went to great lengths to support and treat women. The complexity and severity of the illness of the woman described below posed major challenges for the treating team and it was evident that they strived to achieve a good therapeutic alliance with her and her family.

An older woman died by violent suicide several months after the birth of her child. She had a prior history of anxiety and depression. There were problems with her baby's development, diagnosed in pregnancy, leading to the woman developing more significant depressive disorder. She was well supported by maternity staff and appropriately referred to her specialist perinatal mental health service. She was seen rapidly by a community psychiatric nurse and, within a day, by the consultant. A plan was put in place for her management, including antidepressant medication, close follow up and mother and baby unit admission after delivery. On the mother and baby unit her severe illness presented a challenge to those attempting to form a therapeutic relationship with her. Consideration was given to ECT. Her admission was prolonged and a careful plan was made for gradually increasing time out, with good family involvement, but she took her own life while on leave.

Repeated recommendations

Previous history and good communication

Every previous report has highlighted the importance not just of recognising risk where there is prior mental ill health, but also communicating that risk to all professionals involved in the woman's care.

A woman died by hanging four months after giving birth. She had a prior history of depression, eating problems and self-harm, but this was not passed on to maternity services. Maternity services were therefore unaware of a return of her eating difficulties in pregnancy. In the postpartum period she disclosed concerning thoughts about ending her own, and her children's lives but this information was not shared among professionals. She was seen by a range of different professionals but her care was not well co-ordinated, leading to a poor response to worsening mental ill health.

There is a clear duty on all health professionals to pass on relevant information that may affect the care a woman receives during pregnancy or alter her outcomes.

GPs should inform maternity services of any past psychiatric history and maternity services should ensure that the GP is made aware of a woman's pregnancy and enquire of the GP about past psychiatric history (Knight, Tuffnell et al. 2015).

If the woman is already known to mental health services, they should be made aware that she is pregnant, and they have the same duty of care to the woman to inform maternity services of any risk she faces.

Red Flags

The 2015 Report (Knight, Tuffnell et al. 2015) highlighted a number of clinical scenarios that should act as 'red flags' for professionals. They include (i) recent significant change in mental state or the emergence of new symptoms, (ii) new thoughts or acts of violent self-harm and (iii) new and persistent expressions of incompetency as a mother or estrangement from the infant. This enquiry confirms their importance.

Box 5.1 'Red Flag' presentations which should prompt urgent senior psychiatric assessment

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

A woman died by hanging several months after the birth of her first child. She had prior treatment for depression, appropriately detected by maternity staff. She reported early postpartum mood lowering and her GP altered her anti-depressant treatment and made a referral to mental health. She expressed strong beliefs that her baby deserved a better mother than her, repeating these to the health visitor and mental health team. She described worsening suicidal thoughts of a violent nature but they were described as 'fleeting' by mental health staff. She was accepted for intensive home treatment but died before that commenced.

In addition to demonstrating all three 'red flags', this woman's care also highlighted previous lessons regarding the downgrading of suicide risk through use of shorthand terms such as 'fleeting' or 'impulsive' to equate with lack of intent.

A woman died by hanging several months after the birth of her third child. She had a history of depression with self-harm in the past, which was communicated to maternity services. She had worsening anxiety and depressive symptoms postnatally. On the day she died she contacted her GP to say she had made an attempt on her life. An appointment was made for the following day, by which time she had died.

This woman's presentation starkly demonstrates the need for an urgent response to thoughts or acts of violent self-harm. Making an appointment for review the following day is not appropriate.

Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour.

New expressions or acts of violent self-harm are 'red flag' symptoms and should always be regarded seriously.

New and persistent expressions of incompetency as a mother or estrangement from the infant are 'red flag' symptoms and may be indicators of significant depressive disorder. In some instances, this may reflect psychotic thinking. In the presence of significant illness, such symptoms may be best addressed through inpatient mother and baby care (Knight, Tuffnell et al. 2015).

Amber flags and forward planning

The 2017 Psychiatric Morbidity Review (Knight, Nair et al. 2017) highlighted the care of women who had a pre-existing major mental disorder which placed them at risk in future early postpartum periods. A past history of psychosis and significant family history were identified as 'amber flags' and are echoed in this report examining the care of women who died.

A woman died by violent means several months after the birth of her second child. She had experienced depressive disorder after her first delivery, with suicidal thinking, and was later diagnosed with bipolar affective disorder. There was a strong family history of the same illness. In her discharge from mental health services, several months before the index pregnancy, there was no mention of future postpartum risk or risk minimisation strategies. Her past history was elicited by maternity services and she was referred for specialist review. However, there is no record of her being seen by mental health services in pregnancy. She showed evidence of early postpartum recurrence but, despite periods of inpatient treatment, her subsequent care was characterised by limited recognition of significant risk or an appreciation of the importance of her past history in predicting future risk.

This woman did not receive the information she required, after her first pregnancy-related illness, to make an informed choice about risk minimisation strategies and care in future pregnancies. Mental health services did not appreciate the significant risk she was under and the opportunities available for reducing her risk, including recognition of early postpartum change in mental state, the need for close follow up where high risk exists, the importance of ensuring continuity of care and the recognition of, and acting upon, escalating patterns of self-destructive behaviours.

Recommendations – Amber Flags

Regard women with any past history of psychotic disorder as at elevated risk and requiring individualised assessment of risk.

Closely monitor women with a family history of bipolar disorder or postpartum psychosis and refer if any change in mental state. If they themselves have any mood disorder or history of postpartum mood destabilisation they should have an individualised assessment of risk.

Personal and familial patterns of occurrence and re-occurrence should inform risk minimisation strategies (Knight, Nair et al. 2017).

Recommendations – Forward planning for future risk

Following recovery, it is the responsibility of the treating team to ensure that all women experiencing postpartum psychosis receive a clear explanation of:

- **future risk**
- **the availability of risk minimisation strategies**
- **the need for re-referral during subsequent pregnancies**

Crisis, liaison and home treatment team training

> A mother with no prior history of mental illness presented to her GP with low mood six months after giving birth. She was treated with antidepressants in primary care. One week before her death she presented to the Emergency Department describing low mood with suicidal ideas. She was noted to be slowed in her speech. Her mother had to prevent her from harming herself violently earlier in the day. A consultant psychiatrist advised admission but beds were 'gate-kept' by the crisis resolution/home treatment team, who judged she could be managed at home. She died by hanging shortly afterwards.

While specialist perinatal mental health teams may be aware of the distinctive presentations and risks associated with perinatal mental illness, the enquiries have repeatedly noted that further training is required for other teams managing acute presentations.

Liaison, crisis and home treatment staff should have specific training, at induction and continuing professional development, in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out-of-hours care for pregnant and postnatal women. Formal links should be made with local specialist perinatal mental health services to facilitate training.

Mother and Baby Unit (MBU) availability

As in previous reports, there were a number of examples where emphasis was placed on keeping women out of hospital, even where there were clear indications that admission to a mother and baby unit was needed. At times, it was unclear whether the option of admission had even been considered or broached with the woman and her family. For other women, while there were periods of admission, they were to general psychiatry wards, resulting in separation from the infant and poor engagement with care.

> A young woman died by overdose in the months following the birth of her third child. She had significant early life adversity, a family history of significant mental disorder, a prior history of depression and poor physical health. She struggled to cope during pregnancy and developed a steadily worsening depressive disorder in the postnatal period. She was referred to mental health services five weeks after giving birth. She self-harmed, in a medically serious manner, on at least three occasions, and was admitted to general psychiatric inpatient wards at least twice. Her admissions were very brief, terminating in her taking her own discharge, despite evidence of mounting risk. At no point was admission to an MBU suggested. This may have resulted both in improved engagement with care and a more longitudinal approach to her difficulties.

Admission to mother and baby unit care should be considered where a woman has any of the following:

- **rapidly changing mental state**
- **suicidal ideation (particularly of a violent nature)**
- **pervasive guilt or hopelessness**
- **significant estrangement from the infant, new or persistent beliefs of inadequacy as a mother**
- **evidence of psychosis**

(Knight, Tuffnell et al. 2015)

Experience of loss

A number of women died by suicide in the time after a pregnancy or postnatal loss. These included loss through miscarriage, termination, and neonatal or infant death. As in previous reports, suicide also followed removal of the infant into care. For some women, pre-existing mental health difficulties were exacerbated by the loss.

> An older woman with longstanding anxiety problems died by violent suicide. She was seen by mental health services in pregnancy with anxiety and depressive symptoms, including thoughts of self-harm. Her difficulties persisted in the postnatal period. She remained under psychiatric care and was commenced on antidepressant medication. Her death occurred within days of the accidental death of her baby.

This woman's death highlights the vulnerability after loss, particularly where there is underlying mental illness.

A woman with a long history of depression and alcohol misuse died a few weeks after the removal of her children into care. Her antidepressants had been discontinued by her GP in the first trimester and she had subsequently self-harmed during pregnancy. In the postnatal period, her behaviour was erratic, with excessive alcohol use. There was little communication between her GP and health visitor concerning her risk at the time of child removal.

This woman, like many others, had multiple psychological and social difficulties, including mental illness and substance misuse. However, the appropriate concern for the children's welfare was not matched by similar attention to her and communication between professionals could have been improved. In this, and other similar examples, there is evidence of professionals compartmentalising their responsibilities. Suicide prevention should be seen as all professionals' responsibility.

Loss of a child, either by miscarriage, stillbirth and neonatal death or by the child being taken into care increases vulnerability to mental illness for the mother and she should receive additional monitoring and support (Knight, Tuffnell et al. 2015).

Partner and family involvement

Previous reports have highlighted the need to avoid placing too great a burden of care on other family members, and the importance of education for partner and family on perinatal mental illness, so they can support women to receive appropriate care.

A woman died by violent means several months after the birth of her child. She had a past history of depression following termination of pregnancy and showed evidence of early postnatal depressive symptoms. She re-presented to her Emergency Department some months later with significant depressive symptoms and a clear attempt at violent suicide on that day. By the time of mental health review several hours later, she denied ongoing suicidal intent (despite acknowledging her intent earlier on) and both she and her partner said they did not want any additional intervention. She was discharged and died the following day.

There are a number of lessons here, including the need for more senior review, or at very least discussion with a senior. There was no attempt to explain to her or her partner the risks she might face in view of her underlying significant mental illness.

Partners and other family members may require explanation and education regarding maternal mental illness and its accompanying risks.

Grade of assessor

The 2015 report highlighted the importance of senior review for women experiencing changes in mental state in late pregnancy and the early postpartum (Knight, Tuffnell et al. 2015). For the woman described above, although her presentation was much later, there was still a lack of a more senior view on her care that might have recognised the significant risk she posed to herself.

There should be an expectation of early consultant involvement in the assessment and management of high-risk women and of women exhibiting sudden alterations in mental state in late pregnancy or the early puerperium.

Care by multiple teams

Previously, it has been noted that women's care was characterised by discontinuities rather than being well co-ordinated. The nature of mental health service provision sometimes detracted from consistency of care.

> A woman with known previous psychotic disorder died within days of the birth of her first child. Her infant died with her. During pregnancy, she was referred to her specialist perinatal mental health team, but they do not appear to have assumed main responsibility either for her care or its co-ordination. She was moved from one adult mental health team to a second in pregnancy, and her early postnatal review, while still on the maternity wards, was carried out by a different team again.

This woman's care highlights the need to minimise alterations to continuity of care during pregnancy and the postnatal period, and the central role that perinatal mental health services should play in overall co-ordination and in direct clinical contact, particularly around the times known to pose greater risk, such as assessments made in the early postpartum period. It is inevitable that other services will become involved in care where there is a need for intensive follow-up or presentation occurs out of normal working hours. As noted already however, this, and previous examples, demonstrate the importance of additional training for those teams in recognising the distinctive presentations and risks associated with the perinatal period.

Women should receive continuity of mental health care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care.

Extended suicide

As in previous reports, instances of infant or child death were extremely rare, occurring on only two occasions. For one woman, there was very clear evidence of underlying severe mental illness. In the second, there was insufficient information to make a diagnosis in retrospect.

New messages for care

Multiple adversities

There appears to have been a shift in the pattern of diagnoses among the women who died by suicide. A significant proportion had evidence of longstanding emotional instability, characterised by early life adversity, multiple social disadvantage, chaotic patterns of engagement and, not infrequently, co-morbid substance misuse. While this group is not new to the enquiry, their prevalence amongst women who die by suicide may have increased; changes in the way information was collected prior to 2009 makes this impossible to assess statistically. The consequences for their care are striking. For a number of women, professionals went out of their way to encourage engagement, but for others, there was a sense of therapeutic pessimism and a failure to enquire as to why the woman might be presenting in such a manner.

A young woman, who herself had a disrupted and inconsistent upbringing, died by violent suicide a few months after the birth of her second child. A GP record of previous depressive disorder was not passed on to maternity services. She denied substance use at booking though it subsequently emerged that she had a long history of prescribed opiate addiction. She found it difficult to engage with maternity services antenatally. She presented repeatedly in pregnancy with physical injury but no one questioned the possibility of domestic abuse. Her behaviour became more erratic in the postnatal period. She left the postnatal wards without informing staff and is reported as being verbally aggressive. Two months after giving birth she took an overdose but refused treatment in the Emergency Department. Within several days her mother had contacted services to say she was suicidal. A referral was made for crisis team involvement but she re-presented the following day having overdosed again. A CPN assessment found 'no mental health issues' despite ongoing suicidal ideas. Her children were subsequently removed from her care. She became homeless and had worsening physical health problems. She was seen by addictions services shortly before her death when her longstanding substance use was identified.

There were a number of very clear warning signs regarding this woman's previous difficulties that were not passed on, or detected, at booking or during her antenatal care. There were missed opportunities for engagement with mental health services. Overall, there was a failure to be curious or question the reasons behind her presentations, whether with physical injury in pregnancy or increasingly chaotic behaviour in the postnatal period. This lack of sensitive enquiry is repeated in the care of several other women. These opportunities presented themselves at times of change in pattern of presentation. While this is recognised in previous recommendations on symptom pattern, it bears modifying here to reflect the complexity seen in vulnerable populations.

In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination.

Judgements based on diagnosis or social circumstances

There was evidence that putative diagnoses or the presence of psychosocial factors resulted in a judgement that risk was lowered. In many circumstances, the presence of impulsivity, substance misuse, or social adversity increases, rather than decreases, risk of self-harm and suicide.

A woman died by violent suicide six months after the birth of her sixth child. Her older children were not in her care and there was a history of significant domestic violence. She had a prior episode of depression, with a serious attempt on her life resulting in hospital admission, some years earlier in the context of her social and family difficulties. A decision was made to remove her child at birth. She had a recurrence of depressive disorder postnatally and was treated by her GP with antidepressants and regular review. She had worsening suicidal thoughts (all with a violent theme) and had to be stopped from acting on these by her partner. Her GP made an urgent referral to mental health services but it took a month for her to be seen. The recorded assessment contained little detail and concluded that she had an adjustment disorder in the context of adverse social stressors. She was discharged from care and died by hanging two days later.

For this woman, a more senior assessment may have recognised her real risk, rather than linking risk to diagnosis and social circumstances.

While diagnosis and social circumstances should form part of a holistic risk assessment for self-harm and suicide, they should not be used to categorise women into simplified high or low risk groups.

Avoidance of care

An older woman developed early onset low mood and pervasive guilty ruminations over her care of her infant. She was appropriately referred to mental health services but disengaged despite significant concerns over her mental health. Five weeks later she had died by violent suicide.

Again, while not an entirely new message, the number of women who avoided, or disengaged from, care in the time leading to their deaths is striking.

A young woman, with no previous history of mental health problems, died by violent suicide some months after the death of her infant from an underlying medical problem. Her GP attempted to maintain regular contact but she avoided face-to-face meetings. She also declined contact with a bereavement counsellor. Her symptoms persisted but were ascribed to bereavement.

Disengagement from care should be regarded as a potential indicator of worsening mental state. All professionals involved in the woman's care should be informed of non-attendances and assertive follow-up arranged where there is already concern regarding mental state or prior evidence of risk.

Self-harm

The 'red flags' noted in the 2015 Enquiry included the need to recognise thoughts or acts of violent self-harm as indicators of significant risk (Knight, Tuffnell et al. 2015). In this triennium, there were a number of women who self-harmed, sometimes by overdose, before going on to die by violent suicide. Acts of self-harm in pregnancy or the early postpartum period are unusual events. For that reason, they should prompt referral to specialist perinatal mental health services for review.

A woman from an immigrant background died by violent suicide mid-pregnancy. She had a one-year history of depressive symptoms treated in primary care, with overdose on one occasion pre-pregnancy. In her first trimester, she presented to the Emergency Department following an overdose, with tablets and alcohol, and lacerations to her wrists. While awaiting assessment she made attempts to strangle herself. A mental health assessment noted possible previous alcohol dependency but no acute mental illness. She was discharged without follow-up. At her booking, one week later, she was referred to perinatal mental health services. They rejected the referral based on the mention of alcohol problems, suggesting referral to addictions services instead. Her GP regarded this as an error and asked that the specialist referral proceed. She took a further overdose, with alcohol and attempted strangulation, a week later. The Emergency Department summary noted ongoing thoughts of ending her life but the mental health assessment categorised her act as 'impulsive'. Three weeks later she died violently.

This woman's care demonstrates the 'in the moment' assessments noted in the 2015 enquiry, where the use of the term 'impulsive' seems to ignore the pattern of escalating self-destructive behaviour and worsening mental state. In addition, two acts of significant self-harm in the second trimester of pregnancy, in a woman with a history of mental ill health, should result in urgent specialist perinatal mental health review. In this instance, the woman had been appropriately referred to specialist perinatal mental health services early in pregnancy but rejected without assessment on inappropriate grounds, despite challenge by the GP. Alcohol problems are not a reason to refuse to see women with serious mental health problems.

Self-harm in pregnancy or the early postpartum period is an unusual event, and should always prompt referral for continuing evaluation, ideally by specialist perinatal mental health services.

Gatekeeping, silo-working and co-ordination of care

It has long been recognised that presentations in pregnancy and the postnatal period require a response that takes into account distinct symptom patterns, rapidity of escalation and need for altered thresholds for referral. In this enquiry, these messages are repeated, but there is also evidence that services tended to work in isolation, sometimes creating barriers to rapid assessment, and did not take an overview of complex presentations requiring clinical leadership and care co-ordination. The previous recommendation on care co-ordination is strengthened here to suggest that specialist perinatal mental health services should take on this responsibility where possible.

A woman died by violent suicide several months after the birth of her second child. She had a prior history of depression and a family history of suicide. She engaged poorly with recommendations (for medication and counselling) to manage low mood in pregnancy, but, despite repeated assessments by maternity staff and her GP, it was felt she did not meet the threshold for referral into secondary care mental health services. Specifically, she did not score highly enough on standardised assessment tools used as part of the referral criteria and not all maternity staff could access direct referral.

There were clear barriers to care for this woman. Over-reliance on pro-forma assessments limited access to secondary care services, and included restrictions on who could refer into services.

A woman died by violent suicide nine months after the birth of her third child. She was known to social services and had a history of anxiety, depression and self-harm. She attended very frequently at her GP practice. During pregnancy, she had multiple maternity admissions with varying physical symptoms. Repeated investigations did not reveal an underlying cause. She had four psychiatric reviews while still an inpatient, coming to differing diagnostic conclusions, and with little evidence of a plan for treatment or care co-ordination. In the first six postnatal weeks, she had three changes of antidepressant. She expressed violent suicidal intent on several occasions. She was seen by a number of different specialist mental health teams, received a variety of diagnoses, and ultimately died while awaiting assessment following an overdose.

A woman died by violent means a few months after the birth of her second child. She had a prior history of severe postpartum mental illness but, despite referral, she was not seen in pregnancy for risk assessment and management. She showed evidence of early postpartum recurrence. She had an escalating pattern of significant self-harm. She was seen by several different mental health teams and was admitted, on three occasions, each time to a different mental health inpatient setting. There was limited co-ordination of care or oversight of the pattern of symptom worsening.

Both these women presented very complex challenges and required senior care co-ordination. There was very limited evidence of joint working across teams to manage their care.

> An older woman died by violent suicide almost a year after the birth of her first child. She had a prior history of mental ill health and required intensive post-natal mental health care, including two periods of hospitalisation. There was an extended period where her key worker was on leave and during that time there was no co-ordination with her health visitor despite significant concerns for her mental state.

The woman's care was significantly compromised by discontinuity, although the absence of her key worker was known and could have been planned for.

Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lowered thresholds and direct access for maternity and primary care professionals.

Complex care co-ordination should be led by specialist perinatal mental health services where possible, and ensure continuity when key workers are absent.

Psychiatric co-morbidities

The 2017 Morbidity Report highlighted areas where physical health complaints caused diagnostic confusion and led to poor care planning (Knight, Nair et al. 2017). In this enquiry we noted a number of occasions where the woman's care was adversely affected by overshadowing from other psychiatric co-morbidities, which distracted clinicians from recognising developing suicidality.

> A woman died by violent suicide a few months after the birth of her child. She had a long history of depressed mood, deliberate self-harm and eating difficulties. This was not fully passed on to maternity services and her worsening eating disorder was not picked up in pregnancy. In the postnatal period she also developed significantly worsening mood with suicidal ideation. She spoke of ending her life and said that she could understand how a mother could also end the lives of her children. The response was a referral to the eating disorder service. They proposed admission to treat her eating disorder and for her children to go into foster care. It subsequently transpired that she was judged to be suitable for home treatment but her children were still removed from her care. She died a few days later.

This woman's care focussed on her eating disorder, which, while clearly requiring treatment, nevertheless overshadowed her worsening depressive and suicidal symptoms. The final act of removal of her children, without providing additional support and risk management for her, was the act that likely led to her death.

Evidence of suicidal thinking must be acted on, even where the focus of therapy is on another aspect of the woman's care.

Care of women in prison

There are a small number of women in this report who were imprisoned at the time of their deaths. Although they had access to psychiatric care, the strictures of prison routine, and lack of anticipation of care needs, caused significant problems for them at a particularly sensitive time.

> A woman in her 30s died within a few days of the birth of her child. She had significant polysubstance misuse and her older children were in care. She had a history of overdosing. In pregnancy, she was seen by a prison psychiatrist and was followed up regularly. She repeatedly mentioned thoughts of self-harm, often linked to ongoing child protection procedures, but said that being pregnant was why she did not act on these thoughts. She last had contact with prison mental health services several days before she gave birth. She believed she would be able to remain in hospital with her baby after she gave birth until her baby was removed into care. However, she was moved back to prison without her baby but encouraged to visit daily and to express. Equipment for expressing was not always available to her in prison. On the day she died, she was informed that she could no longer visit her baby, but could express milk. She had no contact with prison psychiatric services in the postnatal period.

For this woman, there was a clearly increased risk in the postnatal period, particularly given the removal of her infant into care. The sudden change of plan by prison services, unavailability of equipment for expressing (a need which should have been anticipated) along with lack of psychiatric review, were likely to increase her sense of loss. In particular, no one asked her about thoughts of self-harm or suicide at a time that she herself had flagged up as more risky, and which is well documented from previous Enquiry reports.

Women who are imprisoned during pregnancy or in the postnatal period face the same range of risks as those in other settings, exacerbated by their particular circumstances, and by the increased risk of separation from their infant.

Prison staff should be actively engaged in assisting the woman to plan for routine aspects of labour, birth and infant feeding, which may be affected by imprisonment, and should receive additional training on the distinctive features of, and risks associated with, perinatal mental illness.

Prescribing issues – de-prescribing

> A woman died violently in her third trimester. She had a previous history of anxiety and depression, with depression in a previous postnatal period. She had been prescribed venlafaxine prior to the pregnancy to good effect, but it was stopped on discovering the pregnancy, either by the woman herself or by her GP. No alternative was suggested and there does not appear to have been any specialist service within her area. She developed worsening anxiety, and then depression, with a range of physical complaints, poor coping and suicidal ideation. As her symptoms worsened, she was referred to a low intensity psychological therapies service. She returned to her GP asking to restart her previously effective venlafaxine. It is clear from the consultation notes that her GP was very reluctant to prescribe and placed responsibility for the decision entirely on the woman, documenting an explanation of the risks, but not the benefits, of taking medication. She died a week later on the day she was due to undergo a mental health assessment.

This woman's care reiterates the need to take changes in mental state and thoughts of suicide seriously, particularly in late pregnancy and the early postpartum period. It also reflects the need for access to specialist perinatal mental health service provision in all areas. In addition, there was a focus on preventing possible harm to the fetus which distracted from her own need to receive ongoing care.

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant.

Prescribing issues – propranolol

Two women died by overdose of propranolol during this enquiry period. One was clearly taken with deliberate intent, the second was less certain. Both had a history of anxiety and deliberate self-harm. The indications for prescribing were uncertain. These women's deaths highlight the toxicity associated with beta blockers in overdose and the need for caution, and ongoing monitoring of prescribing and mental state, where these medications are dispensed.

Adequacy of mental health record returns

We have previously reported on the low rate of returns of medical records from mental health services. In the absence of psychiatric records it is often very difficult to assess the quality or frequency of interaction, or the specific disciplines or teams involved in the woman's care. As mentioned at the outset of this chapter, it is also hard to ascribe diagnoses retrospectively.

In the 2015 enquiry, a recommendation was made that mental health services should publicise Enquiry findings to highlight messages pertaining to improving mental health care. This has not resulted in any improvement in the proportion of psychiatric records received. In the current Enquiry period, mental health records were returned for only 29 of 62 women (48%) women who died from mental health disorders and had been in contact with mental health services. The Maternal Deaths Enquiries form one of the four UK National Confidential Enquiries, which also includes the National Confidential Inquiry into Suicides and Homicides. The methodology ensures anonymity and the aim is to improve care. There are thus no reasons to impede access to clinical records for Enquiry staff and assessors. Indeed, co-operating with the Enquiry should be seen as good clinical practice and good corporate governance.

There is an urgent need to establish pathways for release of mental health records with the Chief Medical Officers and Departments of Health of Ireland and the four UK nations. Records for all women who die during or in the year after pregnancy who have had contact with mental health services should be released directly to MBRRACE-UK from risk/governance departments.

5.5 Messages for pathology

A post mortem was performed in 66 of the 71 women who died by suicide (93%). The methods women used are shown in table 5.3.

Table 5.3: Method of suicide used by women who died, UK and Ireland 2014-16

Method	Number of women (%) N=71
Hanging	42 (59)
Drug toxicity	14 (20)
Fall from height	6 (8)
Hit by train	4 (6)
Suicidal stabbing	2 (3)
Unclear	3 (4)

These violent methods are relatively unusual in suicides in women in the general population but more commonly employed in the setting of maternal death. This has been recognised in previous reports. The three women who used an uncertain method included one woman with probable suicidal insulin injection, which can be extremely difficult or impossible to prove at autopsy, one woman for whom the autopsy report was not available, and one woman whose autopsy report was inadequate and the precise cause of her death was difficult to determine.

In 27 women (39%) the autopsy report was felt to be in need of major improvement by the reviewing pathologist. Pathologists who would not usually undertake maternal death autopsies may find themselves performing these kinds of autopsies where suicide or drug toxicity is suspected and the fact of pregnancy or recent pregnancy may not be known. However, there were often more basic details missing including limited descriptions of injuries or other external findings (including lack of description of a ligature mark or the presence or absence of petechial haemorrhages in cases of hanging), and often poor correlation of findings with the circumstances of death and given cause of death.

Toxicology use and/or interpretation was noted to be in need of improvement in 19 women (28%). Examples include limited toxicology testing (alcohol only), poor quality toxicology reports (levels of drugs not given), for example, in a woman with suspected morphine toxicity, the free and total morphine levels and their ratio was not given which is vital for interpretation of its significance and the interval between administration and death. Additionally there was often limited interpretation of the toxicology findings by the pathologist including the basic question of what effect the drugs or alcohol might have had on the deceased, and no discussion of toxicology findings in the clinicopathological correlation despite their inclusion in the cause of death.

In several instances the class of drug was included in the cause of death but not the specific drug names.

In one instance where the woman died 8 days after admission to hospital, the admission blood samples were not available for testing by the pathologist and therefore the suspicion of a drug-related cause of death from propranolol toxicity was unable to be confirmed.

In two women who died by hanging, an external-only autopsy was performed. There was no internal examination. In both women toxicology was performed but the pathologist's interpretation of the toxicology findings was limited. External-only autopsies, in the absence of post mortem CT scanning, are not recommended by the Royal College of Pathologists on the basis of quality (personal communication from Dr Mike Osborn, Chair of the Royal College of Pathologists Death Investigation Group). Published guidance on the autopsy in cases of suspected suicide from the Royal College of Pathologists is expected in the next year.

In two women in whom an invasive autopsy was performed, the women's brain was not examined. In addition, in one woman where brain pathology was in the given cause of death, the required histological examination of the brain, necessary to reach the given diagnosis, was not performed. Post mortem examination (invasive, by post mortem CT or a combination of both) should include all organs - cases of neurological abnormality (for example frontal lobe pathology) have been encountered where such pathology might have a bearing on the decision making ability of the deceased in taking their own life. This may have direct implications for coroners in coming to a conclusion of suicide or otherwise.

In one woman a post mortem CT (PMCT) was performed in conjunction with an external examination. This is the first example of the use of PMCT seen in MBRRACE-UK maternal death reviews, although as the use of PMCT increases across the UK, it will become more common. In this instance the examination was appropriately carried out in conjunction with an external examination. The combination of external examination with PMCT is in keeping with PMCT guidance from the Royal College of Pathologists. The interpretation of PMCT findings will be dependent on the experience of the reporting radiologist, but in this woman assessors felt interpretation was in keeping with the clinical features. One area of question was the reliability of PMCT in assessing bowel ischaemia/infarction given how challenging this diagnosis is in life with a functioning circulation. It was not stated how soon after death the PMCT was performed or whether contrast or ventilation was used. One additional fact of note was that the CT report did not comment on the pelvic organs, yet the external examination noted a healing lower abdominal scar.

Recommendation for clinicians:

If a pregnant or postpartum woman is admitted with suspected drug toxicity, blood samples from admission should be requested to be retained by the lab so as to be available for detailed toxicology testing if required.

Messages for pathologists:

Pathologists should take care to describe and document external findings including injuries and findings pertinent to the cause of death.

Toxicology should always be performed when women die by suspected suicide, to include a routine screen for known prescribed drugs, drugs of abuse and alcohol.

Pathologists and coroners should ensure the quality of toxicology reports is sufficient to enable proper interpretation in the context of the woman's death. Specifically:

- **Toxicology laboratories should report the levels of drugs detected, along with the levels known to be associated with fatality.**
- **Where morphine is detected, toxicology laboratories should report the free and total morphine levels and their ratio.**

Specific drugs names should be used in reporting the woman's cause of death, not the class of drugs.

Clinico-pathological correlation should draw together the circumstances of a woman's death with the findings at autopsy, with discussion of the significance of toxicology findings and the likely pathological effects.

Post mortem examination should involve all organs including the brain.

External-only autopsies should not be performed, unless in conjunction with post mortem CT scanning.

Post mortem CT scanning (PMCT) should be undertaken in line with Royal College of Pathologists and Royal College of Radiologists guidance and in maternal deaths, care should be taken to ensure comment on the pelvic organs.

5.6 Conclusions

Although a number of examples of good care were identified, assessors felt that in over half of women, improvements in care may have made a difference to their outcomes (Table 5.4). Multiple messages for care were identified which have been described before, perhaps most critically the need to be aware of both red and amber flags in the perinatal period. Alongside this, the need for training of liaison, crisis home treatment and prison mental health teams about the unique features of perinatal mental illness, and particularly the potential for rapid deterioration, is stark. It is notable that very few women who died had acute psychotic illnesses, or a history of such disorders, suggesting these women's illnesses are being recognised and treated. However, the challenge facing both maternity and perinatal mental health services is caring for women with multiple adversities; most of the women who died by suicide faced many difficulties, social, physical and mental. In the light of this theme of women with many complex problems, it is particularly disappointing that the MBRRACE-UK admin team face many barriers when attempting to obtain mental health records for review by the enquiry. This is an urgent area for action.

Table 5.4: Classification of care received by women who died by suicide, UK and Ireland, 2014-16

Classification of care received	Women who died by suicide Number (%) N=68*
Good care	10 (15)
Improvements to care which would have made no difference to outcome	21 (31)
Improvements to care which may have made a difference to outcome	37 (54)

*Records were not available for review for 3 women

6. Messages for the care of women from vulnerable groups

Judy Shakespeare, Esther Youd and Marian Knight on behalf of the MBRRACE-UK other psychiatric and homicide chapter-writing group

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6.1 Key messages

There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy. **ACTION: Policy makers, professional organisations**

Healthcare professionals need to be alert to the symptoms or signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure. **ACTION: Health professionals**

Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse. This is even more important with increasing use of electronic records to ensure all agencies involved in a woman's care are aware of her risk of domestic abuse. This would be further facilitated by support for the intra-operability of systems to support information sharing through electronic records. **ACTION: Service planners/commissioners, service managers, health professionals, police and safeguarding (social care) professionals**

Consider ways of ensuring that, for each woman who misuses substances:

- progress is tracked through the relevant agencies involved in her care
- notes from the different agencies involved in her care are combined into a single document
- there is a coordinated care plan.
  ACTION: Service planners/commissioners, service managers, health professionals

Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues. **ACTION: Service planners/commissioners, service managers, health professionals**

The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange. **ACTION: Service planners/commissioners, service managers, health professionals**

In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications (such as alcohol or substance misuse or interpersonal violence), and should prompt renewed attempts at engagement, diagnosis and care co-ordination. **ACTION: Service managers, health professionals**

6.2 Background

This chapter is focussed on the care of women from vulnerable groups: those who died by homicide as a result of domestic violence, and those who died as a result of drug and alcohol misuse. A recent report on the health and care of vulnerable pregnant women in Europe (Women Political Leaders Global Forum 2018) defines vulnerable pregnant women as "pregnant women who experience a distance in accessing

maternal healthcare, as refugees/ migrants/ ethnic minorities/ second or third generation immigrants, due to problems in speaking the language and/ or understanding the culture, and/ or due to lack of income, housing or social support". In the context of the UK and Ireland, and amongst the women whose deaths were examined for the purposes of this chapter, vulnerability is most often represented by the trio of domestic abuse, mental health problems and drug and alcohol problems. There is often a cycle of families with intergenerational problems. Women frequently have had involvement with the care system when they themselves were children, are victims of child sexual abuse, are known to social services, self-harm, and have depression, anxiety and chronic trauma. Their pregnancy care is commonly characterised by late booking, chaotic behaviours, difficulty keeping appointments and poor engagement with conventionally designed maternity services. Outcomes for children of mothers with these problems are known to be worse than for other children. Health professionals often feel helpless and hopeless about the care of these women, and yet, as a group increasingly represented within these maternal death enquiries, they are a group for whom improvements in care are essential to prevent future deaths. The risk of drug misuse in women is substantially reduced during pregnancy and multiple analyses suggest that this association is largely causal, implying that pregnancy is indeed a strong intrinsic motivator for drug abuse cessation (Kendler, Ohlsson et al. 2017). Pregnancy therefore represents a time of opportunity which should not be ignored.

6.3 The women who died

Fourteen women were murdered, all by partner or a former partner, 10 of whom died during pregnancy or up to six weeks after pregnancy. All were reviewed for the purposes of this chapter. Eleven of the 14 women (79%) received some antenatal care, but only 4 of these (36%) received the recommended level of care (booked at 10 weeks or less and no antenatal visits missed). Eight (73%) received the minimum level of care (booked at less than 13 weeks and no more than 3 antenatal visits missed).

Overall, 43 women died in relation to drug and alcohol misuse, 6 during pregnancy or up to six weeks after the end of pregnancy, and the remaining 37 between six weeks and one year after the end of pregnancy. The deaths of thirty-five women who died in relation to drug or alcohol toxicity were reviewed for the purposes of this chapter; 28 were drug-related, 3 alcohol-related, 1 related to both drug and alcohol toxicity and the exact causes were unclear for 3 women. Two women died from cardiac effects of drugs, two from neurological effects of amphetamine and spice respectively; the remaining women died from respiratory causes. Twenty-nine of the 35 women (83%) received some antenatal care, but only 3 of these (10%) received the recommended level of care (booked at 10 weeks or less and no antenatal visits missed). Thirteen (45%) received the minimum level of care (booked at less than 13 weeks and no more than 3 antenatal visits missed).

6.4 Overview of care and lessons to be learned

Repeated recommendations

Homicide and domestic abuse

All of the 14 women who were murdered were killed by a partner or former partner, five had a known history of domestic abuse. In several others there was no evidence women had been asked about domestic abuse, or they had only ever been seen in the presence of their partner and thus had no opportunity to report abuse. One woman who was at high risk repeatedly denied domestic abuse when asked, and no-one investigated further despite multiple presentations with suspicious signs.

> Two women were killed by partners with known severe mental health problems. In one instance the woman's partner's problems remained unknown to maternity services. One of these women was never seen alone throughout her pregnancy and there is no evidence she was ever asked about domestic abuse. The second woman denied domestic abuse on questioning but presented multiple times during pregnancy and postpartum with minor injuries and other complaints which were never explained or explored.

As well as being aware of the symptoms and signs of domestic abuse, these women also highlight the importance of being alert to the mental health of partners, which may render these women additionally at risk.

Healthcare professionals need to be alert to the symptoms or signs of domestic abuse and women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure.

NICE Antenatal care guideline CG62 (National Institute for Health and Care Excellence 2017)

In another instance, staff reported after a woman's death that they had not been trained to enquire about domestic abuse using the hospital's newly introduced electronic records. Furthermore, it was noted that documentation of domestic abuse was only available to antenatal staff via women's computerised antenatal records and was not shared with other agencies. Computerised prompts help to ensure that all women are asked about domestic abuse, but staff still need training in how to undertake this sensitively and to understand the importance of questioning women alone. It may be helpful to alert women that they will be asked about domestic abuse in the absence of their partner so that it is clear this is normal practice.

As noted in chapter 2, of all the women who died in 2014-16 during or up to six weeks after the end of pregnancy, 8% had a known history of domestic abuse. However, in 64% there was no information about whether they had a history of domestic abuse; it was unclear whether or not they had been asked.

Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse (National Institute for Health and Care Excellence 2014b). This is even more important with increasing use of electronic records to ensure all agencies involved in a woman's care are aware of her risk of domestic violence. This would be further facilitated by support for the intra-operability of systems to support information sharing through electronic records.

There were clear examples of exemplary care.

> A woman revealed a history of domestic abuse. She attended hospital following another episode of violence. She was appropriately referred to the specialist domestic abuse midwife, and during her pregnancy numerous agencies were involved including community, hospital and social services as well as safe-guarding teams. Nevertheless, she remained living with her partner and died following a further episode of violence.

The teams caring for this woman were clearly aware of the pathways of care for women known to be at risk from domestic abuse in their area. Different agencies worked together well but in this instance were unable to prevent the eventual outcome.

All health professionals caring for women should be aware of the pathway of care once domestic abuse is disclosed, and escalate to senior staff if necessary.

NICE Guideline CG110 Pregnancy and complex social factors (National Institute for Health and Care Excellence 2010)

Drug and alcohol misuse

Severe and multiple deprivation (SMD)

Most women who died from drug or alcohol misuse were extremely vulnerable with multiple medical, mental health and social problems, including histories of deliberate self-harm, domestic abuse and children who had been removed. As noted above, the occurrence of the trio of co-morbidities, domestic abuse, mental health problems and drug and alcohol misuse was a strong theme.

> A woman died as a result of acute intoxication from alcohol and heroin in the third trimester of pregnancy. She had a long history of drug and alcohol misuse, depression, self-harm and domestic violence. All of her previous children had been taken into care. Social services were aware of these issues. Her pregnancy was unplanned. She had not taken opiates for some years, and had had a successful inpatient alcohol detoxification. At her first antenatal clinic her history of drug and alcohol problems was noted and she was appropriately referred to the child protection midwife and drug and alcohol team. She was subsequently a poor attender at appointments. She appears to have given no indication to any staff about her use of opiates again and her poor attendance at appointments and lack of contact did not alert any one to her situation.

In this instance, as well as many others in this enquiry, this woman's pregnancy was unplanned. Discussing and considering long-acting methods of contraception remains important in all women with chronic conditions, including these particularly vulnerable groups. During pregnancy, multiple professionals were involved in this woman's care but no one person was identified to coordinate her care; a single named professional may have recognised the pattern of deterioration in her substance use.

Consider ways of ensuring that, for each woman who misuses substances:

- **progress is tracked through the relevant agencies involved in her care**
- **notes from the different agencies involved in her care are combined into a single document**
- **there is a coordinated care plan**

Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor

NICE guideline CG110: Pregnancy and complex social factors (National Institute for Health and Care Excellence 2010)

Guidance is clear that the outcomes of pregnancy for both mother and infant are better for opioid dependent women who enter methadone treatment programmes than for those who do not (Independent expert working group 2017). A recent update to the guideline is clear that the main objective of management is to achieve stability across four domains – pharmacological, social, medical and psychological. As a further protective measure the guideline recommends offering all opiate users in the community access to a take home supply of naloxone with instructions on its use and with training on managing suspected overdoses. Availability of naloxone may have prevented this woman's death from her final overdose.

Substitute prescribing can occur at any time in pregnancy and carries a lower risk than continuing illicit use. Substitute prescribing has the advantage of allowing engagement and therefore identification of health and social needs, as well as offering the opportunity for brief interventions and advice to improve outcomes.

Maintenance opioid treatment, at a dose that stops or minimises illicit use, is most appropriate for ensuring continuity of management of pregnancy and aftercare.

Women prescribed controlled drugs must be advised of the availability of take home naloxone.

Drug misuse and dependence: UK Guidelines on drug misuse and dependence update (2017). (Independent expert working group 2017)

Complex problems associated with drug and alcohol misuse

A woman with known chronic alcohol abuse and acute fatty liver did not report her alcohol use to the midwife at booking. She had an uneventful pregnancy. At 28 weeks she had abnormal blood test results that were not noted nor acted upon. Some months after giving birth she reported suicidal thoughts to her GP, but she was not referred. One week before her death she attended the emergency department with a self-induced fracture while she was drunk, but no action was taken, despite her disclosure of alcohol dependence. A week later she died from a massive gastrointestinal bleed.

Evidence of ongoing problems with drug and/or alcohol abuse was often missed postnatally, emphasising the importance of senior involvement with coordinated postnatal care for these women with complex and multiple problems. A copy of the postnatal plan drawn up at discharge should be given to the woman as well as sent electronically to her GP.

Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues.

The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange.

(Knight, Tuffnell et al. 2015)

Judgements based on medical history

A woman with known drug and alcohol dependence presented to the Emergency Department with abdominal pain and vomiting a few months after giving birth. She was found to have severe hypokalaemia, but was discharged with oral potassium supplements and oral antiemetics. She collapsed and died shortly after discharge. Her death was thought to be due to a cardiac arrhythmia in relation to metabolic disturbance, secondary to vomiting due to alcohol and drug withdrawal.

In this instance, it appears that this woman's symptoms were downgraded simply because she was a drug and alcohol user. Health professionals may feel helpless and hopeless about caring for these women, but fully investigating and managing their symptoms is as important as for women without their multiple and complex problems. There was frequent evidence of this 'fixation error' where significant symptoms were attributed to facets of women's drug and alcohol dependence. In this instance, the severity of the metabolic disturbance caused by her withdrawal was not recognised. Another woman, considered in the malignancy chapter, had similar symptoms which were consistently attributed to withdrawal, which led to late diagnosis of her cancer.

> After a woman with known substance dependence had surgical management of an ectopic pregnancy no risk assessment for VTE was carried out despite clear risk factors. When she presented with shortness of breath and tachycardia the focus was on concern about possible withdrawal symptoms though the cause of her symptoms was the pulmonary embolism from which she died.

At one point this woman, described in the thrombosis chapter, unsuccessfully requested oxygen for her severe breathlessness. Her symptoms were assumed to be drug withdrawal although they did not abate when she was given methadone. She was treated with diazepam and discharged after a day. Her symptoms persisted and when she collapsed she was readmitted to hospital but could not be resuscitated. These issues are clearly reflected amongst women who died by suicide and the following recommendation is reiterated from chapter 5.

In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications, and should prompt renewed attempts at engagement, diagnosis and care co-ordination.

Co-morbid depressive illness

> A multiparous woman with a long history of substance misuse booked late after an unplanned conception. All her previous children were in care. She gave birth uneventfully at term. All postnatal care of her baby on the postnatal ward was supervised, and a court order was made while she was an inpatient for removal of her child to foster care. The woman reported suicidal feelings to staff and was very distressed. She was reviewed by the mental health team on the ward who felt she had capacity and she did not have suicidal intent, but a plan was put in place for follow up once she was discharged. She was visited multiple times by the mental health team up to four weeks post-discharge; visits were continued despite being unable to access her home on several occasion. She was seen and discharged on day 28. There were repeated attempts at contact from the drug liaison team in the following months after birth, but they were unable to engage with her. She died from an overdose a few months later.

Many of the messages for mental health care noted in the previous chapter were echoed here, since co-morbid mental illness was common. However, there were very clear examples of exemplary multidisciplinary care. This woman's mental health problems were taken seriously by mental health and drug liaison services but she withdrew from engagement with them. On other occasions, however, there was evidence of silo working, which prevented women obtaining appropriate treatment for their mental health problems.

> A woman with emotionally unstable personality disorder and a history of drug misuse visited her GP some weeks after birth expressing suicidal thoughts. She was referred urgently to the community mental health team, who assessed her but did not accept her for treatment because she said she was drinking. They discharged her. One month later she died from an overdose.

Many drug and alcohol teams do not have the expertise and/or the remit to manage mental health problems. This community mental health team clearly felt unable or unwilling to manage this woman's mental health problems because of her alcohol dependence. She was thus unable to get the care she needed. Given changes to commissioning pathways and the move in some areas for local authorities to be responsible for addictions services, there is the potential for these gaps in care to become greater.

Perinatal mental health clinical networks should be established to develop local services and clear pathways of care to prevent care being fragmented and uncoordinated. Networks should always include specialist addictions services.

Opioid prescription

A woman with complex problems including an emotionally unstable personality disorder, diabetes, a gastric band and chronic pain became pregnant despite an implant. She was delivered early because of intrauterine growth retardation and discharged home with a large supply of tramadol for pain relief. A few days after giving birth she died and at postmortem was found to have a fatal level of tramadol and other drugs in her blood.

Two women died with a fatal level of tramadol found at postmortem. In neither instance was it clear whether the overdose was taken with deliberate intent. Both women had, however, been discharged from hospital with a very large supply of the drug. It is increasingly recognised that many people are leaving hospital with opioid tablets they do not need (Makary, Overton et al. 2017), and this may have contributed to these women's deaths. Overprescribing has been identified as a major contributor to the opioid epidemic and it has been suggested that decreasing the default take-home dose or considering non-narcotic alternatives are simple actions to address this (Makary, Overton et al. 2017). Detailed guidance exists on prescribing and deprescribing (Royal College of Anaesthetists Faculty of Pain Medicine 2015).

Prescription of opioid analgesics postnatally should follow national guidance and consideration given to decreasing the take-home dose or supplying non-narcotic alternatives.

Capacity issues

An older woman with alcoholic liver disease and multiple social problems was admitted to a tertiary unit with end stage liver disease after she was found to be 18 weeks pregnant while in police custody. Her mental capacity was assessed by a liaison psychiatrist and found to be inconsistent and fluctuating. Her behaviour was very challenging. She died of multi-organ failure at 20 weeks of pregnancy.

There was no evidence that anyone had considered this woman's contraception needs nor her capacity to make decisions about her contraception or her health care needs.

All healthcare staff have a duty to ensure that patients have the mental capacity to make decisions regarding their care. Where there is doubt, an assessment of capacity should be undertaken. Further information and guidance on assessing capacity can be found at:

- **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/348440/OPG603-Health-care-workers-MCA-decisions.pdf (England & Wales);**
- **http://www.gov.scot/Resource/Doc/217194/0058194.pdf (Scotland)**

(Knight, Tuffnell et al. 2015)

6.5 Messages for pathology

A post mortem examination was conducted for 31 of the 35 women who died in relation to drug and alcohol use. In 4 women no pathology report was available for review, thus the autopsy reports of 27 women were reviewed.

In 13 women the autopsy report was considered to be poor by the reviewing pathologist. Issues included lack of clinico-pathological correlation, lack of histology, lack of toxicology, poor interpretation of toxicology findings, lack of comment on the significance of findings, absence of history or circumstances of death, poor conclusions drawn by the pathologist.

For one women the cause of death given by the pathologist was considered erroneous by the reviewing pathologists. A natural cause "left ventricular hypertrophy" was given with little evidence to support this and no histology undertaken. On review the death was considered likely to be related to drug toxicity.

Issues relating to toxicology use and interpretation were similar to those encountered when reviewing deaths by suicide (see section 5.5).

For two women the cause of death was unascertained and in both instances this was due to an inadequate pathological examination. There was an assumption that both women died due to drug toxicity and yet this was not proven on toxicology testing.

> A woman who was a known substance misuser died in the postpartum period; the pathologist made the assumption that her death was due to a drug overdose. However, the toxicology assessment was incomplete and there was no histology undertaken.

Every opportunity to determine the cause of this woman's death was missed. The possibility of sudden cardiac death or other potential causes remains undetermined as the appropriate investigations were not undertaken. The death of any young woman requires adequate investigation to make a diagnosis, irrespective of her past medical history. This was not the situation here and the possibility of identifying conditions which may have implications for surviving family members was not considered.

Messages for pathologists:

Pathologists should never assume a woman's death is due to drug toxicity or any other specific cause without clear evidence. They should keep an open mind about the potential causes of death and conduct testing according to the potential differential causes.

Pathologists and coroners should ensure the quality of toxicology reports is sufficient to enable proper interpretation in the context of the woman's death. Specifically:

- **Toxicology laboratories should report the levels of drugs detected, along with the levels known to be associated with fatality.**
- **Where morphine is detected, toxicology laboratories should report the free and total morphine levels and their ratio.**

Specific drugs names should be used in reporting the woman's cause of death, not the class of drugs.

Clinico-pathological correlation should draw together the circumstances of a woman's death with the findings at autopsy, with discussion of the significance of toxicology findings and the likely pathological effects.

6.6 Conclusions

All the messages in this chapter are repeated from those identified in 2015 (Knight, Tuffnell et al. 2015); in 53% of women, improvements in care were identified and for 16% those improvements may have made a difference to their outcome. The 2015 report recommended practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, during and after pregnancy (Knight, Tuffnell et al. 2015). This has not happened and yet clearly there remain multiple opportunities to improve care. In the context of major reorganisations of maternity care (The National Maternity Review 2015, The Scottish Government 2017) and new mental health services, ensuring safe and appropriate care for this group of women must be a priority. This may require new research into effective interventions and particularly an effective system of coordinated multidisciplinary care.

There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy (Knight, Tuffnell et al. 2015).

Table 6.1: Classification of care received by women who died from other psychiatric disorders and homicide, UK, 2014-16

Classification of care received	Women who died from other psychiatric disorders Number (%) N=35	Women who died by homicide Number (%) N=14
Good care	16 (46)	7 (50)
Improvements to care which would have made no difference to outcome	14 (40)	4 (29)
Improvements to care which may have made a difference to outcome	5 (14)	3 (21)

7. Lessons for treatment of malignancy

Marian Knight, Anita Banerjee, Malcolm Griffiths and Adrian Yoong on behalf of the MBRRACE-UK cancer in pregnancy chapter-writing group

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7.1 Key messages

Previous cervical smear history may be useful in order to assess the possibility of a neoplastic lesion of the cervix as the cause of antepartum haemorrhage. A speculum examination can be useful to visualise a lower genital tract cause for the haemorrhage. **ACTION: Service managers, health professionals**

Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum. **ACTION: Health professionals**

Pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team. **ACTION: Service managers, health professionals**

Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause. **ACTION: Health professionals**

If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same timescale as for a non-pregnant woman, but with caution when there is evidence of specific risks to the fetus. In such instances, a discussion of potential risks and benefits with the woman should be used to determine the most appropriate pathway of investigation. **ACTION: Service planners/commissioners, service managers, health professionals**

For women with cancer, advice on postponement of pregnancy and contraception should be individualised and based on treatment needs and prognosis over time. Most women with breast cancer should wait at least two years after treatment, which is when the risk of breast cancer recurrence is highest. **ACTION: Service planners/commissioners, service managers, health professionals**

All pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered, particularly, but not only hereditary non-polyposis colorectal cancer, with appropriate investigations, including tumour testing, performed and family testing offered as appropriate. **ACTION: Service planners/commissioners, service managers, health professionals**

7.2 Background

Whilst in the majority of women, the occurrence of cancer is coincidental to pregnancy, that is, it would have arisen irrespective of the woman's pregnancy, it is very clear that the simple fact of a woman with cancer being pregnant can have major implications for the quality of her care. Recent data shows an almost 50% higher age-standardised incidence rate of cancer during pregnancy in comparison to non-pregnant women of reproductive age, possibly relating to more frequent examination and therefore an increased chance of detection (National Cancer Registration and Analysis Service 2018). This further emphasises the importance of high quality cancer care in pregnancy and the postpartum period. Compromises in cancer care received during pregnancy can have major implications on women's future quality of life as well as survival, and for this reason this chapter includes reviews of the care of women who died between six weeks and one year after the end of pregnancy. In this chapter, perhaps more than any other, the distinction between direct, indirect and coincidental maternal deaths becomes irrelevant (van den Akker, Nair et al. 2017); there remain many opportunities to improve care irrespective of the type of cancer from which women died. Alongside this, the rising age of the maternity population, and therefore an expected rising incidence of cancer among pregnant and postpartum women (National Cancer Regis-

tration and Analysis Service 2018), emphasises the ongoing importance of not ignoring these 'coincidental' maternal deaths and learning lessons to improve future diagnosis and management of malignancy in association with pregnancy.

7.3 The women who died

One hundred and four women died during or up to one year after pregnancy from malignant disease during 2014-16 in the UK and Ireland. Twenty-six women died during or up to six weeks after the end of pregnancy, a mortality rate of 1.04 per 100,000 maternities (95% CI 0.68-1.53). Of these 26 women, 8 died from breast cancer, 6 from brain or CNS tumours, 5 gastrointestinal tumours, 1 from choriocarcinoma, 4 from tumours in other sites. Two women had an unknown primary. Only nine of these 26 women (35%) had an autopsy, all were coronial or fiscal.

78 women died from cancer between six weeks and one year after the end of pregnancy. Detailed records were available for review of 45 of these women. Of these 45 women, 10 died from a gastrointestinal malignancy, 7 from haematological malignancies, 6 from breast cancer, 5 from cervical cancer, 5 from skin cancers, 4 from brain or CNS tumours, 6 from tumours in other sites. Two women had an unknown primary.

7.4 Overview of care and lessons to be learned

Overall reviewers felt that the care of pregnant and postpartum women with cancer who died was substantially improved compared with the care of the women who died between 2009 and 2013 (Knight, Tuffnell et al. 2015). In particular, there was no evidence that chemo or radiotherapy was inappropriately withheld because women were pregnant at the time of their diagnosis. As with the care of the woman described below, the reviewers identified many examples of good care which ensured women maintained a good quality of life despite their terminal disease and supported them to make their own choices about many aspects of their care both during and after pregnancy.

> A woman developed aggressive inflammatory breast cancer in the first trimester of pregnancy with metastases. Her chemotherapy and surgery was expedited but unfortunately she did not respond. She deteriorated and was delivered early in the third trimester to allow for radiotherapy. Funding was made available from within the hospital to allow her to be nursed on delivery suite. She had patient-centred multidisciplinary team care, with regular consultant input from obstetrics and gynaecology, oncology (surgical and medical), anaesthesia, neonatology, radiology and palliative care. She remained on the labour ward for palliative care for the next month (near her baby on the neonatal unit) until she died.

Recurring themes

Although care after diagnosis in general was felt to have improved, there were still many examples where the fact that a woman was either pregnant or postpartum clearly delayed her diagnosis despite symptoms which were highly suspicious of malignant disease.

Delays to diagnosis

Pain requiring opiates

> A woman presented at 15 weeks in pregnancy with severe left sided pelvic pain which was attributed to symphysis pubis dysfunction. She was referred to a physiotherapist and discharged from consultant care. She presented repeatedly with escalating pain (requiring opiates) along with intermittent PV discharge and a swollen left leg. Only at caesarean section was her large pelvic mass diagnosed, at which point the significance of her history of incomplete treatment of cervical intraepithelial neoplasia was recognised. She died from her metastatic cervical cancer shortly afterwards.

This woman exhibited several 'red flags' previously noted by the enquiry, including repeated presentation and severe pain requiring opiates without a clear diagnosis. Four other women had similar long-standing severe pain managed with opioids without recognition of the significance of their other symptoms and leading to a delay in the diagnosis of their malignant disease.

Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause.

Recurrent vaginal bleeding

Four women had recurrent vaginal bleeding during pregnancy and were subsequently diagnosed with cervical cancer. In one instance, the woman concerned never underwent a speculum examination because of concerns over placenta praevia, and in two others a speculum examination was carried out but on only one occasion. In both women the presence of the cervical tumour was not recognised by the junior doctors concerned. This led to a delay of several weeks in these women's diagnoses. Although the presentation of cervical cancer in pregnancy depends on the stage at diagnosis and lesion size, pregnant women usually present with post-coital bleeding or vaginal discharge (Royal College of Obstetricians and Gynaecologists 2011c). Two of the women reviewed here presented with post-coital bleeding and one with a persistent vaginal discharge. It is important to note that gentle speculum examination can be performed even with placenta praevia to visualise the cervix and check for local causes of bleeding. Two of the women had never had a cervical smear.

> A woman who had a previous normal smear a year earlier presented in the third trimester with vaginal bleeding for approximately two weeks. The senior registrar who attended her undertook a speculum examination and recognised a suspicious cervical mass. The registrar made an urgent referral to colposcopy and the woman's advanced tumour was rapidly diagnosed and treated. She received excellent multidisciplinary care and was able to spend time at home with her baby before she died in a hospice a few months later.

Despite a history of a normal smear, this woman was appropriately examined, referred and her cancer diagnosed quickly. Subsequent multidisciplinary team planning allowed her to spend time with her new baby and control of her pain before she died.

Previous cervical smear history may be useful in order to assess the possibility of a neoplastic lesion of the cervix as the cause of antepartum haemorrhage. A speculum examination can be useful to visualise a lower genital tract cause for the haemorrhage.

If the woman presents with a clinically suspicious cervix she should be referred for colposcopic evaluation in line with guidelines from the British Society for Colposcopy and Cervical Pathology.

(Royal College of Obstetricians and Gynaecologists 2011c)

Delayed radiological investigations

> A woman presented in the first trimester with an extensive lower limb DVT, breathlessness and haemoptysis. A pericardial effusion was noted on echocardiography. She did not undergo a chest x-ray or CT pulmonary angiogram; her records make reference to the fact that she was 'scared' by a radiologist discussing radiation risks to the fetus. She was treated for presumed pulmonary embolism, but became more symptomatic in the third trimester when she was diagnosed with cardiac tamponade. This was drained percutaneously and she was delivered by caesarean section. Continuing respiratory symptoms post-birth led to a chest x-ray and diagnosis of her malignant pleural effusion. She died shortly afterwards.

MBBRACE-UK reviewers as well as the local team caring for her felt that if this woman had not been pregnant, her lung cancer would have been diagnosed when she first presented with her DVT. She would have undergone a chest x-ray and/or CTPA or perfusion scan which would have resulted in earlier diagnosis and treatment and this may have changed her outcome. It is a recurrent message of these enquiries that investigations which are strongly indicated in the non-pregnant should not be withheld because of concerns about the fetus. In this instance it is not known what advice was given to the woman about the risks of investigation, but guidance is clear that the risks are small (Royal College of Obstetricians and Gynaecologists 2015b).

Women with suspected PE should be advised that, compared with CTPA, V/Q scanning may carry a slightly increased risk of childhood cancer but is associated with a lower risk of maternal breast cancer; in both situations, the absolute risk is very small (Royal College of Obstetricians and Gynaecologists 2015b).

If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same timescale as for a non-pregnant woman, but with caution when there is evidence of specific risks to the fetus. In such instances, a discussion of potential risks and benefits with the woman should be used to determine the most appropriate pathway of investigation (Knight, Tuffnell et al. 2015a).

Thrombosis and assessing VTE risk

Malignancy diagnosed within six months of becoming pregnant is an independent risk factor for VTE. RCOG guidance should be followed: antenatal thromboprophylaxis from 28 weeks and postnatal thromboprophylaxis for at least 10 days unless contraindicated, for example if cerebral metastases or blood dyscrasia are present (Royal College of Obstetricians and Gynaecologists 2015).

This recommendation was made in the 2015 report and reviewers noted that it was particularly pertinent once again as several women developed thromboembolic disease. Three women presented initially with a VTE and it must be remembered that thrombosis, particularly in unusual locations, can be the first presentation of a cancer.

> A woman developed an extensive thrombosis in her neck veins two weeks after a caesarean birth. The unusual location was attributed to the fact that she was postpartum. She developed further thrombotic events including DVT and PE but the diagnosis of malignancy was not considered despite review by multiple clinicians from different specialties. The diagnosis was eventually made four months postpartum and she died shortly afterwards.

Two women had Trousseau's syndrome (Varki 2007), presenting with unusual or migratory and multiple thromboses, identified in retrospect to herald their visceral malignancy. In both women the diagnosis was made late. Although reviewers felt that earlier diagnosis would have been unlikely to prevent these women's deaths, more timely diagnosis could have improved their quality of life in their final months.

Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum.

Neurological investigation

> At booking a woman gave a three month history of severe headaches which she described as migraine, causing her to wake at night. These continued through pregnancy until she was admitted to the Emergency Department in her second trimester with falls and loss of consciousness. She was discharged home with no follow-up arranged. Two days later she was admitted in status epilepticus at which time her cerebral metastatic disease was diagnosed. She was treated during pregnancy and gave birth in her third trimester, but her disease progressed rapidly and she died shortly afterwards.

There were several occasions when this woman could have had a full neurological examination and appropriate imaging, which may have led to recognition of her raised intracranial pressure and allowed for earlier treatment. Reviewers also noted opportunities for earlier diagnosis of another woman who died from a primary brain tumour; in this instance she presented with arm weakness in the first trimester with a two month history of headaches. Her GP made a routine neurology referral and she was given an appointment for seven months later. An acute worsening of her symptoms led to the diagnosis of her tumour two months before her appointment date. The importance of a neurological examination, as well as timely referral pathways, has been reiterated repeatedly in these reports.

Neurological examination including fundoscopy is mandatory in all women with new onset headaches or headache with atypical symptoms.

Making a diagnosis not simply excluding one

> A woman attended the Emergency Department late in her third trimester with breathlessness. She had a respiratory rate of 40 but her chest was noted to be clear. She was investigated for suspected pulmonary embolism but as investigations were negative she was discharged home with a diagnosis of presumed pneumonia. Neither an obstetrician nor a physician were asked to review her. Two days later she represented acutely unwell with suspected cholecystitis and was admitted to the intensive care unit. She was not seen by an obstetrician for a further 36 hours. When consulted, the obstetrician advised laparotomy and caesarean section. Her metastatic liver disease was diagnosed on a pre-operative ultrasound scan.

As has been noted before in MBRRACE-UK reports, for several women who presented with symptoms of breathlessness and pain, investigations were undertaken to rule out pulmonary embolism, and once these proved negative, no further attempt was made to establish a diagnosis. It has also been a repeated message of these reports that pregnant women with medical problems who present to the emergency department should be discussed with the maternity medical team. All pregnant women, particularly ill pregnant women, should be reviewed by a member of the obstetric team, and hospital policies should reflect this.

Pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team. (Knight, Tuffnell et al. 2015)

A raised respiratory rate, chest pain, persistent tachycardia and orthopnoea are important signs and symptoms which should always be fully investigated. The emphasis should be on making a diagnosis, not simply excluding a diagnosis (Knight, Nair et al. 2016).

Fixation error

> A woman presented repeatedly postnatally with a painful erythematous breast lump. Her symptoms were attributed on each occasion to mastitis despite a classic peau d'orange appearance and axillary lymph nodes. Her metastatic breast cancer was diagnosed when she was referred to the breast clinic for drainage of a presumed axillary abscess.

Many women whose care was examined for the purposes of this chapter had symptoms that were repeatedly attributed to pregnancy and which failed to respond to standard management. Several others were assumed to have infections of various kinds including, as in this woman's case, repeated courses of antibiotics. Two women with spinal metastases were assumed to have spinal tuberculosis and managed as such for several weeks, despite the lack of a tissue diagnosis. In some instances, these symptoms predated pregnancy. Clinicians need to remain aware of other causes of women's symptoms, particularly in the context of repeated presentation and/or failure to respond to treatment.

Taking a full history and conducting a complete examination is important whatever the route through which a pregnant woman first accesses services (Knight, Tuffnell et al. 2015).

Multidisciplinary team care

As in previous enquiries, reviewers noted that several women with complex cancers were cared for by multiple teams across multiple sites and there was therefore a lack of multidisciplinary planning which impacted on women's quality of life.

There should be an early multidisciplinary discussion about the care of any woman with complex medical conditions in pregnancy. This is particularly important if the woman is managed across several centres. A named individual needs to take overall responsibility for coordinating her care (Knight, Tuffnell et al. 2015).

Contraception

Seven women whose care was reviewed for the purposes of this chapter conceived while receiving chemotherapy, or shortly after completing chemotherapy.

> A 35 year-old woman was amenorrhoeic immediately following completion of chemotherapy for triple negative breast cancer. At her six month review the possibility of pregnancy was not considered and contraception was not discussed. When she presented with terminal metastatic disease four months later, she was found to be in the second trimester of pregnancy. She rapidly deteriorated and both she and her baby died.

In this instance, and for most of the other six women who conceived during or shortly after their cancer treatment, there was no evidence that any of the staff caring for them had even considered the possibility of pregnancy in women of reproductive age or thought to discuss contraception. One woman made an

active decision to stop contraception during treatment of her breast cancer, and no-one discussed with her the risks of pregnancy. All clinicians caring for women of reproductive age, whatever their medical specialty, need to be aware of the risks of pregnancy in women with medical co-morbidities, including cancer, and should be able to give appropriate contraceptive advice.

For women with cancer, advice on postponement of pregnancy should be individualised and based on treatment needs and prognosis over time. Most women with breast cancer should wait at least two years after treatment, which is when the risk of breast cancer recurrence is highest (Royal College of Obstetricians and Gynaecologists 2015c).

Non-hormonal methods of contraception are recommended for women wishing to avoid pregnancy after treatment of breast cancer (Royal College of Obstetricians and Gynaecologists 2015c)

New messages for care

Familial cancer syndromes

Whilst there was evidence that the possibility of an underlying cancer syndrome had been considered following the diagnoses of breast cancer in the women of reproductive age whose care was reviewed for the purposes of this chapter, there was no evidence in other women that familial cancer syndromes had been considered. In particular, there were several deaths of young women with colorectal cancer when there had been no consideration of the need for testing for Lynch syndrome with the potential importance of the diagnosis for surviving close family members.

> A woman presented repeatedly to different locations with shoulder pain, back pain, breathlessness, persistent anaemia and altered bowel habit in the third trimester of pregnancy. These symptoms were attributed to iron deficiency, musculoskeletal pain and acid reflux. PE was considered on two occasions but she was not investigated further. She presented acutely unwell at term at which time liver nodules were identified but thought to be infective in origin. Liver biopsy at caesarean section revealed her metastatic colorectal cancer. She had not received any low molecular weight heparin thromboprophylaxis due to concerns over the possibility of haemorrhage. She collapsed from a massive PE shortly after giving birth and died shortly afterwards.

This woman's care illustrates many of the themes already discussed, including attribution of her symptoms to pregnancy, repeated presentation without a clear diagnosis, and risk of thromboembolism. In addition, however, despite the diagnosis of colorectal cancer in a young woman, no-one considered the possibility of Lynch syndrome (hereditary non-polyposis colorectal cancer or HNPCC) (Lynch, Snyder et al. 2015). Lynch syndrome is one of the most common hereditary colorectal cancer syndromes and is associated with a familial predisposition to cancers, particularly of colorectal and endometrial origin. It is due to an inherited defect in the genes which are involved in DNA mismatch repair and is diagnosed on the basis of family history, tumour pathology and genetic testing. None of the women who died from colorectal cancer in association with pregnancy had the possibility of Lynch syndrome considered; their tumours appear not to have been sent for the relevant genetic testing (for microsatellite instability), nor were their families referred for consideration of screening.

All pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered, particularly, but not only hereditary non-polyposis colorectal cancer, with appropriate investigations, including tumour testing, performed and family testing offered as appropriate.

General anaesthesia

> A woman diagnosed with metastatic cancer early in her first pregnancy deteriorated in the third trimester despite chemotherapy. She was known to have spinal metastases and underwent caesarean birth under general anaesthesia. She died a month later.

Three women known to have advanced cancer were delivered by caesarean section under general anaesthesia. In two women, including the one above, this was because they were thought to have spinal metastases. Another was suspected of having raised intracranial pressure. None were delivered in an emergency. Spinal metastases alone are not an indication for general anaesthesia for delivery. For these women, all of whom were in the late stages of their disease, the delivery under general anaesthesia potentially denied the woman and her partner or other members of her family the positive memory of their baby being born despite the mother's terminal cancer.

Fluid balance

> A woman with a haematological malignancy and known clotting problems received several units of red cells and at least two litres of crystalloid around the time of her caesarean birth. Her exact fluid balance is unclear as there was no clearly documented fluid balance chart in her records, but she appears to have a positive balance of at least six litres. She deteriorated five hours after giving birth and was noted to have pulmonary oedema. She failed to respond to diuretics and died shortly afterwards.

As noted in chapter 3, careful attention to fluid balance is important, including attention to over-replacement as well as under-replacement.

Vulnerability

> A woman known to be a substance misuser with a history of domestic abuse booked late in her pregnancy. She gave birth normally at term and reported on the postnatal ward that she had a breast lump. She was referred to the junior doctor who told her to go and see her GP for a referral to the breast clinic. Three months later she presented to the Emergency Department with chest pain. She was found to have a pleural effusion and 6cm left breast lump with axillary nodes. Advanced breast cancer was confirmed on biopsy and she died shortly afterwards. No local review of her care was undertaken.

Although this woman's drug dependency and lifestyle contributed significantly to her late presentation of breast cancer, nevertheless her death should have merited a local review of care. There was a missed opportunity to treat her after she gave birth when she first complained of a breast lump. This young woman had chaotic life, was known to be a poor attender, and had just had a baby. It was wholly unreasonable to expect her to make an urgent appointment with her GP. This was a situation where delaying discharge while awaiting investigations was justified. The challenges of caring for women with complex and multiple problems, particularly in the postnatal period was highlighted in the 2015 report, and the importance of arranging all appointments before discharge was noted.

Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues.

The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange. (Knight, Tuffnell et al. 2015)

7.5 Conclusions

The care of women who died from malignancy in pregnancy or during the postpartum period appears to have improved considerably since the last review in 2015 (Knight, Tuffnell et al. 2015). Assessors noted particularly that chemotherapy was rarely inappropriately delayed because of concerns over fetal exposure. Nevertheless, delays simply because women were either pregnant or had recently given birth were still evident, underlining the importance of remaining alert to symptoms which are not normal for pregnancy. For several women undergoing treatment for cancer no-one had considered the possibility that they might become pregnant and had not provided appropriate contraceptive advice, leaving them with the additional difficulty of an unplanned pregnancy. It must be emphasised that provision of contraceptive advice should occur in oncology as well as other medical settings. Alongside provision of high quality care for women, the importance of high quality care for surviving family members must be considered; there remain key missed opportunities to identify familial cancer syndromes which could prevent future death and morbidity in family members.

Table 7.1: Classification of care received by women who died as a result of malignancy, UK and Ireland, 2014-16

Classification of care received	Women who died from malignancy Number (%) N=71
Good care	24 (34)
Improvements to care which would have made no difference to outcome	32 (45)
Improvements in care which may have made a difference to outcome	15 (21)

8. Key indicators for local audits to assess implementation of recommendations

Hemali Jayakody and Marian Knight

8.1 Background

The reviews of women's care contained within this report have given rise to more than 70 recommendations to change or improve current practice and care for pregnant and postpartum women. Recommendations alone, however, will not drive improvement unless they are implemented and change monitored regularly to see sustained improvement. In order to assist local units to audit their current practice and identify areas for improvement this chapter therefore contains key indicators according to each thematic area which could be used in local audits and surveys.

8.2 Identification of indicators

In order to identify the indicators, we developed a simplified framework for assessment of the implementation status of recommendations. The framework was developed using the Donabedian model for the assessment of the quality of care and the International Health Partnership and related initiatives (IHP+) framework adopted by the World Health Organisation for monitoring and evaluation of health system performance (Donabedian 2005, World Health Organisation 2010). From the potential indicators identified using the framework, key output and outcome indicators were selected for regular monitoring based on the main recommendations of each topic-specific chapter. The selection was based on simplicity, availability of information at the local level and measurability. These indicators align where possible with auditable areas specified in Greentop guidelines, the Care Quality Commission inspection framework or devolved nations equivalents and other frequently used standards.

8.3 Anticipated local use

The MBRRACE-UK Independent Advisory Group suggest that individual units should audit compliance with at least one indicator from within each theme. This should be undertaken as a quality improvement activity (The King's Fund and The Health Foundation 2017); following initial audit, units should further investigate the care of women for whom the indicator is not met in order to identify changes needed and implement actions to drive improvement. Re-audit after the actions have been implemented is essential.

For ease, where appropriate, suggested denominator and numerator groups are provided to allow calculation of the appropriate percentages.

8.4 Key audit indicators

Prevention and treatment of obstetric haemorrhage

- The percentage of women managed according to the placenta praevia after previous caesarean section care bundle (Paterson-Brown and Singh 2010). *Denominator: total number of women with a placenta praevia following a previous caesarean birth in a specified time period. Numerator: the number of these women meeting all six elements of the care bundle.*
- The percentage of women cared for in maternity settings who developed pressure sores during their hospital stay. *Denominator: total number of women cared for in the unit over a specified time period. Numerator: the number of these women developing pressure sores.*

- The percentage of second stage caesarean sections carried out by trainees that are yet to complete a summative objective structured assessment of technical skills (OSATS) which are attended by a consultant obstetrician. *Denominator: total number of second stage caesarean sections carried out by trainees that have not yet completed a summative OSATS in a specified time period. Numerator: the number of these caesarean sections attended by a consultant obstetrician.*
- The percentage of records of women who have had a major PPH which have accurate documentation of fluid balance. *Denominator: number of women with major PPH in a specified time period. Numerator: the number of these women whose records have an accurate documentation of fluid balance.*

Prevention and treatment of thrombosis and thromboembolism

- The percentage of women who underwent VTE risk assessment at specified times (pre or early pregnancy, pregnancy, postpartum or at any hospital admission or inter-current problems). *Denominator: number of women cared for in the unit in a specified time period. Numerator: number of these women who underwent a VTE risk assessment at each time point.*
- The percentage of women (pre or early pregnancy, pregnancy, postpartum) who had an accurate assessment score for thromboembolism risk. *Denominator: total number of women cared for in the unit in a specified time period. Numerator: number of these women whose VTE risk assessment score was accurately documented at each time point.*
- The percentage of pregnant and postpartum women with a BMI of 30 kg/m2 or more who were informed about the symptoms of VTE. *Denominator: total number of women with a BMI of 30 kg/m2 cared for in the unit in a specified time period. Numerator: number of these women receiving information about the symptoms of VTE.*

Improving care of women with mental health problems

- The percentage of liaison and crisis resolution and home treatment (CRHT) staff members who have completed training in perinatal mental health within the last two years. *Denominator: total number of liaison and CRHT staff members at a specified time point. Numerator: number of these staff who have completed appropriate training in the previous two years.*
- Availability of a local guideline/policy which specifies an early referral pathway for women with mental health problems identified by maternity services and primary care.
- The percentage of pregnant or postpartum women who received care from mental health services who had a named care co-ordinator. *Denominator: total number of pregnant or postpartum women receiving care from mental health services in a specified time period. Numerator: number of these women who had a named care coordinator.*
- The availability of a local training programme for maternity care professionals on perinatal mental health, including the 'red flag' symptoms/signs.
- The percentage of pregnant women who had complete details about their past mental health history documented. *Denominator: total number of women cared for in the unit in a specified time period. Numerator: number of these women whose mental health history was accurately documented.*
- The percentage of mental health records requested by MBRRACE–UK supplied for the confidential enquiry. *Denominator: number of mental health records requested by MBRRACE-UK in a specified time period. Numerator: number of these records returned to MBRRACE-UK.*

Improving the care of women from vulnerable groups

- The percentage of women known to be subject to domestic abuse whose data were appropriately shared across all relevant agencies. *Denominator: total number of women known to be subject to domestic abuse in a specified time period. Numerator: number of these women whose information was appropriately shared across all relevant agencies.*
- The percentage of health professionals in maternity services who have been trained on adult safeguarding. *Denominator: total number of staff members at a specified time point. Numerator: number of these staff who have completed appropriate training.*
- The availability of a clear pathway of shared care between perinatal mental health services and specialist addiction services.

- The percentage of women with complex medical and/or social problems who were discharged with a confirmed follow up appointment date. *Denominator: total number of women known to have multiple/complex health and social problems giving birth in a specified time period. Numerator: number of these women discharged with a confirmed follow-up appointment date.*

Improving treatment of women with malignancy

- The percentage of pregnant women prescribed repeated opiates without a confirmed diagnosis. *Denominator: total number of pregnant women prescribed repeated opiates in a specified time period. Numerator: number of these women without a confirmed diagnosis following appropriate investigation.*
- The percentage of pregnant and postpartum women who were seen within two weeks by specialists for a suspected cancer. *Denominator: total number of pregnant and postpartum women with suspected cancer in a specified time period. Numerator: number of these women seen by specialist services within two weeks.*
- The percentage of women of reproductive age with cancer who received pre-pregnancy counselling and contraception advice. *Denominator: total number of women of reproductive age with cancer in a specified time period. Numerator: number of these women who received pre-pregnancy counselling and contraception advice.*
- The percentage of pregnant and postpartum women presenting to the emergency department seen by a member of the maternity medical team. *Denominator: total number of pregnant and postpartum women presenting to the emergency department in a specified time period. Numerator: number of these women seen by a member of the maternity medical team.*

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MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

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

BCUHB Women's Directorate action plan in response to the following national reports:

- **MBRRACE UK Perinatal Mortality Surveillance Report (January - December 2015 & January – December 2016),**
- **MBRRACE UK Saving Lives-Improving Mother's Care, Confidential Enquires into Maternal Death and Morbidity 2013-15 (Dec 2017)**
- **MBRRACE UK Saving Lives-Improving Mother's Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquires into Maternal Death and Morbidity 2014-16 (Nov 2018)**
- **MBRRACE UK Perinatal Confidential Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death (Nov 2017)**
- **RCOG Each Baby Counts Summary Report (2015)**
- **HQIP National Maternity and Perinatal Audit Clinical Report (2017)**
- **Royal College of Obstetricians & Gynaecologist - Each Baby Counts Progress Report (2018)**
- **National Maternity and Perinatal Audit Report, Maternity Admissions to Intensive Care in England, Wales and Scotland in 2015/16 (January 2019)**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Close monitoring of mortality rates	Stabilised and adjusted SB rate is up to 10% higher than the average - 3.88 (3.88 in 2015) • Reduced fetal movements/GROW recommendations implemented including management of reduced fetal movements (See page 7) • Standardised process in to review all Stillbirths • Perinatal mental health Team appointed • Appointment of Smoking Cessation Maternity Support Workers • Updated Diabetes in pregnancy policy • MBRRACE reporting continued		Raising the awareness of public health issues with women and their families. Outcome measures for obstetric and neonatal commissioned services are being reviewed and where required, improvement plans will be put into place. Annual audit of the following: • No women smokers at booking • No of women smoking during pregnancy • No women commenced on obesity pathway and supported to lose weight during and after pregnancy • No of women with identified perinatal mental health issues who have a plan of care clearly documented in their notes	On-going	Improvement Midwife & Outpatient Matron	**August 2018** The Commissioning team and Heads of services are currently reviewing the outcome measures of commissioned services in the North West of England. The number of women who stopped smoking in pregnancy over the last 12 months is 17% (18% reported the previous year). No women with BMI of 30 or more have increased since 2017. Consultant midwife/BCU to take part in national programme to improve upon this. The number of women with clear plan of care in notes has improved from 56% to 77%. **November 2018**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						Thematic review of all Stillbirths to be undertaken during Sept & Oct 2018 by Women's Governance Lead and Improvement Midwife **January 2019** The Exec team have supported a thematic review of all SB and NND between 2016-2018, to be led by PH The BCU Smoking data collected has been flawed and will now be collected at 38 weeks. Quit data is collected on the Dashboard and is actually higher than initially reported. The number of PMH care plans has increased significantly in the past 12 months, but there has been a drop in referrals - addressed in MT and with matrons. Referrals will now go to adult mental health (CMHT) who will refer

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						to PMH. Also generic template for a care plan available for community midwifery use if woman not eligible for PMH team referral. Can be found on the PMH page on the intranet **May 2019** List of all external NND of Welsh babies has been sent to the North West Network to request investigation feedback to inform the HB and the NND review. Thematic review of Stillbirths for 2018 completed and reported via governance processes. The Public Health led review of all NND and Stillbirths commences on 14 05 19. Referrals to PNMH service continue as above. Staffing in PNMH has now increased – 2

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						additional nurses, full time psychiatry, full time psychology and a nursery nurse have been appointed.

	Stabilised and adjusted neonatal mortality rate is up to 10% higher than the UK average – 1.25 (2.05 in 2015) • Perinatal morbidity/mortality meetings held on each site • Each neonatal death within BCUHB reviewed • Contacts established with external providers of neonatal care • Perinatal mental health midwife appointed • Appointment of Smoking • Cessation Maternity Support Workers • MBRRACE reporting continue		Effective communications with external providers of neonatal care to ensure neonatal death reviews held in external organisations are shared with BCUHB. Annual audit of WG reported incidents to observe for increasing numbers should be undertaken by Children's Services. Outcome measures for obstetric and neonatal commissioned services are being reviewed and where required, improvement plans will be put into place. Bi-annual North Wales Perinatal Morbidity/Mortality meetings to be commenced A neonatal dashboard is maintained and updated monthly. Data from the National Neonatal Audit Programme is collated and reports produced per unit against all Wales and the UK. This data is reviewed by the	Ongoing	Improvement Midwife & Neonatal Services Manager	**August 2018** The Commissioning team and Heads of services are currently reviewing the outcome measures of commissioned services in the North West of England. Stats as reported above. **January 2019** The Exec team have supported a thematic review of all SB and NND between 2016-2018, to be led by PHW **May 2019** As per SB action above

			Neonatal Steering group bi-monthly. Raising the awareness of public health issues with women and their families. Annual audit of the following: • No women smokers at booking • No of women who stopped smoking during pregnancy • No women commenced on obesity pathway and supported to lose weight during and after pregnancy • No of women with identified perinatal mental health issues who have a plan of care clearly documented in notes			

	Crude extended and Stabilised and adjusted extended perinatal mortality rate up to 10% higher than the UK average – 5.12 (5.96 in 2015) • Perinatal morbidity/mortality meetings held on each site • Each neonatal death within BCUHB reviewed • Contacts established with external providers of neonatal care • Perinatal mental health midwife appointed • MBRRACE reporting continued		Effective communications with external providers of neonatal care to ensure neonatal death reviews held in external organisations are shared with BCUHB. Annual audit of WG reported incidents to observe for increasing numbers should be undertaken by Children's Services. Outcome measures for obstetric and neonatal commissioned services are being reviewed and where required, improvement plans will be put into place. Raising the awareness of public health issues with women and their families. Annual audit of the following: • No women smokers at booking • No of women who stopped smoking during pregnancy • No women commenced on obesity pathway and supported to lose weight during and after pregnancy	Ongoing	Improvement Midwife & Neonatal Services Manager	**August 2018** The Commissioning team and Heads of services are currently reviewing the outcome measures of commissioned services in the North West of England. Stats as reported above. **January 2019** The Exec team have supported a thematic review of all SB and NND between 2016-2018 to be led by PHW **May 2019** As per SB action above

			• No of women with identified perinatal mental health issues who have a plan of care clearly documented in their notes			

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Renewed focus on neonatal deaths to achieve a significant reduction in numbers	Perinatal morbidity/mortality meetings held on each site All BCUHB neonatal deaths are subject to a 72 hour case review and either a further concise case review or case presentations and discussion at local perinatal morbidity/mortality meetings. Contacts established with external providers. Weekly Putting Things Right (PTR) teleconference held to discuss incidents of significance, the Neonatal Services Manager attends these conference calls Reportable incidents and NND are discussed monthly at the North Wales Steering group and at the All Wales Neonatal Mortality meetings on a quarterly basis. Attendance at quarterly Neonatal Network Mortality Review meetings where all deaths in Wales discussed.		Effective communications with external neonatal care providers to ensure neonatal death reviews held in external organisations are shared with BCUHB. Annual audit of WG reported incidents to observe for increasing numbers should be undertaken by Children's Services. Bi-annual North Wales Perinatal Morbidity/Mortality meetings to be commenced	Ongoing	Improvement Midwife & Neonatal Services Manager	**August 2018** The Commissioning team and Heads of services are currently reviewing the outcome measures of commissioned services in the North West of England. **January 2019** The Exec team have supported a thematic review of all SB and NND between 2016-2018, to be led by PHW **Feb 2019** Difficulties have recently arisen with obtaining the reports from external reviews and therefore associated lessons learned. MC is now attending North West Clinical Effectiveness Group meetings on a quarterly basis where cases are discussed, to ensure reviews are fed back. **May 2019**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						As per SB action plan above
Identify the extent to which deaths before 32 weeks gestation are avoidable	All BCUHB in-utero and neonatal deaths are reviewed and breach of duty of care and harm caused are identified by the independent review panel and are recorded in the review report		Further work has commenced to collect information from neonatal death reviews held by external providers to improve communication and data collection. Annual audit of WG reported incidents to observe for increasing numbers should be undertaken by Children's Services.	On going	Improvement Midwife & Neonatal Services Manager	**August 2018** The performance outcomes of all healthcare providers is being scrutinised and where required, improvement plans have been requested. **January 2019** Commissioned services will be part of the thematic SB/NND review. **Feb 2019** Issue as reported above **May 2019** All babies of 26-32 weeks gestation are now cared for in the SuRNICC in Central. All NND are reviewed using the PMRT as from 1/1/19 to review care and if death was avoidable. All NND reviewed nationally via Neonatal Network.

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
All Each Baby counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).	Complaint				North Wales Neonatal lead nurse	
There is an urgent need for PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.	Mortality tool only		This is a National decision. Introduction to be considered as part of the national review of the SUI process and development of a standardised trigger list.			**January 2019** National discussions ongoing. **May 2019** No update available
A national forum to be established in Wales to agree best approach to reporting	A Maternity Network and Neonatal Network have been established in Wales and BCUHB have representatives on the Networks and the subgroups					**August 2018** The Maternity and Neonatal Networks are to merge in 2019 to ensure seamless working and partnership working with future improvement projects across Wales
High quality data submission to MBRRACE inclusive of staffing and acuity issues if they were felt to be a contributory factor.	15 out of 18 areas reported 97 - 100% complete			Ongoing	Outpatient Matron & CSfM	**August 2018** The 2016 report indicates data quality has improved significantly. **Feb 2019** Data collection with regards to smoking
	3 out of 18 areas 85 - 96.9% complete: • Smoking		Community midwives updated with this			

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	• Estimated Date of Delivery • Main cause of death		information by and CSfM to monitor documentation.			has been inaccurate and quit rates are higher than initially reported. **May 2019** All smoking cessation support workers now in post.
Placental histology should be undertaken for all stillbirths, preferably by a perinatal pathologist. A high standard placental histology report to be produced.	All placentas sent to Cardiff for histology to a perinatal pathologist who produces the appropriate report required.					
Systems are in place to implement appropriate guidance related to reduced fetal movements and monitoring fetal growth	GAP Programme implemented in BCUHB and guidance in place with regards to reduced fetal movements		Ultrasound capacity issues to fully meet reduced fetal movements/GROW recommendations therefore entered as a risk on the Women's Directorate Risk Register.	Ongoing	Improvement Midwife	**August 2018** Remains on the Women's Directorate Risk Register and awareness raised at secondary care and Board level. **Feb 2019** A joint business case has been put together to increase staffing and capacity in USS. Meetings being held between Radiology

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						and Women's Directorate. **May 2019** Task & Finish Group are still developing USS business case with the preferred option being the recruitment of additional sonographers.
			Issues with GROW documentation and growth trajectory. A task and finish group has been set up to address the concerns identified.	Ongoing	Community Team Leaders	**January 2019** Issue now improved and to be monitored by community team leaders
All Stillbirths and neonatal deaths to be investigated using a standardised process and independent multidisciplinary peer review. A high quality review should be undertaken inclusive of RCA, identification of contributory factors and an effective action plan.	All antenatal stillbirths are subject to a 72 hour case review and potentially a concise review by an independent multidisciplinary panel including children's services as required. A RCA is undertaken for all reviews. All intrapartum stillbirths are subject to a 72 hour case review and a comprehensive review within a 30 day		Further work has commenced to collect information from neonatal death reviews held by external providers to improve communication and data collection.	Dec 2018	Midwifery Risk Team & Neonatal Services Manager	**January 2019** Work ongoing into how to support women and their families when present during investigation process. **May 2019** Bereavement Midwife now in place and will be the point of contact and support for women and their

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Parents should be included in the review. There should be an external multidisciplinary panel to undertake the review. SIRs should comment on the quality of the documentation i.e. observations and the clinical management of adverse serious events. The reviews should also comment on whether there was any process for debriefing and support available to staff involved in these very stressful situations	timeframe and are reported to Welsh Government. All BCUHB neonatal deaths are subject to a 72 hour case review and either a further concise case review or case presentations and discussion at local perinatal morbidity/mortality meetings. All reviews document any contributory factors and include an effective and achievable action plan. Perinatal Mortality Review Tool now available and being used in BCUHB to standardise the review process. Women and their families are currently able to forward questions for the panel to answer during the review process, but they are not currently present at the review itself. Debriefing is offered to staff and women and their families following a serious untoward incident.					families during investigations, who will be invited to take part in the investigation process later this year.

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	Performance against similar Trusts/Health Boards is reported separately.					
All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.	All relevant professionals take part in the investigation process				Risk midwives	
Rates of measures and care outcomes Services should examine their own findings and data quality and compare these to internal audits and against national rates, to determine plans for quality improvement. Results for individual measures should not be interpreted in isolation. In attempting to understand possible relationships between all measures and use this to improve services as a whole.	The maternity Dashboard is completed and reviewed in multi-professional meetings on a monthly basis and is shared with clinical staff in all areas and Maternity Voices. Local data from national audit is reviewed and benchmarked against other health boards. Action plans are developed to improve service provision and outcomes. Any specific measure on the Dashboard that require review will have a deep dive performed and is when it is audited, consideration is given		The Maternity Network are Considering the development of a national Dashboard	On going		**August 2018** Annual performance Board with WG Feedback from NMPA Commissioned services

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Multi-professional teams should familiarise themselves with the findings for their own service and how these compare to the national average in order to determine the focus of quality improvement required. Where the rate for a service differs substantially from overall rates, the service should identify reasons	to the impact other measures may be asserting.					
Audit departments should facilitate dissemination of findings to all relevant stakeholders including Maternity Voices partnerships. Local information about the rates of measures of care and outcomes in labour is made available to all women using the services.	Audit days are held on all three sites and on a North Wales basis to feedback to clinical staff.		Ensure all relevant audit findings are disseminated to Maternity Voices group The intranet requires updating to reflect rates and measures of care	Ongoing	Consultant Midwife CSfM	**January 2019** Ongoing work **May 2019** To be further discussed at Women's Board in June.
Collect information on planned and actual place of birth	Datix has been amended to include a section on whether a woman does not achieve delivery in her chosen place of birth		Dissemination of this new field on Datix to all staff to ensure completion			**August 2018** Now reported on Datix

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Strongly prioritise the provision of resources to support breastfeeding, both in maternity units and the community to reduce variation in the proportion of babies receiving breast milk at their first feed and at discharge from the maternity unit. Every possible effort should be made for all babies to have skin to skin contact with their mothers within one hour of birth	Maternity Support Workers and peer supporters in post. All sites have accredited BFI status. Skin to skin is offered to mum at birth or soon after if a C/S birth. Fathers also encouraged to provide skin to skin if so wished.		Further work required to support the initiation of breast feeding There is a designated neonatal nurse to support breast feeding women. Skin to skin is also offered on all SCBUs.	Neonatal Services Manager	Dec 2018	**August 2018** All SCBU across BCU have applied for BFI accreditation and will be assessed in 2018. **January 2019** National Breastfeeding Strategy to be launched in March 2019 and the local policy will be launched simultaneously. **Feb 2019** BCU Infant Feeding Strategy launch on 25/03/19 Conwy Business Centre and draft 5 year plan being developed on an All Wales basis; will have an associated action plan for BCUHB. **May 2019** Audits ongoing. All NNU have applied for BFU accreditation this year. National Infant Feeding Strategy awaited.
Further work is needed to understand the potential for	Consultant midwife in post to support normality and the		Deliveries in the alongside units increasing but further	Dec 2018	Consultant Midwife	**November 2018**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
increased use of midwifery led settings.	development of midwifery led care.		work required to maximise use Identify how many midwives are needed as MLU core Recruit the required number of core staff Core staff are inspired and enabled to promote the unit.		MLU leads	Delivery number in the MLUs has increased but additional work needs to be performed re core teams. **Feb 2019** Audit and action to improve documentation of whether a woman is for MLU or CLU in labour is in progress– not documented well. Meeting with MLU leads in March to look at missed opportunities and make improvement plans for each unit. Improve the number of women who want VBAC by encouraging more to attend VBAC clinic in East and Central and set up a clinic in West **May 2019** Monthly audit of Missed opportunities for giving birth in MLU is carried out by MLU

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						leads and shared with community leads. Group VBAC being piloted from June in Central. VBAC clinic in process of being set up in West.
Services should conduct an internal audit of their elective deliveries prior to 39 weeks without recorded clinical indication.	Snapshot audits undertaken intermittently. All C/S performed at less than 39 weeks are Datix reportable Action plans for C/S in place in all three units Now reported via Datix.		Regular review and update of action plans	Ongoing	CDs	**January 2019** All reported via Datix and audited on an individual basis.
Antenatal care Appropriate counselling and management plan to be documented for women with previous C/S and management plan to be documented for women with previous C/S	All women seen by consultant or in VBAC clinic in pregnancy and birth choices and discussion documented.					
Treatment of malignancy Previous cervical smear history may be useful in order to assess the	History not always recorded		Community midwives to enquire re history and record in the hand held notes	January 2019	Community Team Leaders	**January 2019** Reminders to be issued at January team meetings. **May 2019**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
possibility of a neoplastic lesion of the cervix as the cause of antepartum haemorrhage. A speculum examination can be useful to visualise a lower genital tract cause for the haemorrhage						Outpatient Matron to confirm whether practice now standardised and this action is now complete.
Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum	Thrombosis would be referred to medical team for full investigation					
Pregnant and postpartum women presenting to the emergency department with medical problems should be discussed with a member of the maternity medical team	Discussed with obstetric and medical teams MOAU criteria					
Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause	All recurrent admissions investigated as a red flag					
If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same	Appropriate referrals would be made and joint decisions made with regards to the wellbeing of mother and baby					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
timescale as for a non pregnant woman, but with caution where there is evidence of specific risks to the fetus. In such instances, a discussion of potential risks and benefits with the woman should be used to determine the most appropriate pathway of investigation						
All pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered, particularly, but not only hereditary non-polyposis colorectal cancer, with appropriate investigations, including tumour testing performed and family testing offered as appropriate	Appropriate referral as required					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Epilepsy and stroke Pre-conceptual advice should be available both verbally and written, inclusive of prenatal screening and its implications, risks of self discontinuation of anti-epileptic drugs and the effects of seizures and anti-epileptics on the fetus and the pregnancy, breastfeeding and contraception	Epilepsy- preconception advice provided in epilepsy clinics across BCUHB as per recommendation, recorded in hospital notes and in letters sent to GP and copied to patients. No communication between secondary care and community pharmacists re women taking anti-epileptic medication. Secondary care has no information on which women of childbearing age are continuing to take Valproate.		There will be an audit form completed following the postnatal appointment with the epilepsy specialist, this will audit pre conceptual counselling The Improvement Midwife met with Mark Allen pharmacist with a special interests in epilepsy. to explore developing the role of the community pharmacists in counselling women on AED medication and GP practices informing secondary care of all women of child bearing age currently taking Valproate. Communication links with GP practices across North Wales in relation to the provision of a current list of all pregnant women on Valproate AED's established.		Dr Sheila Shepley	Action Plan Epilepsy in Pregnancy.docx
Urgent referral to specialist if woman stops taking medication to review her medication and prescribe AEDS if appropriate	There are currently various methods used to arrange an appointment with the Epilepsy Specialist services by the Medical Disorders		The new referral process will permit all Midwives/Medical Disorders Consultant Clinic to refer a woman immediately via a			**August 2018** The referral process will be audited following the postnatal visit to the Epilepsy

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	Clinics/Community Midwives which include email, telephone or letter. Delays frequently occur due to holiday leave, sickness and postal delays		secure email box direct to the Walton Patient Access Centre with Tracy Lea and the Medical Disorders Consultant copied in. A copy of the referral form should be secured into the woman's ANHHN's. This referral will ensure that an urgent/non urgent antenatal/postnatal appointment with the epilepsy specialist team is provided for BCUHB women in a timely manner. The referral process flow chart, the secure email referral form and key safety messages are now uploaded and available on the Womens intranet site.			specialist services by the epilepsy specialist
GP's secondary care providers and commissioners should work together to ensure women with epilepsy have access to appropriately specialised care before, during and after pregnancy	Referral process - As above GP/Obstetrician/Midwife/ Specialist Practitioner will now all have access to any referral as a copy will be placed in the AWHHN's		Baseline bloods levels for all women on Lamotrigine will be taken by the Epilepsy Specialist Team, the medical disorders team will take repeat levels every 4 weeks and send a copy to the epilepsy specialist team for review as a failsafe.		Dr Sheila Shepley and Jan Quarmby Medical Diseases Consultants	**August 2018** The improvement midwife to present key messages at the local and North Wales Women's Audit Days on a rolling programme to ensure all current clinicians

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	Epilepsy WCD written jointly by obstetric, midwifery and specialist care clinicians. All appointment outcomes and any blood levels as they will all be filed in the ANHHN's.				Miss Armstrong Miss Linda Verghese Mrs Leela Ramesh	and new starters receive update.
Pregnant women with epilepsy often face additional physical, mental health or social problems. Additional effort should be taken to ensure they have access to the care they need.	Pregnant women with epilepsy are cared for under CLC. The Epilepsy practitioner for BCUHB is often unaware of that these women are pregnant until late on in their pregnancy		All women will be reminded to carry their ANHHN's to all appointments outside of midwifery care. The three medical disorders CLC will all refer to other specialities should they be required.		As above	**August 2018** All women with epilepsy will receive a copy of the Epilepsy and having a baby booklet **December 18** All midwives and all women with epilepsy are receiving a copy of the Epilepsy and having a baby booklet The direct referral process is now up and running and direct referrals are being made electronically via the intranet to specialist services. Timely referral is currently now being audited on a yearly basis with first results

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						available in September 2019.
Postpartum safety advice and strategies re seizures should be part of antenatal and postnatal discussions with the mother as well as breastfeeding, seizure deterioration and AED intake	Key messages to standardise discussion across BCUHB maternity care to ensure the safety of the woman and her baby during the postnatal period and beyond have been agreed.		Key messages on safety during the postpartum period should be available to all clinicians The epilepsy and having a baby leaflets have now arrived and will be given to all CMW's and all OPD Obstetric Medical disorders clinicians.		MD CLC x3	**August 2018** Key safety messages for all women with epilepsy are now available on the Women's intranet site All midwives will receive a copy of the Epilepsy and having a baby booklet at Mandatory Training CMW will advise on referral to TELECARE, for women with epilepsy who sleep alone at night. All women with epilepsy will receive a copy of the Epilepsy and having a baby booklet
Neurological examination including assessment for neck stiffness and fundoscopy is mandatory for all women with new onset headaches, or	The booking risk assessment and risk assessment in pregnancy both advise CLC referral for women with headaches but not neck stiffness.		Booking risk assessment and assessment in pregnancy to be updated to include neck stiffness. These women do not have		CMW MD CLC x3	**August 2018** Ongoing work **November 2018** Booking risk assessment now updated to contain

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headaches with atypical features, particularly focal symptoms			to be seen in the medical disorders clinic. Clinicians should consider all reasons for these symptoms and exclude preeclampsia and other such non epilepsy conditions and request a general medical referral before referral to epilepsy services.			referral for neck stiffness. Approved at Board and now a standalone document on the Women's WCD page
A change in mental state and new seizures should lead to prompt neurological assessment	There is no standardised pathway for Medical diseases consultants to follow when caring for women with epilepsy in pregnancy		The new referral process will support this action		CMW MD CLC x3	**August 2018** New referral process will address this. To be implemented by end 2018. **December 2018** Direct referral process in place for Medical disorders Consultants and working well.
A lack of an immediately available critical care bed must not be a reason for refusing admission for patients requiring urgent neurosurgery	There is no standardised pathway for Medical diseases consultants to follow when caring for women with epilepsy in pregnancy No issues with regards to admission have been identified		An urgent referral to Neuro Surgery would be required.		MD CLCx3	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Prevention and treatment of thrombosis and thromboembolism There is a need to develop a tool to make the current risk assessment system simpler and more reproducible	Risk Assessment tool in place		An audit is to be undertaken to review all of the areas in this section of the action plan in 2019.	2019	Dr JM	**November 2018** Audit lead identified in YGC. **May 2019** Audit in place and results will be available in August 2019 (Mr Mechery)
Audits should be conducted not only to assess whether thromboembolism risk assessment was performed, but also whether the calculated risk score was correct	Risk Assessment tool in place		An audit is to be undertaken to review all of the areas in this section of the action plan in 2019.	2019	Dr JM	**November 2018** Audit lead identified in YGC. **May 2019** Audit in place and results will be available in August 2019 (Mr Mechery)
All women undergo a documented assessment of risk factors for VTE in early pregnancy or pre-pregnancy, Risk assessment should be repeated if the woman is admitted to hospital for any reason or develops intercurrent problems. Risk assessment should be repeated again intrapartum or immediately postpartum	Risk Assessment tool in place, assessment repeated on each admission.		An audit is to be undertaken to review all of the areas in this section of the action plan in 2019.	2019	Dr JM	**November 2018** Audit lead identified in YGC. **May 2019** Audit in place and results will be available in August 2019 (Mr Mechery)

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth	Risk Assessment tool in place, assessment repeated for each admission		An audit is to be undertaken to review all of the areas in this section of the action plan in 2019.	2019	Dr JM	**November 2018** Audit lead identified in YGC. **May 2019** Audit in place and results will be available in August 2019 (Mr Mechery)
If women need thromboprophylaxis as soon as they become pregnant there should be clear pathways for them to access prescriptions and support to ensure compliance	MOAU prescribe for women				MOAU leads	
Women with a high BMI should be given information about the symptoms of VTE	BMI Pathway in place				Community midwives	
Women with a BMI of $\geq$ 40 score 2 points on the RCOG guideline for thromboprophylaxis in pregnancy and therefore all need postnatal thromboprophylaxis regardless of mode of delivery	BMI Pathway in place				Community midwives	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Prescriptions for the entire postnatal course of low molecular weight Heparin should be issued in secondary care, This will help ensure that women receive the full course without the need to visit their GP to obtain another prescription	Obtained from MOAU				MOAU leads	
Women with psychosis Women with past history of psychotic disorder, even where not diagnosed as postpartum psychosis or bipolar disorder, should be regarded as elevated risk in future postpartum periods and should be referred to MH services in pregnancy to receive an individualised assessment of risk	Referral criteria mirrors recommendations Red flags identified on referral forms Management plans completed Education and awareness sessions for staff have been carried out across all services.				Perinatal MH Team	
Women with a family history of postpartum major illness should be monitored by maternity and primary care services for any change in mental state in late pregnancy and early postpartum. Where the	Education and awareness sessions being delivered to maternity and primary care services Guidance included in referral criteria		Ongoing/continued education and awareness sessions	Ongoing	Maternity and Primary Care services	**August 2018** Ongoing/continued education and awareness sessions **November 2018** For women who are well but have a family history of significant

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woman herself is currently unwell in pregnancy or has previous postpartum mood destabilisation, she should be referred to MH services as soon as possible in pregnancy to receive an individualised assessment of risk						perinatal mental illness and/or an SMI, a management plan should be completed by the community midwife. Those women who have significant history of perinatal mental illness or have moderate or severe current perinatal mental illness should be referred to the CMHT via SPoA. Referral will then be made to PNMH service for input, including completion of a management plan. Education/awareness sessions are ongoing. TNA meeting arranged for December 2018 to determine ongoing training requirements for midwives. **Feb 2019** Plan for women with family history (Mother with bipolar) should

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						have a plan in place and use template from intranet. **May 2019** Memo sent to all midwives requesting women with H/O SMIs are referred to PNMH for completion of plan. For those women who do not meet criteria for PNMH midwives are advised to consider completion of generic plan, which can be found on the BCUHB intranet site. PNMH not being included on the current midwifery mandatory training programme has been added to risk register.
Following recovery, it is the responsibility of the treating MH team to ensure that all women experiencing postpartum psychosis receive a clear explanation of future risk, including the availability of risk	Management plan provided Discharge summary provided Leaflet provided and information regarding supportive agencies given		Further work needed surrounding self-referral back into the service if previously been open	Sep 2018	PMHT	**August 2018** Further work needed surrounding self-referral back into the service if previously been open **November 2018**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
minimising strategies and the need for re-referral during subsequent pregnancies and this is shared with other health professionals						The PNMH service continues to work closely with adult mental health services to ensure that there is continuity of care following a postpartum psychosis and that there is clear, consistent advice for future pregnancies. **Feb 2019** Response to WG re the need for a unit in North Wales, minimum day unit. Pathway being developed for women transferred out of area to a MBU. **May 2019** Out of area MBU pathway continues to be developed. PNMH service continues to collect data for WG to evidence need for specialist inpatient care in North Wales.

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It is the responsibility of MH services to ensure that a late pregnancy and early postnatal care plan is completed jointly with the woman, usually at 28-32 weeks of pregnancy. Where the plan includes decisions about medication management, it should be overseen by a psychiatrist	Management plans completed and shared with all agencies involved Involvement by Perinatal Psychiatrist				PMHT	
Where there is diagnostic uncertainty requiring physical health investigation by obstetric and/or medical specialists, there should be close liaison between and regular review by senior medical staff from obstetrics, medicine and psychiatry	Perinatal Specialist Midwife involved with this.		Continue to review	Ongoing	All services	**August 2018** No issues identified at present. To be monitored. **November 2018** No issues identified. Obstetric, maternity and mental health services continue to liaise effectively where there are both physical and/or mental health issues. **Feb 2019** Improving with obstetrics but more work required re medicine **May 2019** Ongoing work to maintain MDT working, however no

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						major concerns/issues identified.
Statutory health organisations should consider routine monitoring of the proportion of women and babies who are unnecessarily separated when the mother is admitted to psychiatric care	Routine data collection		Ongoing work with WG, PHW and WHSSC		All services	
With the woman's consent, families should be made aware at an early stage of the benefits of joint mother-infant admission	Routinely discussed during completion of management plan				PMHT	
Valproate should not be used in the management of psychiatric disorder in women of childbearing potential. If there are exceptional reasons for use, then it should only be prescribed in conjunction with long-acting reversible contraception and with clear documentation of informed consent	All team members aware of this recommendation				PMHT	
Mental Health	The PNMH service has visited all the adult mental health					**November 2018**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Liaison, crisis and home treatment staff should have specific training, at induction and continuing professional development, in understanding the distinctive features and risks of perinatal mental illness if they are to provide emergency and out of hours care for pregnant and postnatal women. Formal links should be made with local specialist perinatal mental health services to facilitate training	services to provide education sessions regarding the recognition and management of perinatal mental illness. However, not all members of CMHT, HTT and Liaison services have received this.					The PNMH service to continue sessions and to discuss with adult mental health service managers the future provision of formal training in perinatal mental illness.
Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour	All reviews/assessments are completed taking into account previous history.					**November 2018** No issues identified
Discussions on continuing, stopping or changing medication in pregnancy should only be made after	Women can access the PNMH service via a referral to SPoA from their health visitor, GP, mental health nurse or other					**November 2018** For those women with significant mental illness open to

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careful reviews of the benefits and risks of doing so, to both mother and infant	appropriate professional, for pre-conception counselling regarding care and treatment options during the perinatal period. Women open to secondary care services should have this discussion with their named psychiatrist, in liaison with the consultant perinatal psychiatrist if required.					secondary services, the PNMH service continues to emphasise the importance of regular discussions regarding medication during pregnancy and breastfeeding during psychiatric reviews, including pre-conceptionally
Women should receive continuity of mental health care. Where more than one mental health team is involved, there should be a clearly identified individual who co-ordinates care	Women open to secondary care mental health services may have an allocated care co-ordinator who assumes responsibility for coordinating mental health care input during the perinatal period.					**November 2018** PNMH team continue to highlight within secondary care services, that care co-ordinator, where applicable, is responsible for coordinating multidisciplinary management of mental illness. Where a woman is not open to secondary care services then the community midwife must assume responsibility to act as care coordinator for all aspects of maternity

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						care, including mental health. **Feb 2019** Ongoing issue as PMH team will not caseload and therefore named lead still required **May 2019** Ongoing work/education for secondary mental health services, with regards to named care coordinator, however MDT working between PNMH, CMHT, maternity and obstetrics improving
In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications.... and should prompt renewed attempts at engagement, diagnosis and care co-ordination	Healthcare professionals are aware that new presentations of or worsening symptoms of mental illness after 28 weeks gestation should prompt urgent referral to mental health services.					**November 2018** The PNMH service has taken steps recently to reduce the numbers of unnecessary assessments, moving towards the provision of targeted interventions for mental illnesses/issues that related specifically to the perinatal period.

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						As such, all perinatal referrals are sent via SPoA to primary mental health services that provide the initial assessment. Women are then referred to the PNMH service if specialist input is required. **Feb 2019** On MT and within referral criteria documents. Resource pack being developed. **May 2019** Ongoing work/education for secondary mental health services, with regards to named care coordinator, however MDT working between PNMH, CMHT, maternity and obstetrics improving.
New expressions or acts of violent self harm, or new and persistent expressions of incompetency as a mother or estrangement	For women with Perinatal Mental Health Management plans in place, the MBRRACE Red Flags signs are documented to ensure					**November 2018** The PNMH service to continue to highlight the significance of the Red Flag signs and

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from the infant are 'red flag' symptoms and should always be regarded seriously	healthcare professionals continually monitor and escalate appropriately. The importance of monitoring for these is also reiterated within all educational sessions.					management when they are identified
Self harm in pregnancy or the early post partum period is an unusual event and should always prompt referral for continuing evaluation, ideally by specialist PMH services	Women who are actively self-harming during the postnatal period are referred to the PNMH service via SPoA. Depending on the specific presentation and severity, urgent referral to liaison service (inpatient) or duty CMHT (outpatient) may be required. Healthcare professionals encouraged to contact triage services for advice if required.					**November 2018** PNMH service to continue to provide education around the management of self-harm and suicidal ideation in the postnatal period, particularly with regards to lowered thresholds for intervention.
Mental health services should work to minimise barriers to care for women in pregnancy and the postnatal period, recognising the need for lower thresholds and direct access for maternity and primary care professionals	Referrals accepted by all health care professionals.					**November 2018** The PNMH service continuing to provide education sessions regarding routine discussions regarding mental health and wellbeing for all pregnant women to reduce stigma. Also working with CMHT to ensure that women referred are assessed

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						promptly and plans of care/inputs required are provided in a timely manner.
Women from vulnerable groups Healthcare professionals need to be alert to the symptoms or signs of domestic abuse (DA) and women should be given the opportunity to disclose DA in an environment in which they feel secure	RE1 performed		Compliance to be audited		All midwives	**January 2019** A compliance audit is to be undertaken by 2 community Team Leaders. Gail Morris and Dave Farmer to facilitate the audit
Services should develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of experiencing or perpetrating DV and DA. This is even more important with the increasing use of electronic records to ensure all agencies involved in a woman's care are aware of her risk of DA. This would be further facilitated by support for the intra-	Clear processes and policies in place All midwives attend an annual training update					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
operability of systems to support information sharing through electronic records						
Consider ways of ensuring that, for each woman who misuses substances: • Progress is tracked through the relevant agencies involved in her care • Notes from the different agencies involved in her care are combined into a single document • There is a co-ordinated care plan	Substance misuse midwife communicates with midwifery team/named midwife and all documentation placed in maternity notes					
Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This should include input from obstetricians and all relevant colleagues						
The postnatal care plan for women with complex and						

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the woman is discharged and not left to the general practitioner to arrange						
In women facing multiple adversity, changes in frequency or presentations may reflect worsening mental state or the emergence of new complications ....and should prompt renewed attempts at engagement, diagnosis and care co-ordination	Referral process in place		Process not always accessible		PMHT	**Feb 2019** Women who have had babies removed cannot be referred to the PMH Team and this can be an issue. Can be referred in pregnancy and then redirected in the postnatal period. **May 2019** In centre on a weekly basis there is a support session drop in Central and every second week the PMH team attend for additional support. Week 15/4/19 MH week which all 3 units held events/increased publicity to increase awareness of support

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						available to women and their families.
Women with medical and general surgical disorders High level actions are needed to ensure that it is seen as the responsibility of all health professionals to facilitate opportunistic pre-conceptual counselling and appropriate framing of advice when women with pre-existing conditions attend any appointment, and that resources for pre and post pregnancy counselling are provided, together with open access to specialist contraception advice	Variable, depending on specialism		Requires joint working with other Directorates	Ongoing	Lead for maternal medicine (currently vacant)	**January 2019** Ongoing **May 2019** Remains ongoing
Women with pre existing medical conditions should have pre-pregnancy counselling by doctors with experience of managing their disorder in pregnancy	Variable, depending on specialism		Requires joint working with other Directorates	Ongoing	Lead for maternal medicine (currently vacant)	**August 2018** Ongoing **Feb 2019** Remains an ongoing issue **May 2019** No ongoing
Research into the most effective way to encourage	Research supported locally				Consultant Midwife	**August 2018** Ongoing

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obese women to normalise their weight before conception to reduce the risk associated with obesity in pregnancy should be supported						**Feb 2019** Consultant Midwife meeting with Teresa Owen this month to discuss the possibility of rolling out *Foodwise* in pregnancy. Consultant Midwife has also met with Cardiff consultant midwife to discuss Healthy Eating Clinics run by their consultant, BCU may need to think about whether to set up similar clinics. **May 2019** Consultant Midwife meeting with Teresa Owen this month to discuss the possibility of rolling out *Foodwise in pregnancy*. Has also visited Cardiff consultant midwife to discuss Healthy Eating Clinics run by their consultant. If

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						BCU cannot fund *Foodwise*, *may* need to think about whether to set up similar clinics.
In pregnant or postpartum women with complex medical problems involving multiple specialities the responsible Consultant obstetrician or physician must show clear leadership and be responsible for co-ordinating care and liaising with anaesthetists, midwives, other physicians and obstetricians and all other professionals who need to be involved in the care of these women	Managed individually by consultant obstetricians				Clinical Directors	
When a woman is admitted to level 3 care/intensive care, daily consultant and physician involvement must remain to ensure continuity of care, even if only in a supportive role, until such a time the woman is ready to be repatriated to the maternity unit	Managed individually by consultant obstetricians Daily handovers				Clinical Directors	

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Pregnancy should not be viewed as a contraindication to surgery in the presence of a malignancy or progressive symptoms or conditions at high risk of progression or exacerbation in pregnancy	No issues identified				Clinical Directors	
Critical care outreach nurses should work in partnership with midwives to provide better care before transfer to the critical care unit	Critical care team available and called on most occasions		Raise staff awareness to include the outreach team as required	Ongoing	Clinical Directors Inpatient Matrons	**August 2018** Ongoing
Women with multiple and critical and complex problems may require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues	Managed individually by consultant obstetricians leading individualised MDTs				Clinical Directors	
The postnatal care plan should include the timing of follow up appointments,	Managed individually by consultant obstetricians leading individualised MDTs				Clinical Directors	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
which should be arranged with the appropriate services before the woman is discharged and not left to the GP to arrange						
A comprehensive summary by the senior obstetrician of the maternity care episode should be sent to the GP who should be responsible for co-ordinating care after discharge from maternity services	Letters to supplement midwifery discharge often generated after follow up in PN clinic.		Development of electronic discharge via WC Portal that can be accessed by midwives and GPs		Consultants	**February 2019** Ongoing, can be accessed by Gynae, but not currently maternity. Awaiting roll out of Myrddin across North Wales **May 2019** Myrddin now rolled out. Action can now be progressed
Prevention and treatment of sepsis Since women attend maternity services during pregnancy, funding streams should facilitate the offer and delivery of influenza immunisation in maternity services as part of antenatal care, rather than primary care	Maternity Outpatient Assessment Unit staff now trained to offer to vaccinate women					**August 2018** National compliance with women's uptake of the flu vaccine consistently met.
Midwives and others carrying out postnatal	Thermometers carried by community staff				Team Leaders	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
checks in the community should have a thermometer to enable them to check the temperature of women who are unwell						
When assessing a women who is unwell, consider the woman's clinical condition as well as her MEOWS score	No themes or trends identified		Occasional clinical incident review indicates need for wider clinical picture to be taken into consideration. Sharing lessons learned and ongoing education		Matrons Consultants	
The key actions and management of sepsis are; Timely recognition Fast administration of IV antibiotics Quick involvement of experts-senior review is essential	No themes or trends identified Sepsis bundle in use and sepsis policy available				Matrons Consultants	
Consideration should be given to 'declaring sepsis', analogous to activation of the major obstetric haemorrhage protocol, to ensure the relevant members of the multidisciplinary team are informed, aware and act	Declaration of sepsis is part of the PROMPT training for all Women's staff				Matrons Consultants Professional Development Midwife	
It is important to recognise that chronic illness and	Awareness raised				Consultants	

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immunosuppression are risk factors for sepsis. For women with chronic illness or who are immunosuppressed, there should be a lower threshold for admission, the administration of appropriate antibiotics and supportive therapy, as well as input from senior clinicians						
Critical care outreach nurses should work in partnership with midwives to provide care before transfer to the critical care unit.	Critical care team available and called on most occasions		Raise staff awareness to include the outreach team as required		Matrons Consultants	**August 2018** Ongoing
Women should be advised, within 24hrs of giving birth, of the symptoms and signs of conditions, including sepsis that may threaten their lives and require them to access emergency treatment	Staff advise women					

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Anaesthetic care In sudden onset severe maternal shock e.g. anaphylaxis, the presence of a pulse may be an unreliable indicator of adequate cardiac output. In the absence of the absence of a recordable blood pressure or other indicator of cardiac output, the early initiation of external cardiac compressions may be life saving	Compliance achieved in BCUHB, awareness raised amongst anaesthetists		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists in BCUHB	01/03/18	Anaesthetic Leads	
Anaesthetists must continue to be vigilant about the risk of pulmonary aspiration in pregnant women who require GA. An individualised risk assessment should be made and appropriate precautions taken	Compliance achieved in BCUHB, awareness raised amongst anaesthetists		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists in BCUHB	01/03/18	Anaesthetic Leads	
In cases of MOH women must be adequately resuscitated and bleeding stopped prior to extubation following GA, Evidence of adequate resuscitation	Compliance achieved in BCUHB (West) once awareness raised amongst anaesthetists		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists in BCUHB - West	01/03/18	Anaesthetic Leads	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
should be sought prior to extubation						
Aortocaval compression should be suspected in any supine pregnant woman who develops severe hypotension after induction of anaesthesia; even if some lateral tilt has been applied. If there is a delay in delivery, putting the woman into the left lateral position may be the only option if other manoeuvres fail or if the woman has refractory severe hypotension	Compliance achieved in BCUHB, awareness raised amongst anaesthetists		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists in BCUHB	01/03/18	Anaesthetic Leads	
In the absence of contraindications such as hypertension, prophylactic vasopressors should be administered to pregnant women who have spinal anaesthesia	Compliance achieved in BCUHB, awareness raised amongst anaesthetists		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists in BCUHB	01/03/18	Anaesthetic Leads	
The choice of endotracheal tube for pregnant women should start at size 7.0mm and proceed to smaller tube selections if needed. It is	Compliant in BCUHB (West)		No action required	01/03/18	Anaesthetic Leads	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
recommended that all resuscitation carts used in maternity services should include endotracheal tubes no larger than a size 7,0mm and should include smaller sizes, 6.0mm and 5.0mm						
Pregnant women with complex needs or a complex medical history should have timely antenatal multidisciplinary planning and an experienced obstetric anaesthetist should contribute to the planning	Compliant in BCUHB			01/03/18	Anaesthetic Leads	
A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre before the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.	Ongoing work, communication processes being reviewed		Anaesthetic Care – Recommendation has been reviewed by the North Wales Intrapartum Forum. Memo to support this recommendation has been circulated to all areas.	01/02/19	Anaesthetic Leads	**January 2019** The WHO audit will be presented to the Women's Board in January 2019 **May 2019** The audit outcome demonstrated that the WHO checklist was not fit for purpose. Redesigned to meet needs of all three services.

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						Updated and streamlined versions of the Elective & Emergency ICP to QSE in May for approval, inclusive of the updated WHO Safe Surgery Checklist.
Women with haemorrhage, MOH or amniotic fluid embolism Fluid resuscitation and blood transfusion should not be delayed because of false reassurance from a single Hb result	Compliance achieved in BCUHB , awareness raised amongst anaesthetists, obstetricians & midwives Venous blood gas samples used for an immediate assessment followed by lab samples		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists, obstetricians & midwives in BCUHB	01/03/18	Anaesthetic Leads Labour ward leads Clinical lead midwives Labour ward	
Recognition of bleeding remains important. C/S in advanced labour is associated with a risk of uterine angle extensions which can be difficult to control and which can cause concealed bleeding post operatively.	Traumatic PPH is taught during monthly PROMPT training					
Always exclude each of the four 'T's when assessing any woman with ongoing bleeding.	PPH is managed as per the Obs Cymru protocol and using the 4 stage proforma. This proforma prompts the					

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	multidisciplinary team to consider the 4 T's when a woman has ongoing bleeding.					
Misoprostol should always be used with extreme caution for women with late IUD, especially in the presence of a uterine scar. In these women Dinoprostone may be more appropriate	Misoprostol used for these ladies but not Dinoprostone Policies available for staff support and information			Ongoing	Labour ward lead obstetricians	**February 2019** SOP for Stillbirths has been developed inclusive of medication regime. Will be forwarded to Women's QSE Sub group and Board once finalised. **May 2019** In progress
Haemorrhage should be considered when classic signs of hypovolaemia are present even in the absence of revealed bleeding	Compliance achieved in BCUHB , awareness raised amongst anaesthetists, obstetricians & midwives MDT assessment for all obstetric emergency calls		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists, obstetricians & midwives in BCUHB	01/03/18	Anaesthetic Leads Labour ward leads Clinical lead midwives Labour ward	
When there has been a MOH and the bleeding is ongoing, or there are clinical concerns, a MOH call should be activated	Compliance achieved in BCUHB, awareness raised amongst anaesthetists, obstetricians & midwives MOH activated at 1500mls Local and BCU protocols		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists, obstetricians & midwives in BCUHB – West	01/03/18	Anaesthetic Leads Labour ward leads Clinical lead midwives Labour ward	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Documentation of fluid balance....; care must be taken to avoid over-replacement as well as under-replacement	Fluid balance charts are completed for all patients receiving IV fluids. In the case of significant bleeding (PPH/MOH) strict fluid balance may be recorded via a High Dependency Chart including hourly intake and urine measurements.		Currently being updated to the PROMPT intake/output chart			**November 2018** Currently being updated to the PROMPT intake/output chart
Recurrent bleeding, pain or agitation should be seen as 'red flags' in women with placenta accreta and women should be advised to stay in hospital	Compliance achieved in BCUHB (West) once awareness raised amongst obstetricians & midwives		MBBRACE anaesthetic lessons learnt forwarded to all obstetricians & midwives in BCUHB - West	01/03/18	Labour ward leads Clinical lead midwives Labour ward	
Once a retained placenta is diagnosed, obstetric review and transfer to theatre should be expedited and careful recording of observations should be performed as concealed bleeding can be marked and deterioration is likely	Compliance achieved in BCUHB, awareness raised amongst anaesthetists, obstetricians & midwives MDT assessment. ROTEM available for suspected concealed bleeding		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists, obstetricians & midwives in BCUHB	01/03/18	Anaesthetic Leads Labour ward leads Clinical lead midwives Labour ward	
Early recourse to hysterectomy is recommended where bleeding is associated with placenta accreta or uterine rupture or if bleeding continues following an	Compliance achieved in BCUHB, awareness raised amongst anaesthetists, obstetricians & midwives MDT brief for all known cases.		MBBRACE anaesthetic lessons learnt forwarded to all anaesthetists, obstetricians & midwives in BCUHB - West	01/03/18	Anaesthetic Leads Labour ward leads Clinical lead midwives	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
unsuccessful intrauterine balloon. In extremis and/or while waiting for assistance there are measures which can help. These include aortic compression and stepwise uterine artery ligation	Surgical management of haemorrhage in current guidance. Good practice for 2 consultant decision for hysterectomy.				Labour ward	
Women who have had a previous c/s who also have either placenta praevia or an anterior placenta underlying the old C/S scar at 32weeks of gestation are at increased risk of placenta accreta and should be managed as if they have placenta accreta, with appropriate preparations made for surgery	Managed in main theatres					
Any woman with suspected placenta praevia accreta should be reviewed by a consultant obstetrician and consultant anaesthetist in the antenatal period. The risks and treatment options should have been discussed and a plan agreed	Performed by a consultant obstetrician					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Any woman going to theatre electively with suspected placenta praevia accreta should be attended by a consultant obstetrician and consultant anaesthetist. If the delivery is unexpected, out of hours a consultant obstetric and anaesthetic staff should be alerted and attend as soon as possible	Performed by a consultant obstetrician					
There is a need for consideration of how competence in abdominal hysterectomy should be achieved for obstetricians in training, and how these skills can be maintained at consultant level e.g. through simulation training	Awareness of this national issue Conversation commenced with RCOG as to how this is being addressed nationally Discussion with RCOG as to availability of simulation training		On Women's Directorate Risk Register	31/03/19	Lead Clinical Director	**August 2018** Escalated to Health Board Exec team and nationally to RCOG. Source of required teaching remains outstanding. **February 2019** Ongoing discussions with RCOG re simulation training. Equipment and a company rep have been identified and a review of current rate of hysterectomies in Wales is being undertaken to assess

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						what would be required. **May 2019** Benchmarking ongoing
Young women are vulnerable to pressure sores and care should be taken of pressure points in the obstetric population as well as other populations	Pressure areas monitored for all women who are immobile or at high risk of skin deterioration					**January 2019** Health Board considering transferring to Waterlow assessment tool. New guidance, pressure area review tool and reporting forms available within BCUHB
Intrapartum care IOL 1) No delay in starting and/or continuing the induction of labour process 2) Appropriate fetal monitoring during the IOL process 3) Appropriate management of acuity	Delays can be incurred with the IOL process due to the high number ongoing on a daily basis and the acuity of the unit Snapshot audits undertaken of reasons for IOL Maternity Network to review IOL		Ongoing intermittent snapshot audits Participate in the workshops held by Maternity Network Reportable via Datix	31/03/19	Clinical Lead midwife Labour ward Head of Inpatient Services	**August 2018** BCUHB representative for Maternity Network and IOL sub group to be identified at Oct North Wales Intrapartum Forum Audit ongoing labour ward lead mw and consultant-by Jan 2019 **January 2019**

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						December IOL rates on all sites to be audited as >40% Maternity Network have deferred the IOL work at present. **Feb 2019** Reviewed, most IOL performed as per national recommendations and few for non identified reasons which have been addressed. **May 2019** Increased number of IOL. Snapshot audits have not identified any inappropriate IOL.
Correct categorisation of C/S applied Timely decision to expedite birth and the resulting actions to be completed timely	All staff aware of categories and documented in maternal notes. Time from decision to delivery reviewed monthly					
Staff knowledge of how to identify uterine rupture	Current policy requires updating		Policy author identified to update.	ASAP	Mr Mechery	**January 2019** Policy now available on the intranet

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
						Uterine rupture now a skills drill on the PROMPT training day
The Labour Ward Coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal	The Service is Birth rate Plus compliant which allows the Labour Ward Coordinator to remain supernumerary					
There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own speciality but also on behalf of another speciality. The Consultant Obstetrician should always be informed when labour ward activity is high	BCUHB has a ratified Maternity Escalation Policy which supports this recommendation in full. The Women's Directorate operates a 24/7 management on call system which provide staff support and manages the continuity of service as a Network					
Women receiving care from multiple units must have an individualised management	Women are provided with the All Wales Hand Held Notes which are issued at booking					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic	which they carry with them to all appointments/across multiple sites during pregnancy					
There must be clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended	The Directorate has a formalised process to review and develop policies and guidelines and a process to agree any deviation from Nation guidance. Guidelines are reviewed in light of incidents and updated as necessary					
Teams should protect against migration of boundaries by ensuring that	Monitored via incident reporting and audited as part of the review process					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
real practice reflects practice as described in guidelines. Audit indentifies where migration from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these mitigations can be corrected						
Fetal monitoring Intermittent auscultation (IA) Fetal monitoring via intermittent auscultation should be in line with national guidance. Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method. The development of IT tools that bring together data from across a trust's systems to support accurate, easily accessible	FH monitoring guidance in BCUHB is in line with NICE guidance. Throughout the antenatal period all women are risk assessed at each antenatal contact to determine risk status and referred as appropriate should any deviations occur. All low risk women are risk assessed on admission to the SAMLU/ AMLU in labour, the Normal Labour Pathway part 2 initial assessment document provides guidance for Midwives undertaking this assessment. If a woman is deemed not to be suitable for low risk care in labour a discussion should				Clinical Lead midwife Labour ward MLU leads Consultant Midwife	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
risk assessment should be prioritised.	take place with the Labour Ward shift leader regarding the reasons for this, the woman will be transferred to the labour ward and a plan of care will be formulated by the Obstetric team. Women should be able to make an informed choice regarding their care via access to evidence based information. Local and National guidance is in place as follows. This is both research and evidence based and provides a guide to all Midwives, midwifery and medical students providing care to low risk women in labour but should not supersede clinical judgement.- • *All Wales Clinical Pathway for Normal Labour part 2&3* • *BCUHB Guidelines For Caring for Women identified as being Low Risk In Labour (Mid 08; September 2016)* • *BCUHB Alongside Midwifery Led Unit Guideline (November 2015)*					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	• *BCUHB Waterbirth Guideline (Mid 02; January 2015)* • *-All Wales Midwifery Led Care Guidelines (4th edition; 2015).* There is no IT system in place in Women's to support risk assessment and there are no plans to develop this.					
NICE guidance on when to switch from intermittent auscultation to continuous cardiotocography (CTG) monitoring should be followed. This requires regular reassessment of risk during labour	The All Wales Normal Labour Pathway (NLP) parts 2&3 reflect previous NICE guidance in regard to assessment of fetal wellbeing and Intelligent Auscultation of the fetal heart. Should any variance occur in relation to concerns arising from intermittent auscultation CTG monitoring would be indicated and actioned promptly. If continuous CTG has been used because of concerns arising from intermittent auscultation but there are no non- reassuring or abnormal features on the CTG trace after 20 minutes, intermittent auscultation can again be used.				Consultant Midwife Maternity Network Clinical Lead midwife Labour ward MLU leads	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	Monthly data is gathered for audit purpose in relation to women commencing and completing labour on the NLP.					
Continuous cardiotocography (CTG) Staff tasked with CTG interpretation must have documented evidence of annual training. Correct documentation and interpretation of antenatal CTGS.	All midwives and medical staff are required to complete the full RCOG CTG package every three years. I the other two years a minimum of five case studies must be completed. In addition all medical staff are required t attend the local CTG meeting every six months and prove evidence of attendance. Compliance of completion of the RCOG package is 100% for midwifery staff.		100% compliance to be achieved by medical staff Compliance is monitored on a weekly basis by the Head of Midwifery and is reported to the Executive Team and Welsh Government as part of performance measures.	Ongoing	Director of Midwifery	**April 2018** Annual compliance for 2017: Obstetric staff 100% Midwifery staff 99%
Key management decisions should not be based on CTG interpretation alone. Healthcare professionals must take into account the full picture, including the mother's history, stage and progress in labour, any antenatal risk factors and any other signs the baby	Following the revision of NICE Guidance *Intrapartum Care for Healthy Women and Babies* (February 2017), BCUHB *Use of Fetal Monitoring (EFM) in Labour (Mid 06)* is currently being updated. The updated guidance will included advise that no		Updated guidance to be agreed and approved at the Women's QSE group and Board meetings.			**January 2019** National fetal surveillance standards and PROMPT CTG assessment sticker to be adopted by BCUHB

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
may not be coping with labour. There should be hourly review of the CTG documented.	decisions about a woman's care in labour are made on the basis of CTG findings alone but will advise decision making based on inclusion of holistic assessment. Hourly CTG assessment stickers are completed and filed in the maternal records.					
Timely diagnosis of IUD by ultrasound scan	List of Drs with scanning competencies available in all units Main scan department utilised within normal in working hours				Clinical Directors	
There should be one to one care provision in labour and effective management of capacity issues to ensure quality care provision. There should be a fully completed partogram.	One to one care provision achieved. Staffing Birth Rate Plus compliant.		Ongoing review of documentation to ensure partogram completion		Director of Midwifery	
Human factors All members of the clinical team working on the delivery suite need to understand the key principles of maintaining situational awareness to	The principles of Situational Awareness have been included in the midwifery mandatory training sessions for the past 12 months. BCUHB Women's have a plan in place to implement Practical		PROMPT training to be embedded across the three sites.	Sept 2017 onwards	Professional Development Midwife and faculty	**April 2018** PROMPT training now embedded across the three sites and is being introduced nationally.

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
ensure the safe management of complex clinical situations.	Obstetric Multi Professional Training. PROMPT training includes interactive drills and workshops using simulated obstetric emergency situations, the training is underpinned with the principles of team work, communication and situational awareness. PROMPT training pilot in Central July 2017, with full role out from September 2017					The national lead has been recruited from BCUHB Women's Directorate to extend PROMPT to all maternity units across Wales.
A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.	The Labour Ward Shift Leader will maintain supernumerary status to allow an oversight of safety on the labour ward. There is a consultant presence or on- call cover for the labour ward.				Head of Inpatient Services	
Decision making is more difficult when staff feel stressed and/ or tired. A different perspective improves the chances of making a safe decision. Clinical staff should be	BCUHB Women's Jump Call procedure and Managing Emergency Pressures – Maternity Unit Escalation Procedure (Mat 01; April 2017) in place to support staff in decision making and				Head of Inpatient Services	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective (either in person or over the phone). Availability of Jump call and escalation policies.	alleviating workplace pressures. Medical staff will phone Consultant or On Call Consultant to discuss decisions as appropriate. Jump call policy in place.					
When managing a complex or unusual situation involving the transfer of care or multiple specialties, conduct a 'safety huddle' – a structured briefing for the leaders of key clinical teams. This will ensure everyone understands their roles and responsibilities and shares key clinical information relevant to patient safety.	Handover sessions, SBAR approach adopted, complex cases will be discussed by the team. Safety briefs in place. Handover book A full multidisciplinary review will take place for all women on labour ward for more than 72 hours. WHO checklist in use across BCUHB. WHO checklist full compliance noted in relation to completion prior to procedure, full compliance not achieved in relation to completion at the end of the procedure.		To monitor compliance with completion of WHO check list post procedure	Dec 2018	Improvement Midwife	**August 2018** An audit of WHO compliance was undertaken on all three sites and demonstrated the need for improvement. The local WHO check list is being revised to make it more user friendly to ensure appropriate documentation of the checks being performed. Once the new check list is fully embedded a repeat audit will be undertaken. Findings of audit will be reviewed at

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
	Acknowledged need for "Time out" when managing complex cases.					NWIPF in Jan 19 and NW Directorate group. An MDT meeting is held for any woman on labour ward for >24 hours **January 2019** Awaiting audit result **May 2019** The audit demonstrated that safety huddles are well embedded in practice.
Postnatal care High standard of bereavement care Use of bereavement checklist inclusive of record Checklist inclusive of record that all health care professionals have been informed of still birth Continued PN midwifery care clearly documented Joint bereavement care from obstetrics and	Bereavement officers available on each site. Clinical Pathways in place for bereavement inclusive of the recommended documents. Joint feedback sessions now being offered Written information with regards to Post Mortem		Bereavement midwife appointed to ensure high standard of bereavement care	Dec 2018		**November 2018** Bereavement midwife appointed and commenced in post on 18/11/18. **January 2019** Further funding applied for via Tampon Tax fund **Feb 2019** Funding not able to be accessed. BMW has increased to 0.7wte. **May 2019** Bereavement Midwife providing single point of access to women and their families and

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
neonatologist should be provided Written information available to parents to support post-mortem counselling Follow up meeting with bereaved parents arranged and future pregnancy plans discussed Joint obstetric /neonatologist follow up meeting to be offered High quality follow up letter detailing results and plans for future pregnancy						follow up postnatal care. Also ensuring staff are trained in Postmortem consent and bereavement process.
Staff trained and competent in Newborn Life Support Resuscitation equipment to be readily available Appropriate documentation of resuscitation events Senior support for resuscitation should be readily available	Midwifery staff 100% compliant with mandatory training. NLS on the training annually. Paediatric team available via an emergency bleep system as required.		Documentation monitored by CSfM and identified issues addressed on a one to one basis.			

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
Admissions to HDU/ITU Maternity service providers should investigate and monitor maternal admissions to high dependency and intensive care units locally and across their regional networks. Admission counts based on routinely collected data could be supplemented with case reviews to improve insight into who gets admitted and why	All admissions would be subject to a minimum of a rapid review and where necessary this will progress to a concise/comprehensive review The annual number of admissions is recorded on the annual birth statistics				Clinical leads Labour ward	
Neonatal care Appropriate management of babies with HIE If therapeutic hypothermia is being considered, continuous monitoring of core temperature must be undertaken. Early efforts to passively cool the baby should also be considered (turn off the heater, take off the hat).	BCUHB Cooling Referral Criteria pathway is utilised across the 3 sites.  cooling criteria 02-2012.pdf  passive cooling protocol in a referring All relevant cases will be discussed at the site Perinatal Mortality meetings.					

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.	The Neonatal team would be called to attend perinatal events which require the attendance of a Paediatrician at the delivery of the baby as per custom and practice. When a newborn is identified as unexpectedly requiring cooling the risks would be managed by the neonatal team. Alert files in use on the labour ward in East and West to highlight high risk cases attending for delivery.				Clinical lead midwife labour ward Labour ward lead	
Overall care There is a five-fold difference in mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. Action is needed to address these disparities	The proportion of the population in each county from non white backgrounds is as follows: - Wrexham – 6.6% - Gwynedd – 5.1% - Conwy – 3.9% - Denbighshire – 3.9% - Flintshire – 3.7% - Anglesey – 2.8%		Undertake a piece of work to improve recording of ethnicity – staff need to understand this information to plan future services. As our % is low we are at risk of not planning/ delivering services to meet needs of this important minority of families who are at more risk of complications. Need to make extra effort to ensure first contact is as early as possible, and booking/access to antenatal		Dave Farmer PHW	**January 2019** Need to review information for women and families to ensure it is fully accessible to those from all ethnicities – taking into account both language and health literacy **Feb 2019** Not a significant issue for North Wales based on the data from PHW.

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
			care as early as possible. This may need to involve staff training and awareness and increased population awareness in specific geographies/communities on how to access antenatal care. Need to review information for women and families to ensure it is fully accessible to those from all ethnicities – taking into account both language and health literacy.			
There was a statistically non-significant increase in the overall maternal death rate in the UK between 2011-13 and 2014-16, which suggests that implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths	Bench marking against MBRRACE recommendations performed and an action plan has been developed to address areas requiring improvement. Action plan shared via Health Board Governance processes.		Action plan in place and is reviewed quarterly to monitor progress against actions		Director of Midwifery Women's Lead Risk & Governance	
Planning services When planning services, local demographics should be taken into account,	Demographics included in all plans for maternity service development				Director of Midwifery	

Recommendation	Current Status - BCUHB	RAG Status	Action/s - BCUHB	Time Scale	Lead (s)	Progress update
including the increasing age and BMI of women giving birth						

Betsi Cadwaladr University Health Board

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

Women's Directorate Trend Analysis of BCUHB Stillbirths January – December 2018

Situation

Despite significant reductions in maternal and child deaths there has been little change in the number of Stillbirths since 2015 (MBRRACE, 2018).
There is no single solution to reducing the number of babies who are stillborn. Risk assessment and surveillance for fetal growth, supporting the reduction of smoking in pregnancy, raising awareness of fetal movement patterns and effective fetal monitoring during labour are the main actions required.

Background

MBRRACE-UK and Each Baby Counts confidential enquiries identify and share valuable learning with Health Boards to improve maternity care.
To further support these national audits, local intervention is also required via robust investigation of all Stillbirths and Neonatal deaths, reviewing care provision prior to and during the reported incident.
A series of quality improvements are required to ensure that every lesson learned is related back to improvement within clinical practice and learning is understood and shared locally and nationally.

Assessment

In BCUHB, There were 20 Stillbirths between 1st January and 31st December 2018 (see appendix 1 for complete information in full).
Trends:

- Nine of the 20 reviews demonstrated poor staff compliance with the carbon monoxide monitoring policy
- Five of the 20 demonstrated substandard fetal growth surveillance
- Eleven of the 20, 13 declined the offer of post mortem
- One placenta was not sent to the Paediatric Pathologist in Cardiff
- Five of the 20 women who presented with altered pattern of fetal movements had no fetal heart rate heard on admission to the MOAU.
- Four of the 20 cases were allocated a CODAC classification.

Recommendations

- Outpatient Matron to develop an improvement plan for midwifery compliance with CO monitoring, referral to Stop Smoking Wales and documentation.
- Obstetric leads to develop an improvement plan for monitoring obstetric compliance with the GROW e-learning package.
- Continued monitoring of BCUHB performance via the MBRRACE action plan, reviewed and escalated via governance processes on a quarterly basis.
- Women's Services/Radiology build a business case to increase scan capacity to assist Women's Services to comply with the RCOG Green Top 31, optimal screening for the small for gestational age fetus.

- Bereavement Midwife to audit reasons for parents declining post-mortem following Stillbirth and to work with bereaved parents to increase the uptake of post mortem services where appropriate.
- MOAU leads to ensure all staff working in MOAU are briefed and aware of the significance of women presenting with altered fetal movements and the need to auscultate the FHR at the earliest opportunity.
- All local review panels to agree and document a CODAC classification of each Stillbirth during the review.

Conclusion

A further more in-depth review of Stillbirths is required. BCUHB has agreed that Public Health Wales are to lead on a thematic review of all Stillbirths and Neonatal deaths recorded between 2016 and 2018. A Task & Finish group will be established to determine the process for the review in early 2019.

Following completion of this report, Public Health Wales have decided to reduce the thematic review to all Stillbirths and Neonatal deaths recorded in 2016 only.

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
1 DB	Antepartum stillbirth at 36 weeks gestation	Unexpected	Yes East	Yes	• Smoker • No CO monitoring recorded throughout pregnancy • Repeat DNA • No urinalysis on midwifery antenatal check throughout pregnancy • Inappropriately classified as low risk Mental health issues • Although referred to Mental Health team, no review occurred and was not followed up by obstetric team • Missed slow growth trigger therefore missed opportunity to review EFW and Doppler	Declined both post mortem and placental histology		Potentially	CO monitoring Urinalysis Growth Triggers

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					• 1 episode of DFM • BWC 3.2 • BW 2300g				
2 LRI	Antepartum stillbirth at 26+5 weeks	No	Yes East	Yes	• Smoker • No CO monitoring • Mental health issues • Substance and alcohol misuse • Self-harm at 26+5 weeks gestation with alcohol, no fetal heart rate on admission • Social services involvement • BWC 15.5 • BW 860g	Declined post mortem Placenta histology The fetal surface of the placenta was found to be grossly abnormal. No evidence of chorion amnionitis or neoplasia. No significant infarction or haemorrhage is demonstrated	Early identification of maternal pulse rate rather than FH on CTG.	No	CO monitoring Declined post mortem
3 LRA	Antepartum stillbirth at 38 weeks gestation	No	Yes East	Yes	• Fetal demise 5 days after ECV • No CO at bookings SFH < 10th centile scan showed EFW just above the 10th centile	Declined post mortem Placental histology NAD		Without current local & national guidance on scanning follow up for GROW triggers it is	CO monitoring Best practice follow up scan for EFW later in

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					• No further scan to assess growth via EFW • BWC 7.1 • BW 2660g			impossible to say whether this death could have been avoided by additional scan findings.	pregnancy not carried out. Declined post mortem
4 LM	Stillbirth at 34+6 weeks	No	Yes East	Yes	• Previous mental health issues • Smoker • Declined CO monitoring • No TFT's carried out at booking • Early unexplained bleeding in pregnancy • Suboptimal communication • Poor management of Thyroxine therapy during pregnancy • between specialities • Secondary unexplained	Post mortem declined Placental histology nil of note		Potentially avoidable	Declined post mortem appropriate triage of scan requests by Ultrasound Overall responsibility falls on the consultant under whom the patient is initially booked any additional factor that develops during pregnancy must be

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					vaginal bleed • Haematoma noted on scan 28+6 weeks • Low Hb not followed up • Growth Scan request declined inappropriately • Declined scan not followed up by requesting clinician • There was lack of appropriate AN care plan and timely action due to recurrent APHs • Uncertainty around Clexane medication • BW 2630g • BWC 22.8				brought to the attention of her own consultant unless acute emergency necessitating immediate action
5 KTW	Stillbirth at 36+5wks	No	Yes East	Yes	• States non-smoker however booking CO 12 and no further readings taken. • CO not	Post mortem declined Placental histology areas of calcification	Static growth trigger picked up and scan carried out within 1 day	No	No further CO readings despite Declined post mortem

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					repeated during pregnancy • Static growth • DFM for over 12 hrs before admission • Declined post mortem • Placental histology nil of note • BWC 20.5		2.Fetal movements documentation given 3. Fetal movement's discussion documented.		
6 AW	Stillbirth at 36 weeks	No	Yes East	Yes	• Placental histology some retro placental clots covering 10% of placental area. Umbilical cord shows dilated vessels constant with the cord being wrapped round the fetal neck • Non smoker • CO at booking 0 • 2 serial growth scan EFW above 50th centile following growth curve on	Declined post mortem but placenta sent for histology.	Slow growth from SFH at 34 weeks growth scan within 1 day showing good growth from last EFW at 28 weeks	No	Post mortem declined

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					chart • Cord round neck x 3 • BWC 42.6				

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
7 KLJ	Type 2 diabetic on oral control Stillbirth at 36+4 weeks	No	Yes East	Yes	• Type 2 diabetic • Smoker • CO at booking 17 • Only one further CO reading at 35 weeks 11 • BMI 34 • Irreproducible SFH • Serial growth scans showed progressive growth • One episode for DFM at 35 weeks • Mild polyhydramnios • BW 2875j • BWC 45.1 • DFM at 34 weeks for 3 days and mild raised BP • Admitted with vomiting at 36+4 wks no FH, blood cultures and swabs results awaited. CRP	Post mortem, accepted No histology yet	1.On aspirin 2.Excellent joint speciality care between obstetrics and endocrinology 3. Referral to SSW. 4.On BMI pathway Consistent growth scans for fetal surveillance	No	CO monitoring

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					very raised.				

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
8 LJE	Stillbirth at 36 weeks	No	Yes YGC	Yes	• Non smoker • Booking CO 4 • Echogenic area in lung on FM scan identified at anomaly scan, which disappeared later in pregnancy • No SFH plotted by CMW at 26-28 weeks as per local and national guidance • Growth scan at 31 and 35 weeks showing good growth above 50th centile • SFH plotted at 30 and 33 weeks showing good growth • Change in fetal movements over a two week period. • No barrier caused by	Post mortem agreed Placenta showed evidence of distal villus hypoplysia-ie placental insufficiency leading to hypoxic ischaemic damage.	Fetal medicine scan in house at Wrexham	No	No SFH plotted by CMW at 26-28 weeks as per local and national guidance

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					language understanding as understands English well. • BWC 30.9 • BW 2629g				
9 JR	Stillbirth at 37+5 weeks Admitted contracting, reporting normal movements on admission no FH 1 cm dilated	No	Yes YGC	Yes	• Non smoker • No booking CO • Low Hb 8.8 • TFT raised, repeat 3 months • Acute kidney injury alert demonstrated by U&E's • Raised BP 4 days postnatal.	Declined post mortem and placenta went for histology but was carried out locally	SFH plotted according to local and national guidance no growth issues	No	CO monitoring Declined post mortem Placental histology carried out by a non-neonatal pathologist
10 LO	Chorionic, diamniotic twins admitted at 23 +3 weeks	No	Yes YGC	No	• Non smoker • CO at booking 1 • Unresolved RADIS calculation of gestational age on scan resulting in a miscalculation of viability. • PV pink loss at 23+3 weeks at miscalculated gestational age • Synto infusion	Post-mortem and placental histology performed.	Consultant Paediatrician review mother on admission at 23+3 wks and documentation states that parents wish active resuscitation should babies be born with	No	RADIS gestational age calculation issue Transfer pathway Communication

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					commenced then discontinued • Fully dilated for several days • Septic as a result of PROM • Inappropriate discussion regarding risk status with couple • Lack of adherence to transfer pathway • Poor decision making regarding transfer • Communication breakdown of all parties involved • One baby stillborn • One baby neonatal death • Mother distraught over care provision		signs of life. Steroids Magnesium sulphate IV antibiotics		
11 NW	G6P5	No	Yes	Yes	• Non smoker	Post-mortem		No	No booking

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
	25+5wks no fetal movements since previous day. Breech No FH on admission		YGC		• BMI28.5 • Previous cholestasis-bloods this pregnancy normal • Abnormal GTT at 25wks-getstaional diabetes • No FM at 25+5wks following GTT • BWC 69.3 • Non-smoker-no CO at booking • Good growth serial scans growth above 50th centile • BWC 57.7 • IOL	declined Declined placental histology			CO Post-mortem and placental histology declined
12 HD	Primip Admitted with cord prolapse at 26 +1weeks ?SROM, ?Prem Labour Cord	No	Yes YG	No	• BMI 18 significant risk of SGA • Significant MH issues • Looked after child • Social Services involvement • Smoker	Post-mortem declined and placental was not sent for histology in error	Good plan of care for mental health care and support	No	Scan to establish fetal heart rate/presence of fetal heart not carried out Not all SB's are classified

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					• Declined CO at 17 weeks • CO repeated a further 1 time in pregnancy • Lack of support • PV bleed at 13 wks gestation • CTG not commenced- may have been helpful • Scan not performed to establish fetal heart rate/presence of fetal heart prior to C/S • BWC 46.1 • CODAC 5				
13 RM	36 weeks spontaneous labour/C/S Pathological CTG.	No	Yes YG	No	• BMI16.2 • Smoker • Experienced domestic abuse • Involvement with SS and Child protection • Previous small baby • CGC completed scans show	Post mortem carried out Cause of death abruption# Flu viral infection	Good documentation Serial growth scans as at significant risk of SGA	Possible	CO monitoring incomplete Some delay between arrival in theatre and knife to skin 7 minutes

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					good growth • CLC • No documented referral • CO readings 4 throughout pregnancy • DNA x 3 • BWC 47.4 • Some delay between arrival in theatre and knife to skin 7 minutes				
14 EO	G4P1 IUD confirmed at 31+3wks no FMF since previous evening no FH Cord around neck and body	No	Yes YG	Yes	• BMI 25 • Non smoker • CO not completed at booking • CLC-previous baby TOP cardiac anomaly and SGA • BW 1.730 • BWC 33.2 • Prev SGA on aspirin	Declined post-mortem Placental histology Normal no inflammation Probable cause of death cord around neck and body-		No	Classification CODAC 5
15 RM	Concealed pregnancy Abruption birthed at home WAST	No	Yes YG	Yes	• BMI 39 • Previous SGA baby • Smoker	Post-mortem In Alderhey Coroner declined to		No	CODAC classification 8

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
	called				• Substance misuse • Depression • Domestic abuses • SS involvement • Blood transfusion in ED • 1000mls of blood in bathroom/placenta in situ when WAAST arrived • Admitted to ITU following evacuation of uterus in theatre • PRUDIC undertaken • Postnatal sepsis	request further samples			
16 ELO	G6+1P2 Prev Prem lab cervical suture Prev neonatal death 39+4wks Admitted following SROM	No	Yes YG	No	• BMI 27 • Cervical suture removed at 36+5wks • Non-smoker CO booking 2 • Prev SGA and Neonatal Death to be considered	Post-mortem declined Consented to placental histology Placental swab grew Ecoli		Possibly	Plan of care Conservative management was inappropriate at 4cm dilated CTG may have been

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					• Serial growth scans growth normal • Steroids • DFM • MSSU Ecoli treated • Admitted with SROM DFM later same day. • Transferred to LW for forewater ARM • Plan of care • Conservative management was inappropriate at 4cm dilated • CTG may have been helpful as in retrospect she was a high risk women in active labour • BWC 60 • CTG unable to locate FH on transfer to LW • Coliform on cervical suture-treatment				helpful as in retrospect she was a high risk women in active labour

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					arranged through GP				
17 SMW	IUD at 40+9wks Primip	No	Yes YG	Yes	• RE1 yes • BMI 28 • Non smoker • No CO at booking • MLC • SFH slowing at 36+3wks growth scan next day good growth • DFM 39+6wks CTG review by obstetric team not documented • 40+9wks DFM • No FH confirmed on scan at 40+9wk • No evidence of abruption on scans • Progress in labour not monitored on a partogram • BWC 8.2	Post-mortem declined Placental histology no significant findings Just an excessively long cord Not carried out by paediatric pathologist		No	CO monitoring compliance 2 DFM SGA Progress in labour not monitored on a partogram
18 SP	Triplet pregnancy-Triplet c -	No	Yes	Yes	Not a true SB as per description	N/A		No, multiple pregnancy	

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
	abnormalities seen at USS from 13 weeks Hydrocephaly No kidneys Bilateral ventriculomegaly SGA No FH on USS at 24+1 weeks Mum continued with pregnancy and delivered 2 babies at 36 weeks								
19 LSJ	G2 P1 Admitted with SROM Meconium stained liquor Abnormal CTG Cat 1 C/S	No	Yes YG	Yes but thought to be alive	• GTT could have been considered at 32+ weeks gestation due to high risk of polyhydramios, as per BCU Guideline "Management of Increased Liquor Volume in Pregnancy". • Lack of awareness re section of the	Post-mortem performed		No, extreme prematurity	

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					HHN dedicated for documenting plan of care (page 27 of HHN) • No benefit in commencing Aspirin at 34 weeks gestation • Lack of awareness that the maternal pulse can be picked up through FSE on a deceased baby. If the CTG traces are similar and there is any doubt ultrasound scan could be performed.				
20 HO'G	G4 P2 WAST transfer PV bleed en route No FH	No	Yes YG	Yes	• Suboptimal documentation of a detailed plan of care by the obstetric clinician in the Maternity	Post-mortem and placental histology declined		No, abruption	

Case	Context	Anticipated	Booked with BCUHB	Demise before admission	Findings	Post-mortem and placental histology	Good practice	Avoidable	Theme
					Outpatient Assessment Unit • The MOAU assessment proforma was not utilised, which encourages detailed documentation of the proposed plan of care • Obstetric clinicians are responsible for completing the appropriate proforma following review of the patient				

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Appendix 2: Women's Directorate

Benchmarking exercise against the Healthcare Inspectorate Wales unannounced Inspection Report of the Royal Glamorgan hospital Maternity Services (Jan, 2019)

To ensure shared learning across Wales and to identify any areas for improvement within the Women's Directorate, a benchmarking exercise has been undertaken to compare BCU performance against the recommendations made by Healthcare Inspectorate Wales (HIW). The investigation team used the Health and Care Standards (2015) to inform their review and the following standards were highlighted for improvement:

- Standard 2.1 **Managing Risk and Promoting Health & Safety**
- Standard 2.4 **Infection Prevention & Control and Decontamination**
- Standard 2.6 **Medicines Management**
- Standard 2.9 **Medical Devices, Equipment and Diagnostic Systems**
- Standard 3.5 **Record Keeping**
- Standard 4.1 **Dignified Care**
- Standard 6.3 **Listening and Learning from Feedback**
- Standard 7.1 **Workforce**
- **Governance, Leadership and Accountability**

No	HIW Recommendation	Health & Care Standard	Current status	RAG Status	Action required	By whom	By when
1	The health board is to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is available and safe to use in the event of an emergency on the A/N, P/N and labour wards. The health board is to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is available and safe to use across all other wards and departments across the health board.	2.6 & 2.9	Compliant. All clinical areas have a checklist which is signed to confirm that all emergency equipment is checked on a daily basis. To be monitored corporately.		Matrons perform quality audits on a monthly basis which incorporates compliance with daily checks and the results are discussed at the QSE subgroup meetings on a monthly basis.		
2	The health board is required to provide HIW with the actions it intends to take to safeguard the sustainability of the service. The health board is to provide HIW with the details of the actions it intends to take to ensure the health and wellbeing of staff is maintained and protected.	2.1 & 7.1	Birth Rate Plus compliant and repeated every three years Medical staffing optimised and agency used as required Student midwife/nurse numbers reviewed and agreed annually. Skill mix monitored on staff rotas. PADRs over 90% compliant. Full complement of Clinical Supervisors of Midwives for staff support.		Medical staffing remains on the risk register, but is much improved with less than 11% usage of locums.	Lesley Brown	Ongoing

			Mandatory training compliance is 99-100%. Sickness absence is managed as per policy to support staff.				
3	The health board should consider appropriate toilet facilities for partners during labour.	4.1	Toilet facilities available on all labour wards for visitors including men.				
4	The health board must display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council	6.3	Displayed in all clinical areas.				
5	The health board must ensure access to the wards is securely maintained for the protection of staff and patients. The health board should ensure that mats within the birthing suite are not a trip hazard to staff and patients. The health board should ensure that the entrance into and out of the birthing pool is safe and secure.		All entrances are locked with swipe card access only and all have video images of entrance/exit. All MLC rooms risk assessed. Plumbed in birthing pool has holding rail and stairs to ensure safe entry/exit.				
6	The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support staff with	2.4	Stock maintained by Housekeepers.				

	undertaking their roles.						
7	The health board must ensure that medication fridges are lockable and are kept locked when not in use and that staff record the daily temperature of the fridges on a daily basis. The health board must ensure that controlled drug medication checks are carried out consistently on a daily basis.	2.6	Drug checks are recorded twice daily as the keys are handed over from shift leader to shift leader. The fridge temperatures are recorded daily.				
8	The health board must ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner.	2.9	All equipment replaced as required.				
9	The health board must ensure that patient records include the appropriate patient identification and labels on each page.	3.5	Documentation sessions delivered by Clinical Supervisors for Midwives. The importance of documentation is iterated on mandatory training and PROMPT training days.			CSfM Leadership Team	Ongoing
10	The health board is to provide HIW with the details of action taken/to be taken to ensure that communication channels are clearly defined, so staff are fully informed about information or changes that impact on them and their work. The health board is to provide	Governance Leadership & Accountability	Staff are involved and informed of change, but staff feel that improvements could be made. The senior management team have monthly staff drop in sessions at all sites across North Wales. Lessons learned are developed and circulated following the			Senior Leadership Team Governance Team CSfM Team	Ongoing

	HIW with the details of action taken/to be taken to ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients. The health board is to provide HIW with details of the action taken/to be taken to ensure that staff responsible for reviewing Datix incidents have the time and the resources to be able to do so within agreed timescales. The health board is to provide HIW with details of the action taken/to be taken to ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients. The health board is to provide HIW with details of the action taken/to be taken to ensure multidisciplinary working is embedded for the wellbeing of staff and patients.		review of major incidents. Any staff member who has contributed to an incident review, produced a statement etc. Will receive an executive summary of the investigation report. Face to face feedback is given to staff following a clinical incident review if preferred. Clinical Supervisors for Midwives support staff through the investigation process and feedback on any clinical practice issues. Datix are allocated on a daily basis by the midwifery Governance Team to the appropriate handler. The Women's Directorate are working in real time with Datix reported. Corporate Concerns meet with the Governance Lead weekly to discuss incident and concerns trajectories, to ensure appropriate management. Monthly Quality Assurance reports are developed by the matrons following audits. All IP audit results are displayed on the ward performance boards for the public to view.				

			PROMPT training has been in place for over 12 months developing team working and multi-professional training for the wellbeing of staff and patients.				
11	The health board is to describe how it will ensure that its workforce: • Maintains and develops competencies to meet patients' needs • Attend induction and mandatory training programmes. The health board must ensure that the provision of clinical supervision is appropriate to the number and need of their workforce.	7.1	Midwifery staff are rostered to attend mandatory training and PROMPT training days. The days are repeated monthly on each site allowing catch up dates if any session is missed for an urgent reason. Staff are required to undertake a period of induction both by the health board and locally if they are new starters. There is a training group that review applications for non-mandatory training applications to ensure equity across all sites.				

RAG Status key

	No progress
	In progress
	Complete

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Women's Directorate

MBRRACE Meeting Agenda

Medical Seminar Room, Ysbyty Gwynedd

Tuesday 14 May 2019, 11.00hrs

1.	Apologies:	MW	
2.	Update revised action plan	All	
3.	Outstanding actions and time frames	All	
4.	AOB	All	
5.	Date and time of Next Meeting		11-12.30pm, 6 Aug 2019 Venue TBC

Royal College of Obstetricians & Gynaecologist - Each Baby Counts – 2018 Progress Report

1) **Introduction:**

Each Baby Counts (EBC) is a national quality improvements programme led by RCOG to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

In individual Maternity Units, these events are rare and it is therefore difficult to see clear patterns or identify how best to avoid them. The EBC programme brings together the results of local investigations into stillbirths, neonatal deaths and brain injuries occurring during term labour to understand the bigger picture, share the lessons learnt and prevent babies from dying or sustaining brain injuries in the future.

The national ambition is to reduce by half the rate of stillbirths, maternal and neonatal deaths and brain injuries that occur during or soon after birth by 2025. The overall aim of the programme is to ensure that Maternity Services learn from mistakes to reduce and prevent available harm wherever possible.

The EBC 2018 Progress report presents key findings and recommendations based on the analysis of data relating to the care given to mothers and babies throughout the UK, to ensure each baby receives the safest possible care during labour.

2) **Key Findings**

In total, 1123 babies born, out of 700,00 term babies born in the UK in 2016 , met the eligibility criteria for EBC. There were;

- 124 intrapartum stillbirth (11%)
- 145 early neonatal deaths (13%)
- 854 babies with severe brain injuries (76%)

The EBC reviewers concluded that in 674 babies (71%) the outcome might have been different with different care. The main themes identified where improvements could have been made were failures by health professionals to identify or act upon relevant risk factors, issues related to monitoring of fetal wellbeing with CTG and blood sampling, and education or training issues.

3) **Key Recommendations for Clinical Care**

The recommendations in the Report, identified through detailed thematic analysis, address critical factors in the care of many of the EBC babies that may have prevented their death or brain injury.

The identified factors were as follows:

- Workload
- Escalating high aquity
- Cross-site communication
- Local Guidelines
- Migration of Boundaries
- Anaesthetic Care

These factors and the related recommendations are described in full in Table 1 – Appendix 1.

4) **Recommendations for Future Reviews**

Improving the quality of local reviews is essential and will improve the lessons learnt and ultimately improve care. The report recommends the following when undertaking local reviews;

- Involving Parents
- Utilising the Perinatal Mortality Review Tool (PMRT)
- Securing Neonatal Input
- Securing Anaesthetic Input

5) **Local Benchmarking**

The Women's Directorate has reviewed the Report and benchmarked local practice against the recommendations, identifying areas for improvements in practice and in the reviews process. Please see Table 1 in Appendix 1

6) **Conclusion**

Whilst some local systems and practices reflect the recommendations of the Report there are specific areas that need improvement if we, as a local maternity service, are to truly learn from mistakes to reduce and prevent avoidable harm wherever possible. Local improvements and implementation plans will be reported to and monitored by the Women's QSE and Quarterly the Women's Board, Secondary Care QSE and QSG of the Health Board.

Appendix 1

Each Baby Counts 2018 Progress Report

Table 1

Key Recommendations for Clinical Care	BCU Position	RAG
Workload The Labour Ward Coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal.	The Service is Birth rate Plus compliant which allows the Labour Ward Coordinator to remain supernumerary.	GREEN
Escalating High Activity There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own speciality but also on behalf of another speciality. The Consultant Obstetrician should always be informed when labour ward activity is high.	BCUHB has a ratified Maternity Escalation Policy which supports this recommendation in full. The Women's Directorate operates a 24/7 management on call system which provide staff support and manages the continuity of service as a Network.	GREEN
Cross-Site Communication Women receiving care from multiple units must have an individualised management plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic.	Women are provided with the All Wales Hand Held Notes which are issued at booking which they carry with them to all appointments/across multiple sites during pregnancy.	GREEN

Local Guidelines There must be clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended.	The Directorate has a formalised process to review and develop policies and guidelines and a process to agree any deviation from Nation guidance. Guidelines are reviewed in light of incidents and updated as necessary.	GREEN
Migration of Boundaries Teams should protect against migration of boundaries by ensuring that real practice reflects practice as described in guidelines. Audit indentifies where migration from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these mitigration can be corrected.	Monitored via incident reporting and audited as part of the review process.	GREEN
Anaesthetic Care A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre before the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.	Anaesthetic Care – Recommendation has been reviewed by the North Wales Intrpartum Forum. Memo to support this recommendation has been circulated to all areas. The Action Plan will be presented to the Women's Board in January 2019.	AMBER

Recommendations for Future Reviews		
Involvement in Parents All Trusts and Health Boards should inform the parents of any local review taking place and invite the mm to contribute in accordance with their wishes.	Parents are informed of and invited to input into Reviews. Plan is invite parents to the Review Panels as of January 2019	AMBER
Utilising the PMRT All Each Baby counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).	The PMRT is utilised in all neonatal reviews.	GREEN
There is an urgent need for PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.	This is a National decision. Introduction to be considered as part of the national review of the SUI process and development of a standardised trigger list.	RED
Neonatal and Anaesthetic Involvement All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.	The Directorate is compliant with this recommendation.	GREEN

@eachbabycounts

Royal College of Obstetricians & Gynaecologists

each baby COUNTS.

2018 progress report

November 2018

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Contents

Abbreviations

BMI	body mass index
CNST	Clinical Negligence Scheme for Trusts
CTG	cardiotocography
DAS	Difficult Airway Society
FSE	fetal scalp electrode
HSIB	Healthcare Safety Investigation Branch
IT	information technology
LMS	Local Maternity System
LSCS	lower segment caesarean section
MDT	multidisciplinary team
NICE	National Institute for Health and Care Excellence
NMPA	National Maternity and Perinatal Audit
NPSA	National Patient Safety Agency
OAA	Obstetric Anaesthetists' Association
PMRT	Perinatal Mortality Review Tool
RCM	Royal College of Midwives
RCoA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
STP	Sustainability and Transformation Partnership
VBAC	vaginal birth after a previous caesarean section
WHO	World Health Organization

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Finally, we are grateful to members of the RCOG committees and other organisations who have provided useful thoughts and valuable feedback on draft versions of this report, particularly the RCOG's Clinical Quality Board, the Obstetric Anaesthetists' Association (OAA), the Royal College of Anaesthetists (RCoA) and the RCOG's Clinical Quality Assurance Committee.

Chapter authorship is attributed as follows:

Guidelines, protocols and standard operating procedures: challenges in implementation: *Sarah Prince, Edward Prosser-Snelling*

Themed chapter on anaesthetic care, including lessons identified from Each Baby Counts babies born 2015 to 2017: *Marian Knight, Janet Barrie (Consultant Anaesthetist), Ross Clark (Consultant in Obstetric and General Anaesthesia) and Elizabeth Walker (Consultant Anaesthetist)*

Barriers to reporting to Each Baby Counts: *Sarah Prince*

Overall findings for 2016: *Emily Petch*

Foreword

Welcome to the second Each Baby Counts annual report into stillbirth, early neonatal death and severe brain injury occurring during labour at term. Based on data for babies born in the UK in 2016, this report shines a spotlight on the care provided to women and their babies and provides an opportunity to measure progress and identify areas for improvement in maternity safety. The work of Each Baby Counts, and of everyone who contributes to it, plays an important role in driving forward the national maternity ambition to reduce by half the rate of stillbirths, maternal and neonatal deaths and brain injuries that occur during or soon after birth by 2025. The programme also recognises the impact that each of these tragic events has on parents and families. Our aim is to ensure that maternity services learn from mistakes to reduce and prevent avoidable harm wherever possible.

As in previous years, this report presents an overview of the learning gained from all babies reported to Each Baby Counts, as well as taking a more detailed look at key contributory factors where improvement is needed. Sadly, once again this year's report finds that different care might have made a difference to the outcome for almost three-quarters of these babies. This shows that much work is still needed to ensure maternity healthcare professionals are supported to implement recommendations not only from Each Baby Counts but also from other national reports and programmes, including MBRRACE-UK, NHS Resolution's Early Notification scheme and the forthcoming Healthcare Safety Investigation Branch (HSIB) maternity reports.

Importantly, this report also confirms that the reasons for these outcomes are complex and multifactorial. For the babies reported to Each Baby Counts, the reviewers concluded that there was rarely one single cause of the stillbirth, early neonatal death or brain injury. Rather, on average there were 7 critical contributory factors leading to the poor outcome. This complexity and interdependency highlights the need for continued investment to improve care for women and babies across the UK, using methods that recognise the context in which these events occur.

The work of Each Baby Counts and the quality of the recommendations are inherently linked to the quality of the local investigations on which we base our analysis. Compared with 2015, there was a 14 percentage point increase in the overall quality of local investigations, with a total of 89% of completed reports in 2016 being assessed as containing sufficient information. This is a significant improvement, and the efforts of the midwives and obstetricians who produce these reports must be commended. However, much more must be done to ensure that these investigations are of the highest possible quality to ensure that the recommendations for future improvements to care are evidence-based and reflect the true picture of care across the whole of the UK.

It is also heartening to note an increase in the number of parents who were invited to take part in reviews – a key Each Baby Counts recommendation – with an increase to 41% in 2016 from 34% in 2015. However, there is still a lot more to be done since parents were not involved, or even made aware of reviews taking place, in nearly one-quarter of cases.

The three areas we have chosen for a 'deep dive' in this report are anaesthetic care, adherence to guidelines and barriers to reporting. This follows the previous annual report's focus on fetal monitoring, human factors and neonatal care. Our aim is to gain a deeper understanding of key contributory factors in order to develop recommendations that will improve care.

The anaesthesia chapter highlights a core theme of the Each Baby Counts programme – a commitment to supporting multidisciplinary working and collaboration. Our analysis demonstrates the importance of anaesthetic care for maternity safety and calls for greater teamworking across midwifery, obstetrics and anaesthesia. It also highlights opportunities for shared learning across the wider maternity team. We are calling for investment in the development of a communication tool to allow for informed choice of method of anaesthesia and to facilitate communication between teams during urgent situations.

The guidelines and local best practice chapter provides an honest account of the everyday challenges that our maternity teams are facing on the front line, day in, day out. Our analysis presents urgent areas for improvement based on some hard facts, highlighting the impact of issues affecting workload, time and capacity. All leaders within maternity services must place a high priority on empowering and supporting our workforce, and on promoting a culture of teamworking, mutual respect, learning and reflection.

The final thematic analysis focuses on ongoing work by the Each Baby Counts team to drive up the quality of local reviews and remove barriers to reporting. We have learned a significant amount since the programme began in 2014 and are now offering support to units to re-review and re-submit reports where needed. I believe this support has been pivotal in helping to improve the data we receive, and I would like to thank the Each Baby Counts team – and the maternity units with whom they engage – for the time they have dedicated to this work. The introduction of the independent reviews carried out by the HSIB across England will further contribute to the improvement of reviews within maternity services, providing guidance and support to NHS organisations on the conduct of safety investigations.

There is plenty of rich context provided throughout this report, with our thematic chapters providing important insight and meaning behind the overall figures and the quotes that offer snippets of reflection and learning in action. I urge all those working in maternity services – frontline healthcare professionals, managers and clinical leaders – to review the detail behind the recommendations to allow them to take action. I remain optimistic that the will is there to take note, learn and act. The RCOG will continue to highlight the importance of maternity safety in the training and education that we provide, as well as advocating for high-quality care for women and their babies. We will also continue to work in partnership with the Royal College of Midwives (RCM) and the Royal College of Paediatrics and Child Health (RCPCH), as well as charities and, of course, the women and families for whom we provide

care. We remain absolutely committed to ensuring that our maternity services are the safest in the world.

I am also struck by the significant investment that has gone into addressing stillbirth in the UK, and the firm commitment from a range of sectors to improve the care of women and their babies. It is crucial that we sustain the momentum and progress to date, and bring together all of the available learning to ensure that we really make a difference to maternity care in the UK.

I therefore believe that now is the time to establish a national centre dedicated to improving maternity care – a space for sustained improvement at scale, through the collaborative input of women and families, frontline maternity teams, academics and policy makers, with the aim of making the UK the safest place in the world to have a baby. Only by bringing together the shared expertise and experience of all these groups will we achieve this goal.

I would like to finish by thanking everyone who has contributed to this report, in particular the core Each Baby Counts team and the maternity professionals across the country who are supporting the RCOG in our shared determination to improve the quality of maternity care.

Professor Lesley Regan
President, Royal College of Obstetricians and Gynaecologists

Parent foreword

I feel the pain and sadness of the loss of my son, Harry, every day. The impact on my and my family's lives has been huge – we all miss Harry terribly and live with the haunting question of 'what if?'. Some families have been unable to have more children and now live with the most terrible void and the indescribable pain of what should have been.

Since its launch 4 years ago, the RCOG Each Baby Counts project has gained incredibly valuable insight and information – information we did not previously have. We now know the numbers of babies that tragically sustain brain injury or die during or following term labour. Each Baby Counts has also confirmed what many parents, like me, already suspected – that the majority of these injuries and deaths are potentially avoidable.

This ground-breaking project is now allowing us to understand the reasons why these tragedies occur and this report gives further recommendations for action. The Each Baby Counts website also has practical help in the form of the Implementation mini-site.

Nothing will change my situation or that of the families who have suffered loss like me; however, we now have the knowledge and power to ensure others do not suffer.

I urge you to read this report, share with others and implement the recommendations. You will save lives.

Nicky Lyon, mum of Harry

Nicky and Harry (12 days old)

Harry sustained profound brain damage during term labour. He was resuscitated but was left with little tone, seizures and could not feed. He died of a chest infection in November 2009, aged 18 months.

Nicky Lyon and Michelle Hemmington are the parent representatives on the Each Baby Counts Advisory Group. They are also the co-founders of the Campaign for Safer Births (www.campaignforsaferbirths.co.uk).

Executive summary

Introduction

Each Baby Counts is a national quality improvement programme led by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. In individual maternity units, these events are rare and it is therefore difficult to see clear patterns or identify how best to avoid them. The Each Baby Counts programme brings together the results of local investigations into stillbirths, neonatal deaths and brain injuries occurring during term labour to understand the bigger picture, share the lessons learned and prevent babies from dying or sustaining brain injuries in the future.

This report presents key findings and recommendations based on the analysis of data relating to the care given to mothers and babies throughout the UK, to ensure each baby receives the safest possible care during labour.

Key findings

Clinical findings

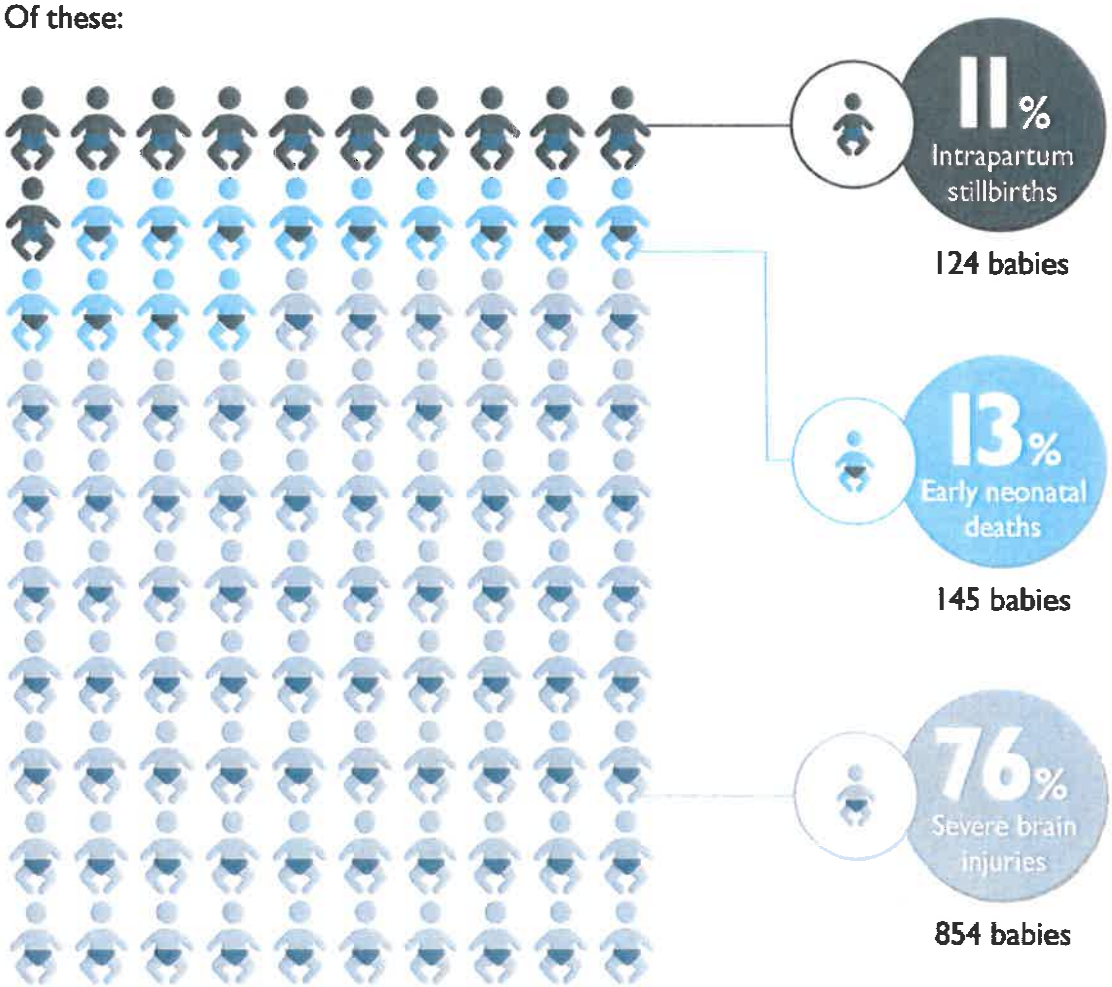
Of nearly 700 000 term babies born in the UK in 2016:

How many babies?

1123
BABIES IN 2016

The total number of babies that fulfil the "Each Babies Counts" criteria in 2016 was **1123.**

Of these:



Note: These categories are mutually exclusive. Babies with a severe brain injury who died within the first 7 days of life are classified as early neonatal deaths.

In total, 1123 babies born in 2016 who met the eligibility criteria for Each Baby Counts were reported. There were 124 intrapartum stillbirths, and a further 145 babies were born alive following labour but died within the first 7 days after birth. There were 854 babies who met the Each Baby Counts eligibility criteria for severe brain injury.

The Each Baby Counts definition of severe brain injury is based on information available within the first 7 days after birth and it is not known how many of these babies will have a significant long-term disability as a result of the injuries sustained during birth.

Of the 955 babies where the review provided sufficient information to draw conclusions about the quality of care, the Each Baby Counts reviewers concluded that 674 babies (71%) might have had a different outcome with different care. The main themes identified where improvements could have been made were failure by health professionals to identify or act upon relevant risk factors, issues related to monitoring of fetal wellbeing with CTG and blood sampling, and education or training issues.

Care impacts outcomes

71% of babies might have had a **different outcome** with different care.

Where Each Baby Counts reviewers considered that different care might have made a difference to the outcome, an average of 7 critical contributory factors were identified for each baby. This highlights the complex interaction between interrelated clinical and non-clinical factors as the main reason for these serious adverse outcomes.

Complexity

An average of **7 critical contributory factors** were identified for each baby where different care might have made a difference to the outcome.

This report has looked thematically at two different clinical areas: adherence to guidelines and anaesthetic care.

Guidelines

In the analysis of reports from Each Baby Counts babies born during 2016 where at least one reviewer felt that different care might have made a difference to the outcome, guidelines and locally agreed best practice were not followed in 45% (304) of the reports reviewed. Reasons for not following guidelines included lack of recognition of problems, communication issues, heavy workload, staffing levels, local guidelines not being based on best available evidence and gaps in training.

In order to improve the care provided to women and their babies, it is vital that reviews go beyond simply identifying that a guideline was not followed. The reviews must also look at why this occurred.

The analysis identified a need to include discussions with staff about their thought processes and decision making surrounding these events. To identify improvements, holistic reviews of the service as a whole are required. Such reviews should focus on organisational structure, unit culture and training, the way individuals communicate together and as wider teams, also on the environment in which care is expected to be delivered. Lessons on improving care and adherence to guidelines will not be achieved without identifying and addressing these distinct causes.

Anaesthetic care

Analysis of the anaesthetic care provided to the mothers of 49 babies reported to Each Baby Counts from 2015 and 2017 where anaesthetic care was identified as an issue showed that most of the anaesthetic problems noted during the review process contributed to, but were not solely responsible for, delays in birth. The findings echoed many of the lessons on situational awareness and the need for a 'helicopter view' identified in the *Each Baby Counts 2015 Full Report.*[1]

The results showed that there is a clear need to optimise communication about the urgency of birth to allow for informed choice of method of anaesthesia. Key themes for improvement also included the care of women with partially effective regional anaesthesia or airway problems.

One of the key recommendations identified is a need for the development of a structured communication tool to include the three-fold elements of the plan for birth: mode of birth, location of birth and category of urgency. The Each Baby Counts project team is now working with the Obstetric Anaesthetists' Association (OAA) and Royal College of Anaesthetists (RCoA) on the development of this tool.

Findings related to reviews

Barriers to reporting to Each Baby Counts

Following findings from babies born in 2015 which showed a significant variation in the quality of local investigations,[1] the Each Baby Counts project team initiated a formal feedback process for units when a review was deemed to contain insufficient information, along with the reasons why. Units were then encouraged to address the feedback and re-submit the information.

The implementation of this policy led to the re-review of 104 investigation reports, and 82 (79%) were subsequently assessed as containing sufficient information taking into account the additional detail that had been provided. This led to a 42% reduction in the total number of reports with insufficient information.

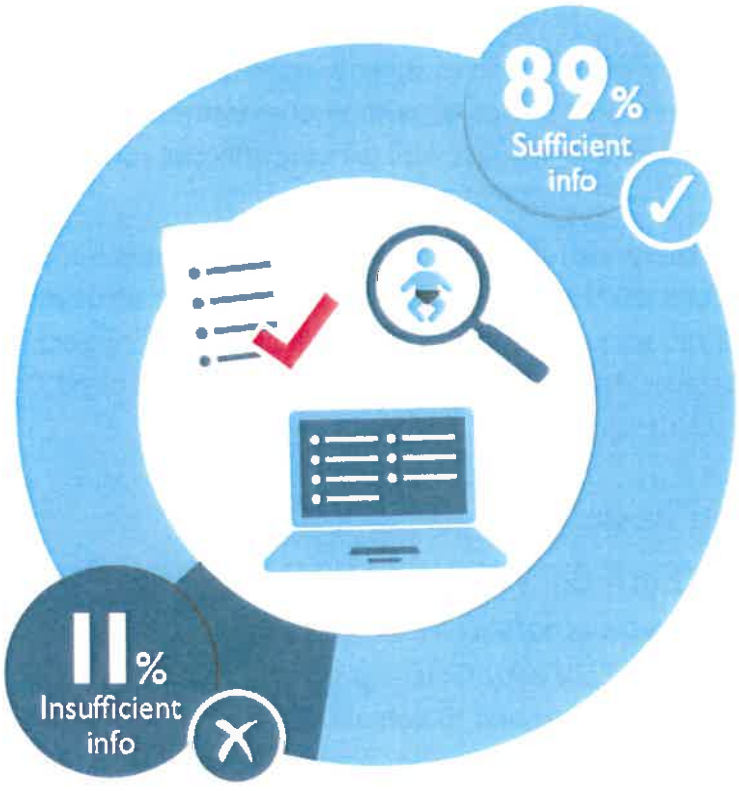
In liaising more directly with units, barriers to reporting to Each Baby Counts were identified in a number of areas, including high staff turnover and insufficient handover, lack of resources available to complete reviews, lack of availability of colleagues' input from other specialties, as well as attitudes to conducting reviews.

Quality of reporting

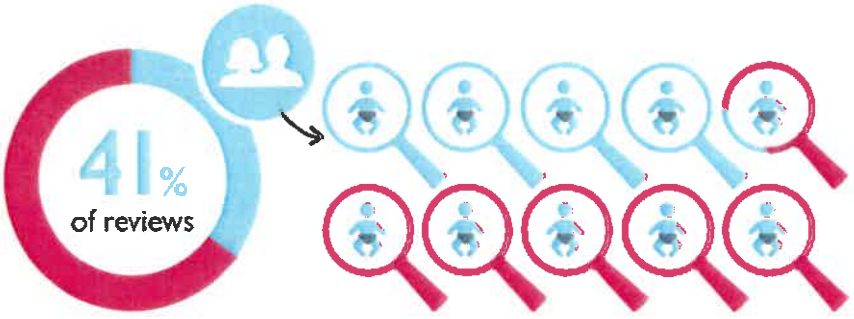
Results from the analysis of Each Baby Counts babies born in 2016 showed that 11% of the local reviews did not contain sufficient information to draw conclusions about the quality of care provided, which is a reduction compared with the 2015 results.

Information

89% of local reviews contained sufficient information to draw conclusions about the quality of the care provided.



In addition to this, the reports were assessed against other important markers of quality and the key results are shown on pages 7 and 8.

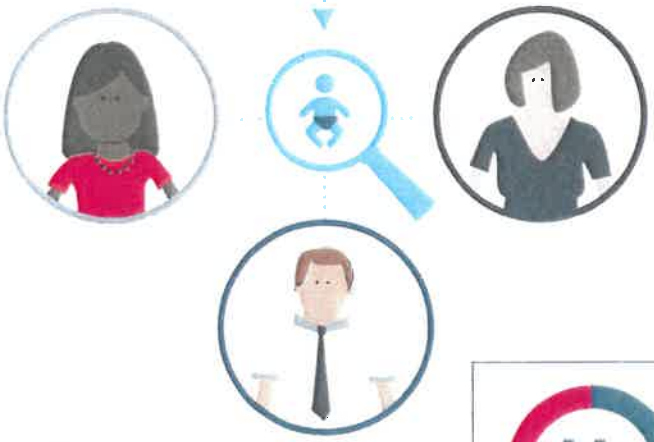


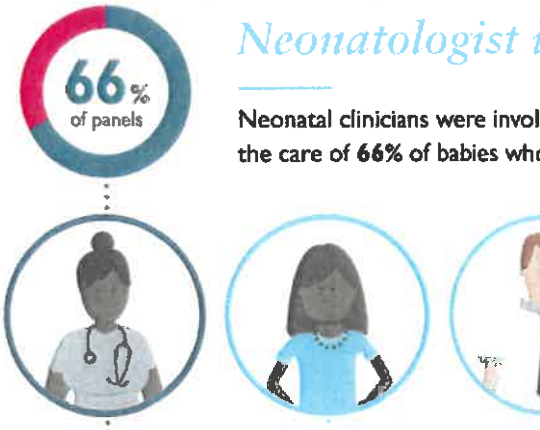
Parental involvement

Parents were invited to be involved in **41%** of reviews.

External panel members

External panel members were involved in **10%** of reviews.





Neonatologist inclusion

Neonatal clinicians were involved in reviewing the care of **66%** of babies who were born alive.

Actions and recommendations

Where clear actions or recommendations were made in local reviews, **83%** focussed on **systemic recommendations.**

Key recommendations for clinical care

The recommendations below have been identified through detailed thematic analysis of the reviews submitted to Each Baby Counts. They address critical factors in the care of many of the Each Baby Counts babies that may have prevented their death or brain injury. This report focuses on guidelines and anaesthetic care.

Guidelines

Workload

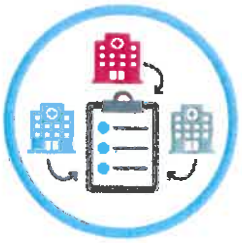
The labour ward coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal period.

Escalating high activity

There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own specialty but also on behalf of another specialty. The consultant obstetrician should always be informed when labour ward activity is high.

Cross-site communication

Women receiving care from multiple units must have an individualised management plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic.



Local guidelines

There must be a clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended.

Migration of boundaries

Teams should protect against migration of boundaries by ensuring that real practice reflects practice as described in guidelines. Audit identifies where migrations from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these migrations can be corrected.

Anaesthetic care

A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre before the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.

Recommendations for future reviews

This full analysis of the 2016 data underlines the recommendations for reviews highlighted previously.[1] Improving the quality of local reviews will improve the lessons learned and, ultimately, improve care.

Barriers to reporting to Each Baby Counts

Neonatal input

Assess your local processes for involving neonatal team members in the review of Each Baby Counts babies to see whether this needs to be improved to ensure a collaborative multidisciplinary approach. This could include identifying an Each Baby Counts neonatal lead for each unit.

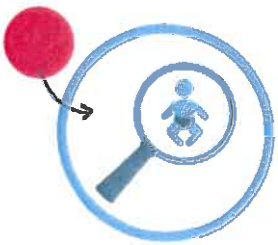
Local reviews

All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.

All Each Baby Counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).

There is an urgent need for a PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.

All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.



Methodology for the Each Baby Counts programme

Each Baby Counts is a UK-wide quality improvement programme led by the RCOG. Its ambition is to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

The Each Baby Counts project team, based at the RCOG, has compiled this report. The programme relies on 402 local Lead Reporters, who have responsibility for completing an online registration form for all eligible babies born in their unit, and 77 multidisciplinary reviewers, who complete an independent review of the local investigation reports submitted by Lead Reporters. A full list of Each Baby Counts reviewers and our methodology, including details of thematic analysis methods, is available in previous reports and on the RCOG website: www.rcog.org.uk/eachbabycounts.

Report structure

This report comprises four main sections:

- Thematic analysis 1. Guidelines, protocols and standard operating procedures: challenges in implementation
- Thematic analysis 2. Themed chapter on anaesthetic care, including lessons identified from Each Baby Counts babies born 2015 to 2017
- Thematic analysis 3. Barriers to reporting to Each Baby Counts
- Overall findings for 2016 – a quantitative summary of the number of eligible babies, the quality of local reviews and the proportion of babies for whom Each Baby Counts reviewers felt that different care might have made a difference to the clinical outcome.

Working with trusts/boards to improve reporting

During the preparation of the *Each Baby Counts 2015 Full Report*,[1] the Each Baby Counts project team identified that information relating to potentially eligible babies had not always been checked locally by Lead Reporters (282 babies) and that local Lead Reporters had begun reporting but not completed the required information about a baby (113 babies). In 25% of instances in 2015 there was insufficient information included to assess the care provided. To ensure that the Each Baby Counts data are as accurate as possible, and to ensure that all babies have the thorough review they deserve so that it is possible to learn lessons to improve, the project team implemented a process of working directly with trusts and boards that had information outstanding to try to improve the completeness of reporting. The team contacted each trust and board where a report had been assessed as containing insufficient information to ask for further information to be submitted. The results of this process are outlined in the chapter 'Barriers to reporting to Each Baby Counts' on page 43.

Thematic analysis 1

Guidelines, protocols and standard operating procedures: challenges in implementation

Introduction

This chapter focuses on reviews in which the Each Baby Counts reviewers identified that there was a need to improve the way in which guidelines and/or locally agreed best practice were followed. While the chapter looks at each of the key themes in turn, it should be noted that in the majority of reviews it is the combination of these themes and their interaction that lead to a baby being eligible for Each Baby Counts reporting. For the group of babies identified within the 'guidelines' theme (54 babies), there were an average of 6 critical contributory factors.

The main guideline applicable to intrapartum care is the National Institute for Health and Care Excellence (NICE) *Intrapartum Care* clinical guideline CG190.[2]

This chapter aims to understand the reasons why this and other best practice was not followed, and to inform clinicians, managers and policy makers of the issues and to present some of the systematic changes that they can put in place to improve this and to address the causes.

Methods

Case identification and analysis

From babies born in 2016, the Each Baby Counts reviewers identified 304 babies in whom problems with following 'guidelines/locally agreed best practice' was a critical contributory factor. A decision was made to thematically analyse the reviews submitted to explore the reasons why there are problems with following guidelines. To avoid duplication with the Each Baby Counts 2015 report, reviews that highlighted fetal monitoring (continuous cardiotocography (CTG) or intermittent auscultation) as a contributory factor were excluded. This produced a sample of 54 babies of whom 44 are included in this thematic to explore the reasons why guidelines were not followed. All 44 reports in the sample were included in the analysis and data saturation was achieved after 32 reports.[1,3] A sample of 25% (11 reviews) of the 44 reviews in the sample was then independently cross-checked by an additional reviewer, with the coding framework subsequently reviewed and revised collaboratively. Verbatim quotes from local reviews are used throughout this report along

with extracts from national guidance and the literature to support the recommendations that are intended to address the contributory factors identified.

Presentation of findings and learning

Each theme has several elements, and each element is accompanied by three summary statements, namely:

- key learning points
- recommendations
- things you can do.

As this is a chapter that focuses on why guidelines are not followed, there is a key role for auditing adherence to guidelines as part of any improvement. It should be emphasised that, while audit reveals whether guidelines are being followed, it is only by understanding the reasons why they are not being followed and then using quality improvement methods to support implementation of guidance that outcomes or processes will be improved.

Thematic analysis

Theme 1.1 – Capacity

Workload capacity was identified as being a significant contributory factor to difficulties in staff being able to follow guidelines.

Element 1 – Workload

Caring for more than one woman at a time was a significant contributor to the delays in recognising that further action was required and, as a result, to guidelines not being followed. When a clinician is caring for multiple women, it becomes more difficult to recognise any issues because the clinician is unable to focus their care on one individual. Clear national guidance exists to support one-to-one midwifery care in labour.[2] The NICE *Intrapartum Care* quality standard QS105 specifies how to calculate the porportion of women who receive this standard of care.[4] In 2017, nationally it was 54% in low-risk women, according to the National Maternity and Perinatal Audit (NMPA) report.[5]

Examples of this included instances where the labour ward coordinator was unable to remain supernumerary and, as a result of trying to care for a woman alongside their coordinating role, became involved in other events that compromised the care of their allocated woman and of others on labour ward.

> "The midwife who was looking after the patient was coordinating [the labour ward] and helping another emergency delivery. As the patient was uncomfortable and in pain, it is likely that [she] was establishing in labour and as per guidance should have been put back on CTG. As the midwife was helping another delivery, it is likely that the clinical picture of establishing in labour was not identified and hence delay in putting patient back on CTG."

Key learning points

Labour ward coordinators looking after women in labour compromises their ability to maintain situational awareness and to deliver high-quality care. The NICE intrapartum care guidance was not followed because of staffing issues.

Recommendation

The labour ward coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal period.

Things you can do

Review the frequency with which the labour ward coordinator in your unit is asked to look after women in labour alongside their coordinating role. Consider whether a senior colleague, such as a midwifery manager, could assume one of these roles temporarily. In England, share these findings with your maternity safety champion and agree an action plan if necessary to address ongoing staffing issues, drawing on the requirements outlined in the Clinical Negligence Scheme for Trusts (CNST) incentive scheme.[6]

Element 2 – Supervising students

Clear guidelines exist for the supervision of students.[7] Examples were seen where students were directly involved in caring for women without appropriate supervision because their supervising midwives had additional women to care for.

> "Midwife A informed student Midwife Z that if Mrs X had not been transferred to [the] labour ward during the morning, a CTG should be performed before lunch as per induction of labour protocol…
>
> Midwife A was engaged in caring for a number of ladies with complex nursing needs… Midwife B (labour ward coordinator) had been unable to facilitate Mrs X's transfer… due to the complexities of the women in labour and the high level of activity being experienced on [the] labour ward on that day.
>
> At 16:15 Midwife A realised that Mrs X's CTG had not yet been performed therefore she requested student Midwife Z to perform it straight away. Student Midwife Z was unable to obtain a CTG trace therefore she sought assistance from the nearest registered midwife (not Midwife A). No fetal heartbeat was detected."

Key learning points

Students should not be expected to step into a trained midwifery role and be able to accept the same level of responsibility. The intrapartum care guideline was not followed because untrained staff were used as a substitute for trained midwives.

Recommendation

Student midwives need appropriate support and supervision from a registered midwife at all times. If the workload is too high, student midwives should be moved to an area where they can practise in a supported environment.

Things you can do

Ensure that student midwives are being trained in areas where they can be appropriately supported and recognised as supernumerary.

Element 3 – Escalating high activity

There continued to be examples of situations as previously identified[1] where despite extremely high activity in the maternity unit the local escalation policy was not instigated and the consultant who was on call from home was not informed of the high activity levels or asked to attend. This led to further instances where workload capacity impaired the ability of staff to follow clinical guidelines, impacting on the care they provided.

> "The senior midwife coordinating [the] delivery unit was aware of Patient X's transfer, but there were several other urgent cases requiring medical input on the unit. The registrar left Patient X's room to answer a bleep to attend a bradycardia… Patient X's case was discussed with another registrar (who was delivering another woman) who advised to continue with the current management. The consultant obstetrician was not informed of Patient X's admission to the unit. If the consultant obstetrician had been aware of Patient X's case, earlier delivery may have been expedited… Despite intensive resuscitation efforts and ongoing care on the neonatal intensive care unit, Baby A died 5 days after birth."

Key learning points

Women and their babies are at potentially higher risk of adverse incidents and outcomes when concerns over staffing levels are not acknowledged or escalated.

Recommendation

There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own specialty but also on behalf of another specialty. The consultant obstetrician should always be informed when labour ward activity is high.

Things you can do

Changing unit culture is a complex process that cannot be achieved overnight but the use of audit and data to demonstrate where improvements need to be targeted can be powerful.

Awareness that higher risks to patients occur when concerns over staffing levels are not escalated may prompt engagement as to how units can embed local escalation policies. Where escalation policies or safety huddle processes are not in place, these should be implemented as a matter of urgency.

Element 4 – What to do when waiting for an urgent review

Situations were noted where the whole obstetric team were unavailable as they were in theatre. On one occasion, a woman's care had been appropriately escalated to the obstetric team but they were unable to attend to care for her as they were all in theatre. In this instance, rather than midwives and junior clinicians feeling empowered to continue the woman's management within their remit or escalating to the wider senior obstetric team, the woman was instead escalated to the on-call doctors and then left without review until this could occur, which meant opportunities for correction of reversible causes were missed.

> "The admission CTG shows reduced variability, with repetitive shallow decelerations after approximately 30 minutes and no accelerations in the absence of contractions, therefore it is pathological at 19:53. Escalation to a senior obstetrician and [the] midwife in charge of [the] labour ward should have occurred at this point. The obstetric team were in theatre therefore consideration should have been given to taking the CTG to theatre at this time… There are no apparent efforts to initiate conservative measures such as fluid resuscitation or to facilitate transfer to [the] labour ward. The panel are aware that the unit was very busy during this time. Additional staff had been called into the unit."

Key learning points

Lack of initiative in obtaining a review and failure to consider what could be done while waiting, in normal working hours when options for escalation were present, led to a poor outcome.

Recommendation

Skills and drills training should include situations where the obstetricians are unavailable, with staff given support to empower midwives and junior clinicians to consider transferring the woman to the labour ward, taking the CTG to theatre, acquiring alternative obstetric support, implementing conservative measures and administering terbutaline as indicated while awaiting obstetric input.

Things you can do

If you need an urgent review of a clinical situation, draw on your local escalation policy and consider what steps you can take in the meantime based on skills and drills training.

Element 5 – Lack of beds

Several reviews identified lack of bed availability on the labour ward preventing women from being transferred even as their clinical condition worsened as contributing to guidelines not being followed. This was particularly apparent for women undergoing induction of labour; there seemed to be false reassurance that, as they were in an antenatal bed, they were being adequately cared for and therefore less of a priority than those women newly presenting to the labour ward.

> "There was a delay in transfer of Patient X from the induction of labour bay to the delivery unit by 5 days… Despite the subsequent presence of spontaneous rupture of membranes…which made transfer a clinical priority, there was a further 1 day delay in transfer. Following the development of maternal sepsis and fetal heart-rate abnormalities, there was a delay in transfer to the delivery unit which may have affected the opportunity for earlier senior review… Baby A died following birth; a placental swab and blood cultures from Baby A revealed *Staphylococcus aureus* infection."

Key learning points

In this instance, the guideline for induction of labour clearly stated that transfer to the labour ward should be expedited because of the rupture of membranes.

Recommendation

When women are unable to be transferred to the labour ward, despite clinical need, an escalation meeting must be held involving the multidisciplinary team (MDT) to discuss current workload, priorities and solutions. This must consider the labour ward and antenatal ward activity. The result may lead to 'divert' policy activation. Networks of managed care such as the Local Maternity Systems (LMS) and Sustainability and Transformation Partnerships (STPs) should seek to facilitate such meetings.

Things you can do

Ensure that women undergoing induction of labour in need of labour ward care are included in the labour ward handover, added to the labour ward board and discussed as part of the safety huddle. In the long term, work with your board-level safety champion (or equivalent) to address the lack of resources and the contributory factors identified.

Theme 1.2 – Communication issues

Communication issues were cited as being a significant contributory factor in instances where difficulties in staff being able to follow guidelines were identified. This was observed both within and across MDTs, during telephone discussions with consultants and where care was being provided across multiple sites.

Element 1 – Cross-specialty communication

As identified in the previous Each Baby Counts report,[1] there were further examples of poor communication between the maternity and neonatal teams that impaired their ability to be able to follow the relevant guidelines.

There were examples where a difficult birth was anticipated but the neonatal team were not asked to attend at an early stage. Other reports detailed a lack of a dedicated neonatal bleep, leading to delays in the arrival of the neonatal team at a difficult birth. Further examples of poor communication between maternity and neonatal teams regarding the urgency of the situation and of how to escalate to obtain more senior neonatal support when required were also seen.

> "Paediatric staff attended when Baby F was 4 minutes old, the resuscitation of Baby F was commenced by the midwifery staff and chest compressions were in progress by this time. A baton bleep is being secured for neonatologists to facilitate a more robust process for contacting and ensuring prompt attendance of the paediatricians in an emergency."

Key learning points

If any member of clinical staff feels that the clinical situation needs a more senior team member, or that specialist help is required, they should escalate accordingly.

Recommendation

All units should have a clear escalation policy including how to contact neonatal team members in an emergency with a rapid bleep system (or equivalent). The policy should be further reinforced through skills and drills MDT training to ensure that it is used appropriately in everyday clinical practice.

Things you can do

Ensure familiarity with your local mechanism for summoning senior team members and specialist help; test the efficacy of this through MDT skills and drills training. Reflect on your communication style in an emergency and support other team members to develop their communication skills.

Element 2 – Team communication

There were several examples where, during emergency situations, poor communication had a negative impact on team performance and subsequently guidelines were not followed.

This was compounded by the presence of staff unfamiliar with the local setting, by a lack of knowledge regarding local equipment and by a loss of awareness of time. There was evidence that, on some occasions, team members were aware of the poor communication but did not know how to resolve it; they felt that if they mentioned it they would make things worse or upset the parents.

> "If there was the feeling that resuscitation was suboptimal, why did no one else speak up, or indeed, take action? This question was reflected on by two of the midwives, Midwife A and Midwife B. Both felt that, in retrospect, it would have been better to speak up. At the time, Midwife A felt distanced from the resuscitation because she was concentrating on Mrs X. Midwife B felt that she was junior to the other team members and that it was not her place to voice concerns. And, in fact, Dr G reflected on this himself. He was able to see that communication was poor, but did not know how to fix it in a stressful situation. He also felt he wanted to shield the parents from the difficulties the team were having."

Key learning points

By talking about the challenges they were having in this scenario, the team could have identified their different mental models, developed a team perception of events and in doing so communicated more effectively to improve team performance overall.

Recommendation

All team members should introduce themselves and state their role. If they are in an unfamiliar clinical environment, this should be made clear to the rest of the team. Where there is a perceived communication difficulty, all team members should be able to raise their concerns and encourage more open conversations about what the difficulties are in order to help find a resolution. The shielding of staff or parental feelings should not be a reason for poor communication to persist, particularly at the expense of patient safety.

Things you can do

Use skills and drills training to develop effective communication strategies for high-risk situations and include every member of the team. Implement debrief sessions after high-risk events to examine how well events were handled, where things went well and where improvements might be made in the future. Consultants and senior midwives must role-model the communication they hope to see around them. Communicating worrying or difficult matters in front of parents is inevitable in some situations and should be practised in skills and drills training.

Element 3 – Cross-site communication

Communication breakdowns were also observed where women were being cared for across multiple sites. This also occurred where women required expertise from a tertiary hospital

for the management of fetal or maternal conditions. Difficulties arose where clinicians were not able to access the notes of the woman they were reviewing because they were computerised or held at a different site, with the result that they were unaware of an important factor that would have prompted them to implement a guideline. Communication errors also occurred where there were no clear definitions of the roles and responsibilities of each site in the individualised management and organisation of a woman's antenatal, labour and postnatal care. This meant that important elements and details were missed and the need to follow a guideline was not recognised.

> "[Patient X] booked for antenatal care at Hospital 1 with her first ongoing pregnancy [risk factors at booking were maternal age of 42]. She was seen regularly throughout pregnancy and at… [anomaly] scan the baby was diagnosed with [a non-lethal heart condition].
>
> [Patient X] was referred to a paediatric cardiologist at Hospital 2 for shared care and a plan was made for delivery at Hospital 2… at 32 weeks [Patient X] attended Hospital 2… a fetal wellbeing scan was performed by the fetal medicine consultant which showed normal growth, liquor volume and Dopplers [no further scans took place].
>
> [Patient X] was admitted to Hospital 2 for planned induction of labour at 40 weeks' gestation…Induction was commenced with Propess following a normal CTG… 6 hours later the CTG was re-commenced, very sadly there was no detectable heart rate heard, and intrauterine death was confirmed… baby girl F was stillborn weighing 2830 g, birthweight on the 8th centile.
>
> Had [Patient X] been booked at Trust 2 initially, it seems likely that – according to Trust 2 guidelines – serial growth scans would have been planned in view of maternal age (including one at 36 weeks which may have prompted earlier induction). Sharing of care between her own trust [1] and Trust 2 may sometimes lead to confusion as to which trust should be providing which aspects of antenatal care."

Key learning points

Communication breakdowns occurred because care was spread over two sites, which led to important clinical factors being missed. If these factors had been recognised, a different guideline and plan of care would have been instigated.

Recommendation

Women receiving care from multiple units must have an individualised management plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic.

Things you can do

Ensure a robust process for women whose care spans two sites.

Theme 1.3 – Lack of recognition

There were multiple cases where lack of recognition of the pathology resulted in the appropriate guideline not being implemented. This included several instances of focusing on only one element of the care at the expense of other key details.

Element 1 – Confirmation bias

Multiple examples were seen both in the antenatal and intrapartum period where the focus of care became narrowed to one element of the women's clinical picture. As a result, other key details were missed that would have prompted management according to a different guideline. If clinicians do not recognise the factors that would alert them to the relevant guideline then ultimately the management will be affected.

In one example, the team became focused around the woman's high body mass index (BMI) and concerns regarding how difficult a caesarean section would be. This led to a focus on vaginal birth, with multiple issues surrounding the monitoring of the fetal heart, including repeated attempts at using a fetal scalp electrode (FSE) and ultrasound, being interpreted as obstacles that could be overcome to achieve vaginal birth rather than as prompts to change the course of their thinking. The focus on BMI led to decisions being made with the difficulty of a caesarean section being the overriding principle, rather than what was in the woman's best interest given the balanced clinical picture.

Key learning points

This illustrates how cognitive dissonance can play a powerful role in deciding between options in labour. Cognitive dissonance[8] describes our ability to believe two contradictory things at the same time. We are naturally averse to the idea we could have made a mistake, and, once we have settled on a course of action, this can result in interpreting any new evidence as confirmation of our position even when this is obviously not the case; this is also referred to as confirmation bias. In situations such as this, obtaining an opinion from a clinician not previously involved in the care is very important, as it will provide an objective assessment.

Recommendation

Healthcare professionals should recognise that in the midst of a dynamic situation, new evidence is often not interpreted objectively. A holistic assessment of fetal and maternal wellbeing will help minimise confirmation bias and ensure the use of the correct guidance and management.

Things you can do

Use your wider MDT or external objective third parties to develop a holistic plan of care for women with complex or multiple needs.

Element 2 – Loss of awareness of the passage of time

Instances were seen where the potential for shoulder dystocia was recognised before the birth but rapid escalation did not subsequently occur. Owing to a fixation on the task in hand (the birth), awareness of the passage of time was lost and escalation was delayed. This was compounded by the absence of a visible clock in the birthing environment.

> "At 03:30 the fetal head is just visible, and confirmed by Midwife A. Observations were undertaken every 5 minutes in accordance with guidelines during the second stage. By 03:59 the baby's head had delivered up to the nose… the baby's head delivered at 04:06. The baby's body did not deliver for the remainder of this contraction and the woman was placed into McRoberts position by 04:08. The baby remained undelivered by 04:10 at which time suprapubic pressure was started. At 04:12 an obstetric emergency bleep was put out, and the neonatal team was also requested. The obstetric registrar arrived at 04:13 and noted suprapubic pressure was being performed. They then proceeded to deliver the posterior (right) arm, following which a live female baby delivered at 04:16."

Key learning points

'Freezing' in an emergency is a common response,[9] during which time the perceived passage of time becomes distorted.

Recommendation

When engaged in a complex emergency, early help should be summoned as staff might not notice the passage of time when task-focused. It is essential to have a person who can take the role of the helicopter view in this situation. This needs to form part of regular scenario-based skills and drills training to embed learning.

Things you can do

Ensure that all staff undertake regular skills and drills training. The use of a team debrief following such events can aid reflection and understanding of the human factors involved.

Element 3 – Ask why

In a few instances, women disclosed an underlying issue directly to a healthcare professional but that person failed to appreciate and act on the significance of the issue, which meant that the appropriate guideline was not subsequently instigated.

> "Patient X attended at 28^{+6} weeks' gestation for an antenatal review. An ultrasound scan was performed by Dr F, the liquor was normal… and the estimated fetal weight (EFW) was 1377 g, which plotted on the 50th centile. At this visit, Patient A disclosed that she had previously had a shoulder dystocia. This was documented in her chart… no delivery plan was made, there was no discussion regarding the previous obstetric history with the consultant obstetrician at the antenatal clinic and Patient X's previous

obstetric notes were not requested… Patient X subsequently went into spontaneous labour at 40+4, shoulder dystocia occurred at delivery, Patient X was assisted into the McRoberts position, suprapubic pressure was applied and internal manoeuvres… facilitated the delivery of Baby A. Baby A required extensive resuscitation… was admitted to the neonatal intensive care unit (NICU) [for cooling] and required subsequent surgery to her right arm.[55]

In another example, a woman presented at 39 weeks in active labour following spontaneous rupture of membranes at 8 cm. She was aiming for a vaginal birth after a previous caesarean section (VBAC). Care was given on the labour ward and, following 4 hours of regular contractions, her cervix remained 8 cm dilated. A decision was made for an assessment in a further 2 hours by the registrar and, if this remained unchanged, she was to have a lower segment caesarean section (LSCS). At the local review, this was thought to have been too long and the decision could have been made after the first 4 hours of no progress, as per guideline.[2]

After 6 hours, she remained 8 cm and a decision for a category 3 LSCS was made. This should have been a category 2 LSCS in view of the circumstances. In keeping with the local guidance, the consultant was not informed of the woman's management plan. In theatre, there was a very difficult delivery of the fetal head, taking over 8 minutes. This required a T incision towards the bladder and a breech extraction. The consultant was not called during this event. Following birth, there was extensive bleeding and the woman proceeded to lose her total circulating volume, at which point senior support was requested; subsequently she had a cardiac arrest. Rapid escalation occurred at this stage and support from a multitude of surgical specialties including urology and vascular surgery was mobilised. She left theatre 6 hours after the procedure commenced, following hysterectomy and a 12 litre blood transfusion.

Key learning points

A common theme among local reviews was a failure to ask 'why' errors occurred, with most simply stopping when the failure to follow a guideline had been identified. With regard to the examples above, the Each Baby Counts team is left wondering why the clinicians behaved in this way. Because the reviews either did not ask or did not report the answer to this question, not much can be learned from it.

Recommendation

Where it is recognised that a guideline was not followed, a reason for 'why' this happened should be identified and documented. The use of debrief as a tool will aid these insights.

Things you can do

When undertaking a review of a serious incident (SI), always reflect on the reasons why something has been done or not done. Documenting errors alone does not help to avoid their repetition.

Theme 1.4 – System and review culture

There were a number of instances in reviews where guidelines/locally agreed best practice were not followed and where a system or review culture error was clearly identified as being a significant contributory factor. These included outdated or unclear guidelines, the review team not recognising that care was outside guidance, migration of boundaries, tolerance of rule breaking and inadequate equipment or processes.

Element 1 – Local guidelines

There were instances where the local guideline was incorrect or unclear and this had led staff to believe they were following the 'correct' course of action. However, this actually resulted in contributing to a baby eligible for Each Baby Counts reporting being born.

> "During a ward round following delivery, the couple were told by Obstetric Consultant 1 that the [woman] should have been transferred to the labour ward at the time meconium was first seen. Guideline 078 on meconium-stained liquor at birth states that a 'risk assessment should be carried out and if additional risk factors are present transfer arranged' [whereas the NICE intrapartum care guideline explicitly recommends transfer if there is significant meconium]... The midwife felt that the patient did not have any risk factors at this time... in accordance with Guideline 078, the midwife did not transfer the patient to the [obstetric unit] ... An hour later, delivery had not occurred... a fetal bradycardia was heard... Patient was transferred to [the obstetric unit] and [the registrar performed a] forceps delivery... the baby required extensive resuscitation... hypothermic cooling... Sadly, a redirection of care was agreed with parents to a palliative pathway at 36 hours of age and the baby died."

Key learning points

Some local guidance was ambiguous and this contributed to staff thinking that they were following the correct course of action when they were not.

Recommendation

There must be a clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended.

Things you can do

Ensure that local guideline teams are properly resourced and that guideline changes are up to date and evidence based.

Element 2 – Local reviews

There were further instances where the review team did not recognise that care had not been in line with national guidance. It was not clear whether the local guidance was out of date or whether the review team had not recognised the issue. This was particularly prevalent around the management of reduced fetal movements and of shoulder dystocia, and in women requiring additional fetal growth monitoring.

Several babies did not have serial growth scans arranged, which was not mentioned during their reviews. In other reviews, it was noted that the unit had yet to fully implement the Saving Babies' Lives care bundle;[10] however, this had only just been released in 2016 when these events occurred.

Key learning points

Local reviews were not always up to date with national guidance.

Recommendation

Review teams should be multidisciplinary to ensure that the full breadth of up-to-date clinical guidelines from across specialties relevant to the care provided are considered.

Things you can do

Ensure that local review teams are properly resourced, with adequate time within job plans set aside for reviewing care and keeping up to date with national guidance.

Element 3 – Migration of boundaries

Over time, with repeated exposure to risk, clinicians become desensitised and begin to take risks. They move away from what they know to be safe practice into unsafe, and eventually dangerous, areas.[11] There were several instances where this was demonstrated.

> "Mrs C called triage with a history of red vaginal loss and was invited in for assessment, she was subsequently discharged home following a midwifery review. In this case if the bleeding had been deemed to represent a 'show' it would have been reasonable to give telephone advice and not see the woman at the hospital. However, because the coordinator had asked the woman to come into hospital to be seen, there is an implication that she felt it may be more than a 'show'. Then the antenatal guideline should have been followed where a speculum examination, swabs and review by an obstetrician should have taken place. The ultimate outcome may still have been that the cause was considered 'benign' and the woman discharged home. However, the obstetrician may have given consideration to induction of labour being brought forward. It was acknowledged by the panel that, had this been the case, it is unlikely this would have been done straight away, and the fetal death may still not have been prevented."

Key learning points

When faced with repetitive tasks (such as dealing with predominantly well women in obstetric triage), a false reassurance may develop for common presentations that are mostly benign, but occasionally dangerous, such as antepartum haemorrhage.

Recommendation

Teams should protect against migration of boundaries by ensuring that real practice reflects practice as described in guidelines. Audit identifies where migrations from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these migrations can be corrected.

Things you can do

Consider and reflect upon your own personal biases and how they affect your practice. This could be part of a human factors course, or equally by reading a resource on decision making such as *Thinking, Fast and Slow* by Daniel Kahneman (2011).[12]

Element 4 – Tolerance of rule breaking

Examples were seen where the review team identified that care was not in line with national guidance but justified that care was acceptable in the given circumstance. Rules are not always hard and fast and guidelines can be deviated from in certain circumstances; however, it is important that all staff included in review teams are aware of the development of these tolerances and ensure that they do not begin to shift into tolerating rule breaking that would not be considered reasonable practice. An area where staff need to be aware of this occurring is in the assessment of the use of multiple instruments at difficult obstetric births.

> "The baby suffered a sudden acute hypoxic event around the time of delivery which has led to her suffering a degree of hypoxic ischaemic injury. The use of three sequential instruments is not recognised normal practice and is a known risk factor for increased hypoxic injury. It is noted that senior clinicians will at times use their clinical judgement and step outside the boundaries of usual practice. Due to the complexities of the decisions that needed to be made by the senior obstetric consultant at the time of delivery the panel were unable to conclude whether delivery by emergency caesarean section may have led to an improved outcome… The case was therefore discussed with two further senior obstetric consultants. Both of these concluded that this action was against recommended guidance from the Royal College of Obstetricians and Gynaecologists."

Key learning points

If guidelines are not being followed, the question needs to be asked why. If the guideline is unworkable in the given setting, it needs to be changed; tolerating a guideline being ignored undermines the whole process of guidelines and gives rise to a unit culture where breaking the rules is acceptable.

Recommendation

Clinicians need to clearly document their reasoning for decisions that are out of line with national guidance. Maternity teams need to be aware of the risk of developing a culture of tolerating rule breaking. This risk can be minimised by encouraging staff to raise concerns and involving external reviewers in the review of cases.

Things you can do

Follow the guideline. If you need to deviate from it, document why and inform your supervisor.

Element 5 – Equipment

Several reviews identified delays due to labour ward rooms not being ready in advance of use and to lack of equipment, leading to staff being unable to follow guidelines promptly. Time was lost trying to locate key equipment such as a CTG machine and FSE following a transfer from midwifery-led care, and also when a neonatal resuscitaire was not available at a high-risk VBAC.

> "High-risk woman. VBAC, significant meconium noted at delivery of the head, neonatal senior house officer asked to attend but resuscitaire not placed into the room and not ready for use."

Key learning points

Lack of key equipment in labour ward rooms led to delays in appropriate care being provided.

Recommendation

Labour ward rooms on an obstetric unit should be ready for use with appropriate equipment (including CTG, FSEs and a neonatal resuscitaire) at all times; this ensures that all equipment is readily available should it be needed quickly.

Things you can do

Ensure that labour ward rooms are regularly checked and ready for use in an emergency. Equipment needs should be escalated to the maternity board-level safety champion (or equivalent) to be actioned.

Element 6 – Process

Examples were seen where the review team identified that a guideline wasn't followed but focused on an individual being at fault rather than reflecting on whether the system the individual had to use was fit for purpose.

A registrar appropriately identified the need for serial growth scans and requested them. However, only one scan at 28 weeks occurred and at birth the baby was noted to have intrauterine growth restriction (IUGR) that would have been potentially detectable had the scans taken place. On review, it was recognised that the registrar had requested all three scans on one request form and this had in turn meant that only one was booked. The conclusion reached by the review team was to retrain staff to complete separate scan requests. However, this is a rather individual-based approach and it would have been better to recognise the flaws in the system and address these instead.

Key learning points

The process provided for staff to follow a guideline, in this case ordering growth scans, can be at fault rather than the individual.

Recommendation

When system issues are identified, local guideline changes and recommendations should focus on how to make the system work better for the staff and women, not on what is easiest for the system.

Things you can do

If you notice risks in the way a system is run, speak to your managers and see whether the system can be changed to work better for clinicians and women before errors occur.

Theme 1.5 – Informed choice

In some of the reviews it was noted that women chose not to be cared for in line with locally agreed guidelines and this was identified by reviewers as being a critical contributory factor in the subsequent outcome.

Situations were identified where clinicians were unable to undertake vaginal examinations owing to women's birth preferences. In one example, there was a failure to recognise the initiation of active labour and thus inappropriate monitoring occurred. Care seemed to become focused on the woman's preferences and how these were challenging, resulting in loss of situational awareness of the woman's care as a whole and failure to undertake the other routine actions that could have been done to ascertain whether she was in active labour.

In another example, a woman who attended for a VBAC induction declined a non-pharmacological method because this had not been mentioned to her in advance in the clinic so she had arrived with an a expectation of pharmacological induction, which was not in line with the local guideline.

> "The departure from policy was instigated by Patient A. it is not known whether the decision would have changed if she had been fully informed prior to being admitted for induction of labour. It does not appear that the use of a cervical balloon was discussed when she was booked for induction of labour; however, this was discussed when she was admitted. Clearly her expectation was that she would have a drug, not a balloon, and this expectation seems to have led to her refusal of the balloon."

Two further examples were seen where women were not in agreement with the suggested mode of birth proposed by the registrar. In one, the registrar wanted to abandon the instrumental birth but persisted at the woman's request. It is very challenging to have a full discussion of the risks and benefits of the available options in these circumstances, although it would clearly not be appropriate to proceed to caesarean section without consent.

Clear explanation of procedures in advance of birth allows for identification of any issues, manages women's expectations and enables informed consent and shared decision making to be achieved. In an emergency situation, clinicians should ensure that they do their best to explain risks and benefits and act in accordance with their clinical expertise. Whether the ultimate decision is to do nothing or to proceed with the woman's preferred course of action, ensure thorough documentation after the event. Consultants and senior midwives should be involved wherever possible.

Key learning points

Situations will arise where women choose not to be cared for in line with guidelines.

Recommendation

When a woman chooses care that is not recommended in local guidelines, shared decision making with a senior clinician should take place and be documented in the woman's notes. Wherever possible, this should occur prior to her going into labour.

Things you can do

When you are unable to follow guidelines because of a woman's preference, ensure that senior clinicians are involved in discussions and decision making at an early stage.

Summary

Analysis of reviews where failure to follow guidelines was identified as a critical contributory factor demonstrates that the underlying reasons are extremely varied. In order to improve the care provided to women and their babies, it is vital that reviews go beyond simply identifying that a guideline was not followed. The reviews must also look at why this occurred so that future care can be improved. This analysis identified a need to include discussions with staff about their thought processes and decision making surrounding these events. To identify improvements, holistic reviews of the service as a whole are required. Such reviews should focus on organisational structure, unit culture and training, the way individuals communicate together and as wider teams, and also on the environment in which care is expected to be delivered. Without identifying and addressing these distinct causes, guidelines will not always be followed and the same mistakes will persist. Clinicians do not routinely intend to deviate from guidelines but, where this occurs, it is vital that an understanding is reached of why this has happened and how this can be addressed.

Thematic analysis 2

Themed chapter on anaesthetic care, including lessons identified from Each Baby Counts babies born 2015 to 2017

Methods

All reviews in which critical anaesthetic contributory factors had been identified by Each Baby Counts reviewers or which had been referred for review by an Each Baby Counts anaesthetic assessor were included in this analysis. This led to inclusion of 21 babies born in 2015, 20 babies born in 2016 and eight babies born in 2017 (note that not all hospitals have yet provided complete data for 2016 and 2017). This report is thus based on the reviews of the care of 49 babies. As has been previously described,[1] a thematic analysis was undertaken. All reports were read and re-read and a coding framework developed by the lead author (MK); the coding framework was subsequently reviewed and revised in discussion with the Each Baby Counts anaesthetic reviewers (JB, RC, EW). Verbatim quotes from local reviews are used throughout this report to support the recommendations that are intended to address the contributory factors identified.

Characteristics of the mothers and babies included in this analysis

Descriptive data were complete for all analyses apart from for body mass index (BMI), for which information was available for 44 (90%) of the 49 women included in this review. Data were complete for all of the babies. Twenty (41%) of the 49 women had epidural or attempted epidural anaesthesia, in 11 of whom the epidural did not provide adequate pain relief. In total, 21 of the 49 women (43%) had spinal, combined spinal-epidural or attempted spinal anaesthesia; the spinal anaesthesia was difficult or considered inadequate in ten of these women. Thirty (61%) of the 49 women had general anaesthesia for birth; among these women there were five with failed endotracheal intubation, the majority of whom did not have any recognised risk factors for a difficult airway.

The mothers of the babies whose care was reviewed here had a median BMI of 28.5 kg/m^2 (interquartile range 23–34 kg/m^2); 30 of the 44 women with known BMI were overweight or obese (69%) and 17 were obese (39%). Thirty-eight of the 49 babies were born by caesarean

section (78%), with seven of these babies being born after a failed trial of operative vaginal birth. A further eight babies (16%) were born with the assistance of forceps, and the remaining three (6%) had unassisted vaginal births. Thirty-seven (76%) of the babies had severe brain injury, six (12%) were stillborn and six (12%) died in the neonatal period.

An internal anaesthetic reviewer was involved in the hospital review team for only 20 (41%) of the 49 babies who were felt to have critical anaesthetic contributory factors to their care. Only one review team (2%) involved an external anaesthetic reviewer. Overall, external reviewers (mostly obstetric) were involved in five review teams (10%).

Thematic analysis

As would be anticipated from the figures above, it was notable that very few anaesthetists were involved in the reviews of the care of these babies, all of whom were thought to have had an anaesthetic issue as a critical contributory factor. In many instances, essential detail was missing from the reviews concerning anaesthetic management, and the Each Baby Counts assessors were unable to determine whether appropriate management had taken place. In several records, comment was also made that anaesthetic records were unavailable for review. Where an anaesthetist had been involved in the review panel, a clear and detailed account of events was given. Unless all reviews involve an anaesthetist, there is a danger that, where anaesthetic input was not recognised as being needed, anaesthetic issues will be missed.

Recommendation

All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.

Theme 2.1 – Communication – 'compound delay in delivery', 'cumulative delays'

> "Compound delay in delivery due to capacity, acuity and anaesthetic difficulties… The anaesthetist attempted to top up the epidural in the room and again in theatre but could not achieve adequate anaesthesia, and therefore converted to a spinal with full knowledge by the obstetric team… The anaesthetist kept in contact with the obstetric team in theatre regarding his actions and progress [but] the obstetric team did not verbalise concern around the timing of the anaesthetic… No time frame for delivery was declared."

This is a clear example of failure of communication between obstetric and anaesthetic teams – the category of urgency should have been made clear in theatre. In most instances, anaesthetic delay occurred in the context of established concerns over fetal wellbeing and/or other delays, and may have led to exacerbation of compromise, but no instances were identified where anaesthetic delays were the sole contributory factor. However, it was clear on a number of occasions where anaesthetic delays occurred that the communication around the urgency of the birth needed to be improved. This was particularly evident in the context of anaesthesia

for an urgent operative vaginal birth, where widely understood classifications of urgency (for example, the four categories[13] of classification of urgency of caesarean section) are not used. Thus anaesthetists were unaware of the urgency with which the obstetric team assessed the need for the operative vaginal birth. Reports note a *'lack of shared understanding of the urgency'*.

Direct obstetrician-to-anaesthetist communication concerning the urgency of any birth will ensure that the anaesthetist is making an informed decision about the appropriate method of anaesthesia and, in the context of anaesthetic difficulties, when to revert to an alternative. The obstetrician must directly communicate with the anaesthetist if she or he wants the birth expedited. When an anaesthetist is task-focused, he or she may not be aware of the time and there should be someone else with this responsibility. As the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) report noted in 2000,[14] reluctance by obstetricians and midwives to interrupt anaesthetists, particularly if they are having difficulties, may contribute to delays.

Recommendation

Anaesthetists should always be informed of the degree of urgency of the birth. As an aid to communication, the classification of urgency of caesarean section should be used for all operative deliveries, vaginal as well as abdominal.

One review noted that, at a trial of an instrumental vaginal birth in theatre, *'During delays in achieving anaesthesia, methods of how to advance the delivery should be considered by the obstetric team'*. National Institute for Health and Care Excellence (NICE) guidelines are clear that a pudendal block is an appropriate alternative in this situation for instrumental birth.[2] However, it is important to be aware that, when an instrumental birth is planned in the presence of fetal compromise, a pudendal block will never be sufficient for caesarean section and is therefore unlikely to be appropriate for a trial of an instrumental vaginal birth in theatre.

Recommendation

If there is concern about fetal compromise, offer either tested effective anaesthesia or, if time does not allow this, a pudendal block combined with local anaesthetic to the perineum during instrumental birth.[2]

It was noted on several occasions that the urgency of caesarean section was changed, with an initial call for a category 1 (birth within 30 minutes) caesarean section, which was subsequently downgraded to category 2 and then upgraded again. It was evident from the reviews that this led to confusion among staff and altered the anaesthetic decision concerning the method of anaesthesia, which led to delay when the caesarean section classification was reassessed as category 1. This might have been avoided if the obstetrician had stayed with the woman and communicated directly with the anaesthetist. In some instances, continuous fetal heart-rate monitoring was not carried out while anaesthesia was established and thus no one was aware of a significant deterioration in the fetal condition that should have increased the urgency with which the birth was expedited.

"When this decision was made, I discussed the priority for caesarean section with the obstetric team and was told I had time to top up the epidural. My usual practice is to start with a 5 ml bolus of 2% lidocaine with adrenaline followed 5 minutes later by a further 10 ml bolus. I recall that I had given a total of 15 ml of the epidural top-up mix and was asked if the epidural would be [ready] to proceed with the caesarean section within 1 minute. I stated that the epidural would need longer to work and so moved to a general anaesthetic immediately."

The review group noted that the decision to top up the epidural, which was then abandoned when the category 1 caesarean section was re-called, caused some delay in preparing [the woman] for her caesarean section under general anaesthetic.

Obstetric staff need to be aware that the decision to downgrade the urgency of a caesarean section may have an impact on the chosen mode of anaesthesia, which may lead to delay if the birth subsequently needs to be expedited.

Recommendation

A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre prior to the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.

It is worth noting that many hospitals now have a 'reduced' World Health Organization (WHO) checklist for category 1 caesarean sections, so this review of the degree of urgency will not add substantially to the in-theatre preparation time.

"The Consultant declared an emergency caesarean section… but there was no documented evidence of the grading within the medical records… Upon review, the panel identified that the caesarean section should have been classified as a Grade [category] 2… The woman was prepared for theatre and was seen by the anaesthetic specialist trainee (ST6) [18 minutes after the initial decision to deliver]. [38 minutes after the decision for caesarean section was made] a Grade 1 LSCS [lower segment caesarean section] was called for a second woman; this delayed the first woman going to theatre. At [43 minutes post-decision], the fetal heart was auscultated by the midwife and was recorded at 30–50 beats per minute (bpm). The obstetric consultant was called and immediately classified a Grade 1 LSCS at [48 minutes after the initial decision]. The woman was in theatre [54 minutes after the original decision]. The midwife was unable to auscultate (listen to) the fetal heart in theatre. Scan was performed by the consultant obstetrician and an intrauterine death […] was confirmed. The obstetrician proceeded to LSCS under general anaesthetic and female stillbirth was delivered [80 minutes after the initial decision to deliver]."

There were multiple occasions when the anaesthetist was busy elsewhere in the labour ward and the need for a category 1 caesarean section was not adequately communicated to allow them to reprioritise the order in which they attended, and this led to delays. In other instances, plans were made for a category 1 caesarean section, but the deadline for the birth was allowed to slip because of other emergencies, either within the labour ward or in other departments.

> "The ODP [operating department practitioner] was busy in the emergency department. When contacted, she asked about the urgency of the case, and although the term Grade 1 caesarean section was used, there was no urgency attached to the discussion and she did not leave the department immediately. The on-call ODP was phoned [in] from home. The emergency in [the emergency department] was dealt with before attending [labour ward]."

There should be an ODP immediately available (within 5 minutes) at all times in consultant-led units. There should be contingency plan in place if a second ODP is required in maternity. All staff working in maternity must understand the implications of the categories of urgency. Multiple emergencies are not uncommon on busy labour wards, and this should be anticipated when staff are additionally covering other areas of the hospital. If they need to come from home, early escalation is a priority.

Recommendation

Contingency plans need to be made ahead of time for calling in additional staff and/or undertaking prioritisation decisions in the event of multiple simultaneous emergencies.

Antenatal referral to an anaesthetist is the best way of flagging up potential anaesthetic problems, which can then be identified by a sticker (for example) in the records.[15] However, on several occasions, delays resulted from unsuccessful regional or difficult general anaesthesia in women who had identifiable risk factors for problems with anaesthesia. The anaesthetists did not appear to be aware either that these women with risk factors were in labour or that they had labour complications which might necessitate an expedited birth. In some instances, an anaesthetist on a previous shift had been aware but the information did not appear to have been passed on after a change of shift. In other instances, the risk factors were not recognised by the obstetric or midwifery teams. Use of a structured and validated anaesthetic handover tool between shifts[15,16] and anaesthetic participation on the ward round at the beginning of each shift would mitigate both of these situations, enabling early identification of potential airway difficulties, anticipation of the need for or potential problems with regional analgesia, and helping ensure appropriate communication. If these are not possible then the anaesthetist should receive a handover from the obstetrician or coordinating midwife. If this is a 'board' handover then the anaesthetist should familiarise themself with women whose labours are complicated.

Recommendation

Anaesthetists should use a structured and validated anaesthetic handover tool between shifts and, if possible, participate in the routine labour ward handover/review of the labour ward board. This will help maintain situational awareness and enable early anticipation of anaesthetic difficulties.[15]

Theme 2.2 – Regional anaesthesia

There were several instances when an epidural in labour had been only partially effective and yet attempts were made to top up this epidural when a decision was made for category I caesarean section. This led to delays in obtaining effective analgesia when the birth was considered urgent.

> "It is difficult to comment on the decision to proceed with operative delivery under epidural anaesthesia as this can only be made by the individual at the time. However, this particular labour epidural required multiple top-ups despite the use of an infusion. The need for multiple top-ups in this situation has been shown to be an independent risk factor for failure to extend labour analgesia to anaesthesia for caesarean section."

As noted in this review, it is unlikely that an epidural that has already been at best partially effective during labour will be able to provide an adequate block for caesarean section.

Recommendation

All women who receive epidural analgesia should be reviewed to ensure the effectiveness of the epidural and to minimise delays should the need for an operative birth arise. The functioning of an in-labour epidural should be taken into consideration when deciding on the most appropriate and timely means of anaesthesia for an operative birth.

In two instances, inadvertent dural punctures led to delay in anaesthesia for subsequent caesarean section.

> "Inadvertent dural tap occurred with the first attempt at epidural placement, with cerebrospinal fluid on aspiration through the epidural catheter. According to the anaesthetic notes, it is documented that there were two attempts at epidural placement at two separate interspaces (L4/5, L3/4), the second of which was a combined spinal-epidural. The midwifery notes describe three attempts, the third of which was successful… The anaesthetist decided to top up the epidural for the caesarean delivery… However, there were several problems… the patient was known to have a known dural tap and was therefore at risk of unexpectedly high block on epidural top-up if intrathecal spread occurred."

Inadvertent dural tap will occur with an incidence of approximately one in 100–200 epidural attempts[17] and it is reassuring that it was identified as a significant contributing factor in only two Each Baby Counts babies over a period of 3 years (more than two million births). However, it remains important to be aware of the possibility of a higher block with epidural top-up in the event of dural puncture. In circumstances such as this, if the anaesthetist anticipates difficulties/delays in establishing anaesthesia they should communicate this to the obstetrician so that an appropriate anaesthetic can be administered, taking into account maternal and fetal factors for that time frame.

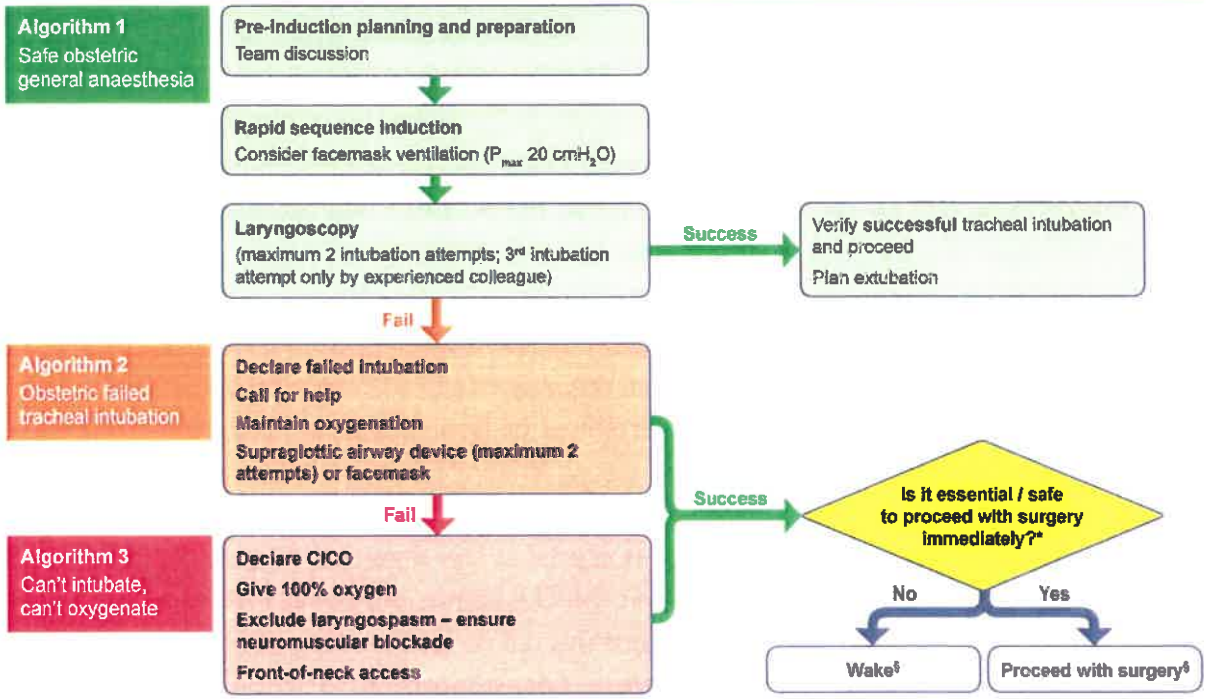
Theme 2.3 – Difficult intubation

There were five instances of failed intubation, the majority in women who did not have clear risk factors. Even in an emergency, there must be optimal preparation and positioning of the woman to minimise the risk; hypoxia during failed/difficult intubation is more likely to damage the fetus than the additional few seconds of preparation. Should failed tracheal intubation occur, avoiding maternal hypoxia is crucial as low maternal oxygen saturations are a predictor of neonatal intensive care unit (NICU) admission.[18] In all instances, the woman's safety was appropriately ensured, but this did result in a delayed birth. In some instances, there was evidence that the Obstetric Anaesthetists' Association (OAA) and Difficult Airway Society (DAS) guidelines[19] were not followed. Three unsuccessful attempts at intubation were made by an anaesthetic trainee who subsequently, appropriately, used a laryngeal mask:

> "When the events were discussed over the telephone with the anaesthetic consultant, they were informed that attempts at intubation had failed and the airway was being maintained with a laryngeal mask and advice was sought regarding the ability to undertake the caesarean section using the laryngeal mask as an airway. The consultant advised that a cord prolapse was not an indication to proceed and ideally the patient should be woken up."

The OAA/DAS guidelines[19] include a table (Table 1; see overleaf) of criteria to consider, both prior to and following induction of anaesthesia, as to whether to proceed with surgery or wake up the woman, which includes consideration of both maternal and fetal condition. This is a decision for the anaesthetist looking after the woman. As noted above, the primacy of maternal safety must be emphasised, and this may well require the anaesthetist, especially when junior and stressed by this life-threatening situation, to consult with a more experienced colleague. Note that correct use of Table 1 in the OAA/DAS guidelines will require input from the obstetrician. The whole team should therefore discuss what actions should be taken in the event of a failed intubation. The OAA/DAS guidelines should be displayed/available in all operating theatres to facilitate these discussions.

Master algorithm – obstetric general anaesthesia and failed tracheal intubation



*See Table 1, §See Table 2

Table 1 – proceed with surgery?

	Factors to consider	WAKE			PROCEED
Before induction	Maternal condition	• No compromise	• Mild acute compromise	• Haemorrhage responsive to resuscitation	• Hypovolaemia requiring corrective surgery • Critical cardiac or respiratory compromise, cardiac arrest
	Fetal condition	• No compromise	• Compromise corrected with intrauterine resuscitation, pH < 7.2 but > 7.15	• Continuing fetal heart rate abnormality despite intrauterine resuscitation, pH < 7.15	• Sustained bradycardia • Fetal haemorrhage • Suspected uterine rupture
	Anaesthetist	• Novice	• Junior trainee	• Senior trainee	• Consultant / specialist
	Obesity	• Supermorbid	• Morbid	• Obese	• Normal
	Surgical factors	• Complex surgery or major haemorrhage anticipated	• Multiple uterine scars • Some surgical difficulties expected	• Single uterine scar	• No risk factors
	Aspiration risk	• Recent food	• No recent food • In labour • Opioids given • Antacids not given	• No recent food • In labour • Opioids not given • Antacids given	• Fasted • Not in labour • Antacids given
	Alternative anaesthesia • regional • securing airway awake	• No anticipated difficulty	• Predicted difficulty	• Relatively contraindicated	• Absolutely contraindicated or has failed • Surgery started
After failed intubation	Airway device / ventilation	• Difficult facemask ventilation • Front-of-neck	• Adequate facemask ventilation	• First generation supraglottic airway device	• Second generation supraglottic airway device
	Airway hazards	• Laryngeal oedema • Stridor	• Bleeding • Trauma	• Secretions	• None evident

Criteria to be used in the decision to wake or proceed following failed tracheal intubation. In any individual patient, some factors may suggest waking and others proceeding. The final decision will depend on the anaesthetist's clinical judgement.

Reproduced from Mushambi MC , Kinsella SM, Popat M, Swales H, Ramaswamy KK, Winton AL, Quinn AC. Obstetric Anaesthetists' Association and Difficult Airway Society guidelines for the management of difficult and failed tracheal intubation in obstetrics. *Anaesthesia* 2015;70:1286–1306, with permission from Obstetric Anaesthetists' Association/Difficult Airway Society

Recommendation

The safety of the mother must be the primary concern at all times. Women should not be put at risk of airway problems through inadequate preparation/positioning due to haste to achieve a rapid birth. The required equipment for the management of difficult and failed tracheal intubation in obstetrics detailed in the OAA/DAS guidelines[19] should always be available and all anaesthetists should undergo specific difficult airway training.

The impact of a difficult intubation was minimised when the anaesthetist remained aware of the situation and followed standard practice:

> "There was a very short delay commencing the LSCS due to a difficult intubation; according to the anaesthetist, a rapid sequence induction was commenced; the patient was pre-oxygenated, medication given and the application of cricoid pressure was commenced by the Operating Department Practitioner (ODP). The laryngoscopy was attempted with a standard laryngoscope and bougie insertion, but failed. The anaesthetist noted that the cricoid pressure was making the laryngoscopy and bougie insertion difficult and therefore the ODP was asked to remove the cricoid pressure and the intubation was successful."

Failed intubation is recognised to be uncommon[20] and to fully prepare for this eventuality requires training and/or simulation.

Recommendation

Skills and drills training: anaesthetists should help organise and participate in regular multidisciplinary drills covering labour ward emergencies such as major obstetric haemorrhage, maternal collapse and failed intubation. These drills should be followed by debriefing and feedback so that lessons can be learned at both an individual and a systems level.[21]

The OAA/DAS guidelines[19] note the importance of follow-up after a difficult intubation and of providing women with written information documenting the problem. There was only one instance when it was clear that the woman had been given the appropriate information/ advice after a difficult intubation:

> "The woman was reviewed by a senior anaesthetic trainee (Anaesthetist 4) on Day 8 and a difficult airway letter was given to her. As the woman's husband was not present at this visit, arrangements were made for further anaesthetic follow-up the next day. The woman and her husband were seen by another consultant obstetric anaesthetist (Anaesthetist 5) on Day 9. Anaesthetist 5 offered condolences and explained the anaesthetic management of the case. The difficulties with correct positioning of the tracheal tube were discussed. In addition, it was stressed that if anaesthesia were required in the future, the anaesthetist must be informed that intubation had been previously difficult."

Recommendation

Where management of a woman's airway has been difficult, she should always be provided with a letter giving details for her and her GP. A pro forma is available from the Difficult Airway Society.[22] Follow-up should take place in a postnatal anaesthetic clinic for debriefing.

Theme 2.4 – Human factors

There was evidence of lack of situational awareness and/or fixation errors in the care of most babies, as well as among some of the local review teams. In some instances, there was a collective failure to identify simple solutions to problems. For example, a woman collapsed and the oxygen tubing from the piped supply was too short to reach where she fell. The team tried to find an oxygen cylinder rather than moving the woman closer to the supply, which led to an 8 minute delay in administering oxygen; this solution was not identified or discussed in the review.

On other occasions, symptoms were attributed to the anaesthetic and/or poor functioning of the anaesthetic when there was clear evidence of other problems.

Element 1 – 'Epidural fever' – sepsis

The anaesthetic reviewer in one hospital team noted the following in the local review:

> "Epidural fever recognised but does shivering and very high temp for over an hour indicate epidural fever or maternal sepsis/chorioamnionitis?"

This woman had clear signs of sepsis with a temperature persistently over 39 °C and with both maternal and fetal tachycardia. Her temperature was attributed by staff as being due to the epidural, blood cultures were not taken and antibiotics were not prescribed. Concerns over the fetal heart rate led eventually to an urgent delivery of the baby. The baby was admitted to NICU with moderate–severe neonatal encephalopathy and group B Streptococcal sepsis.

Many women experience a moderate rise in temperature after an epidural is inserted. However, any rise in maternal temperature should trigger a review of her other physiological observations. The UK Sepsis Trust maternal inpatient sepsis tool[23] can be used to assess presence and severity of sepsis.

Element 2 – 'Breakthrough pain' – uterine rupture

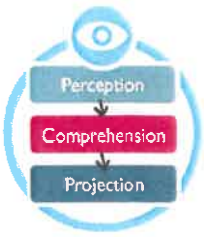
> "The mother was tachycardic 110 and feeling breakthrough pain between contractions. Syntocinon was commenced as there was no change from earlier vaginal examinations and she was still 5 cm dilated."

This woman, undergoing a trial of labour after previous caesarean section, had breakthrough pain that was treated with repeated epidural top-ups. No alternative cause for her pain was considered over the subsequent 3 hours when there were also repeated concerns about the cardiotocography (CTG). Her collapse led to a category 1 caesarean section at which her uterine rupture was diagnosed.

Recommendation

Breakthrough pain with a previously working epidural in a woman with a history of uterine surgery should trigger an obstetric review for scar rupture.

Human factors are examined in the 'Guidelines' chapter of this report (page 12) but the recommendations from the previous report[1] deserve reiteration here.

All members of the clinical team working on the delivery suite need to understand the key principles (perception, comprehension, projection) of maintaining situational awareness to ensure the safe management of complex clinical situations.	
A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.	

Theme 2.5 – Anaphylaxis

There were two occasions when urgent delivery of the baby was needed following maternal anaphylaxis to penicillin received in labour. Management was appropriate in both instances but both mothers required emergency delivery of the baby under general anaesthetic. Neither had known allergies. Anaphylaxis is unpredictable and should be included in skills and drills training in the management of maternal collapse. The Royal College of Anaesthetists' sixth National Audit Project report into perioperative anaphylaxis noted that obstetric units should ensure immediate availability of anaesthetic anaphylaxis treatment and investigation packs wherever general or regional anaesthesia is administered.[24]

Theme 2.6 – Maternal tachycardia

When a mother is tachycardic, it can be difficult to differentiate the maternal pulse from the fetal heart rate, which may lead to evidence of fetal compromise, for example a bradycardia, being missed. On several occasions, it was noted that the anaesthetist pointed out when the CTG was recording a maternal tachycardia instead of the fetal heart rate. However, on another occasion, the anaesthetist was aware of a maternal tachycardia but this was not communicated to the obstetric staff who remained unaware that the CTG was inadvertently recording the maternal pulse.

Recommendation

In the event of a maternal tachycardia the anaesthetist and/or ODP should ensure that the duty obstetrician and midwife caring for the woman are informed.

Conclusion

Although there were no babies for whom anaesthetic issues were thought to be the sole contributory factor to their outcome, most of the anaesthetic problems noted in these reviews contributed additionally to delays in a birth. Many of the lessons on situational awareness and the need for a 'helicopter view' identified in the Each Baby Counts 2015 full report[1] are echoed here. In addition, there is a clear need to optimise communication about the urgency of the birth to allow for informed choice of method of anaesthesia. The CESDI report in 2000[14] started with the statement '*the safety of modern obstetric care is based on teamwork… the anaesthetist is a key member of the perinatal management team*', and this is still a clear message today.

There is a need for the development of a structured communication tool to include the three-fold elements of the plan for delivery: mode of birth, location of birth and category of urgency. This will form a key Each Baby Counts implementation output from this report, and the RCOG is committed to collaborating with the relevant organisations to produce this at the earliest opportunity.

Thematic analysis 3

Barriers to reporting to Each Baby Counts

The first full Each Baby Counts report[1] covered a complete year of data and identified that 25% of local reviews did not contain sufficient information to draw conclusions about the care provided, while a further 7% were either incomplete or a review was never undertaken. In view of this, the Each Baby Counts project team began a process of feeding back to units when a review was deemed insufficient, outlining the reasons why. Units were then given an opportunity to address the issues identified and re-submit the information. The missing (potential reportable babies identified through cross-checking with other national sources of data) and incomplete reports were also more actively highlighted to units to encourage greater overall reporting. Where responses and engagement were not achieved by the team based at the RCOG, communication with these trusts and boards was escalated to senior members of the Each Baby Counts project team who contacted clinical directors (or equivalent) and medical directors at the relevant units to ensure that high-level support for full engagement existed in all units.

The Each Baby Counts project team appreciates that this placed an additional burden of work on the Lead Reporters, their units and the Each Baby Counts reviewers. The team is extremely grateful for the efforts that went into improved reporting and re-reviewing of reports. Further details of the impact of this are discussed below.

Reports sent for re-review

Where a Lead Reporter uploads further documentation to a report that has been assessed as containing insufficient information, the Each Baby Counts project team receives a notification of this and can then arrange for the information to be re-reviewed (Figure 1).

Case ascertainment

The overall case ascertainment for 2016 was 99.9%, with 11% of reviews being deemed to contain insufficient information and 5% having no review submitted (owing to no review being performed or to incomplete reporting); see the 'Overall findings for 2016' chapter on page 50 for further details. This is a substantial improvement on the 2015 results and highlights the success of implementing the new Each Baby Counts feedback policy and the hard work of all involved in the programme, particularly the Each Baby Counts Lead Reporters.

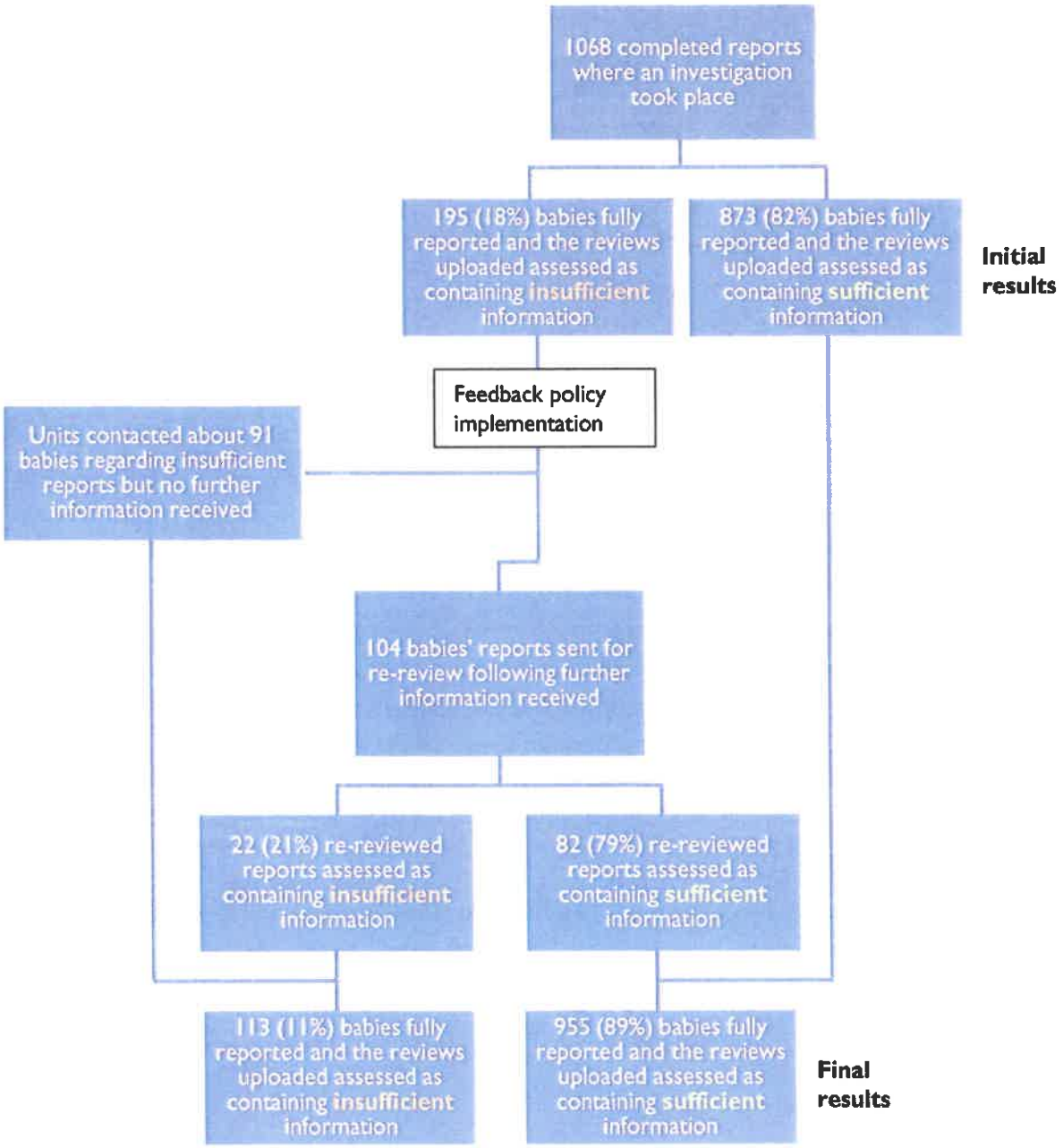


Figure 1 Flow chart to describe reports sent for re-review

Thematic analysis

As part of the process of liaising more directly with units, the Each Baby Counts project team had the opportunity to gather information as to why there were difficulties in producing timely reports of sufficient quality. All Each Baby Counts Lead Reporters and trust/health board clinical directors were contacted (via formal letters, telephone calls and emails), inviting them to complete the potential missing cases or to re-review the insufficient documents and report back any concerns regarding this process. A log was kept of all responses that were received. It is important to note that the majority of responses came from units that were struggling to manage the workload of re-reviewing cases; the responses may therefore not be representative of all units. The log of responses was then reviewed

and grouped by theme, which are discussed in turn below. The project team recognises that this method of qualitative analysis has limitations; however, it does highlight some important issues that warrant further investigation into the challenges units face in producing good-quality, timely reports.

Theme 3.1 – Change of staff

A frequently cited barrier to good-quality, timely reporting was a change of staff. This was most commonly due to Lead Reporters going on a period of long-term absence or the role being transferred to a new staff member either as a change of role or new appointment. In both scenarios, the common issues were that the Each Baby Counts project team was not notified of the change and therefore continued to contact the wrong person and also that very little or no formal handover of the role within the organisation took place. This meant that the project team was unable to support the new Each Baby Counts Lead Reporter in their role and that the new Lead Reporters were frequently unsure of the extent of their responsibilities and expectations. This subsequently led to cases not being reported, insufficient information within the reports or significant delays.

> "Called the trust and was told that Lead Reporter Y left 2 years ago"
>
> "I only took over this role in the latter part of last year, so haven't had much chance to go back through previous babies entries"
>
> "X has been off sick for a while, which explains why no follow-up on missing/outstanding cases"

Key learning points

The change of Each Baby Counts Lead Reporter process within a unit has been identified as a potential barrier to good-quality, timely reporting.

Things you can do

Try to minimise changes of Each Baby Counts Lead Reporter. Whenever there is a change of Lead Reporter, please notify the Each Baby Counts project team so that additional support can be offered. Ensure that within your unit there is a formal handover of the role and responsibilities and of the organisation's reporting structure to enable a smooth transition.

Things the Each Baby Counts project team can do

Through more direct communication with each unit following the implementation of the new feedback policy, the Each Baby Counts project team has now updated its list of contact details for Lead Reporters nationally. With continued close relationships moving forward, this will be kept up to date and any issues will be identified more quickly. All new Lead Reporters will continue to receive a training manual and additional support from the project team following appointment to the role.

Theme 3.2 – Lack of resources

Another significant barrier to producing timely, good-quality reviews was a lack of resources. This included a lack of time to complete the cases, a lack of appropriate IT software and a lack of staff. Frequently, units reported that they were undertaking verbal reviews of the cases but did not have the capacity or process in place to write up the findings from these meetings into a written report.

There was also a predominance of concerns around the need for more administrative support, both in note keeping from meetings and the use of IT software, which if in place would have made the role much more manageable for the Lead Reporter. There were also concerns raised about individual workload and the number of reports that needed to be produced being difficult for the current staff members to manage.

> "They were investigating and reviewing cases but this wasn't being written up and they do not have the capacity to go back and retrospectively write up"
>
> "We do not have resources to investigate all cases"
>
> "Difficulty reviewing the cases as they had been uploaded in pdf form so he was unable to modify them"
>
> "I have had some problems accessing BadgerNet and our IT person is on maternity leave"
>
> "She informed us that their patient safety team is in flux with no admin support and that she has been concentrating on NHS R"

Key learning points

Lack of resources including adequate protected time, IT and administrative support are potential barriers to units producing good-quality, timely reports. At both local and national level, the importance of high-quality local reviews in learning from cases and addressing issues needs to be prioritised and appropriately supported and resourced.

Things you can do

Ensure that the importance of high-quality local reviews is deemed a priority within your unit and assess whether any additional support and resources can be obtained to facilitate this more effectively, including appropriate IT software. Involve your maternity safety champion[25] in England, Quality Improvement Team in Scotland, or equivalent in other nations, who is placed to escalate resource issues to your hospital board.

Things the Each Baby Counts project team can do

The project team is working with other stakeholders (including HSIB and NHS Resolution) towards a shared ambition of developing a single reporting portal for all eligible cases to minimise the burden of reporting for units. Each Baby Counts will continue to support and facilitate at a UK level the importance of high-quality local reviews, implementation of the Perinatal Mortality Review Tool (PMRT) and, in England, the role of the Healthcare Safety Investigation Branch (HSIB).

Theme 3.3 – More information required

Another barrier in the production of good-quality, timely reports was the need for a clear understanding of what should be included in reviews for them to be deemed as containing sufficient information. For the first time, the new feedback policy enabled units to re-submit cases after adding information based on reviewer feedback. Introducing this new process highlighted that there was confusion surrounding the expected content. Following discussions between Lead Reporters and the project team, and from the individualised feedback provided for each case through the Each Baby Counts reviewers, it was found that where cases deemed previously as having insufficient information were re-submitted, 79% of these cases were subsequently found to now contain sufficient information. This suggests that, through direct communication and feedback, some of these issues have begun to be addressed. Units also reported that, through undertaking these re-reviews, additional lessons were identified (initially missed on first review) and new action plans have now been put in place to address them.

> "Asked for further information regarding what information is missing from the case description and timeline"
>
> "Local neonatal consultant rang regarding expectation of what to include following query. Spoke to Y, added four Lead Reporters to system, went through and explained all outstanding cases"
>
> "We were under the impression that we had to wait until all actions had been completed prior to sending... Based on your advice we will forward the reviews to you"

Key learning points

Expectations around what should be included in reports need to be clear in order to address any misunderstandings and facilitate good-quality, timely reporting.

Things you can do

Assess the feedback that stems from reports judged to be of insufficient quality, circulate any new learning points that are identified and look for any recurring themes that may need to be addressed in your unit's local review process. Use the PMRT to facilitate a thorough review of care where a baby has died and use its principles for reviewing babies with severe brain injury. Contact the Each Baby Counts project team at an early stage should you have any queries regarding the reporting process or expectations.

Things the Each Baby Counts project team can do

The project team has run an additional training session for Each Baby Counts reviewers to highlight the importance of providing specific feedback to the units concerned in cases where reviews are deemed to be of insufficient quality. The project team will continue to contact units directly regarding insufficient and missing reports, and to provide telephone support to any units that request it.

Theme 3.4 – Neonatal input

A further barrier to producing good-quality, timely reports was a lack of cohesive multidisciplinary working. There were frequent instances of delays due to the lack of a formal process for including neonatal input. Rather than being a shared responsibility, it was evident that some reports had been the sole responsibility of certain professions/specialties. As discussed in the first Each Baby Counts report,[1] it is vital that the care as whole is reviewed by the appropriate professional groups together. It is not appropriate for a midwife to review the neonatal care nor for a neonatologist to review the labour care in isolation.

> "I have checked all these cases and they are neonatal cases. I do not report the cases that go through to the neonatal unit. All the midwifery cases are on and completed"
>
> "Apologies it has taken some time due to competing priorities for the neonatal unit team to arrange our 'cooled babies' meeting"

Key learning points

Maternity and neonatal teams need to work together to ensure that collaborative multidisciplinary reviews of the care provided take place.

Things you can do

Assess your local processes for involving neonatal team members in the review of Each Baby Counts babies to see whether this needs to be improved to ensure a collaborative multidisciplinary approach. This could include identifying an Each Baby Counts neonatal lead for each unit.

Theme 3.5 – Attitudes to reviews

The introduction of the feedback policy has overall been met positively by units. While it is appreciated that this may have caused additional work, units have, on the whole, agreed with the feedback about why report were found to contain insufficient information. Some units have also been able to use this as evidence of the need to restructure their governance teams, to ensure a more robust process and to identify additional learning that can be addressed, which was missed on the first review.

> "Used Each Baby Counts red results (insufficient information) to support restructuring their governance team and now believe that they have a system that works better"
>
> "We had done a preliminary enquiry into the case mentioned in your letter and found no avoidable factors – this was the data sent to you. I can see why this would not have met Each Baby Counts requirements. We will forward you the results of a more detailed report as soon as this is available"
>
> "Feedback on what was missing from red reviews [insufficient information] would be helpful"

There have been a few instances, however, where the relevance of re-reviewing 2016 events has been challenged. Concerns included the additional workload this would place on staff and the need to prioritise more recent reports; these concerns appear to be due to capacity issues as previously outlined.

There were also isolated examples of attitudes which suggested that nothing could be learned from these events. This included the care of babies born before arrival or following a ruptured uterus during VBAC as well as births complicated by shoulder dystocia, which were felt by some individuals to be unanticipated events where no improvements to care could be identified.

Undertaking only a brief review or deciding the cause of the outcome in advance does not permit a thorough assessment of the care, limits the information that can be fed back to parents, and potentially risks not identifying lessons and therefore recurrence. While not every Each Baby Counts outcome can be avoided, areas of care that can be improved can be identified even in situations where the outcome would not change.

Key learning points

The culture and attitudes within a unit towards the review of babies eligible to be reported to Each Baby Counts has an effect on the ability to produce timely, good-quality reports.

Things you can do

Assess whether at every level within your organisation staff understand the value of thorough reviews. If any lessons learned are not being appropriately shared and acted upon, involve your maternity safety champion[25] in England, Quality Improvement Team in Scotland, or equivalent in other nations, who has a duty to escalate to the hospital board. Appreciative inquiry can be used to provide a positive framework in which problems are identified in order to generate solutions[26] as part of this process. Appreciative inquiry is a method of looking at organisational changes with a focus on identifying positives and expanding what is known to be already working as opposed to identifying problems or issues and attempting to rectify them.

Things the Each Baby Counts project team can do

The Each Baby Counts project team will continue to work at a UK level with the Department of Health and Social Care, the devolved nations and key stakeholders to emphasise the importance of high-quality local reviews and the need for appropriate local resources to facilitate this.

Overall findings for 2016

The final results for the babies born in 2016 who have been reported to the Each Baby Counts programme are presented in Figure 2.

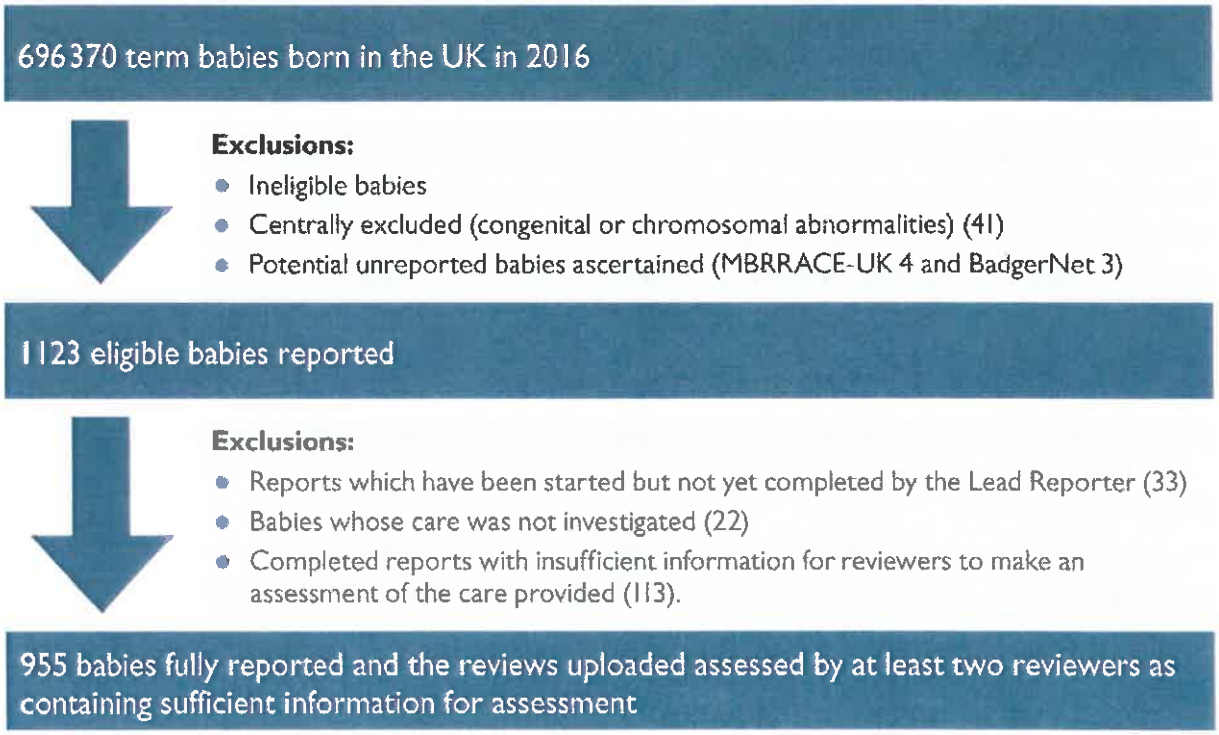


Figure 2 Final results for babies born in 2016 who were reported to the Each Baby Counts programme

Out of 696 370 term babies born in the UK in 2016,[27] a total of 124 died during labour, of whom 86 were confirmed to have been alive at the onset of labour by a health professional. The clinical history suggests that the remaining 38 might also have been alive at the onset of labour, but this was not confirmed. A further 145 term babies were born alive following labour but died within the first 7 days after birth. There were 854 term babies reported as meeting the severe brain injury definition. See Figure 3 for a breakdown of reported babies by eligibility.

The estimated proportion of babies in 2016 who met the Each Baby Counts definition of stillbirth, early neonatal death or severe brain injury was 1 of every 620 term babies (1.6 per 1000 term births).

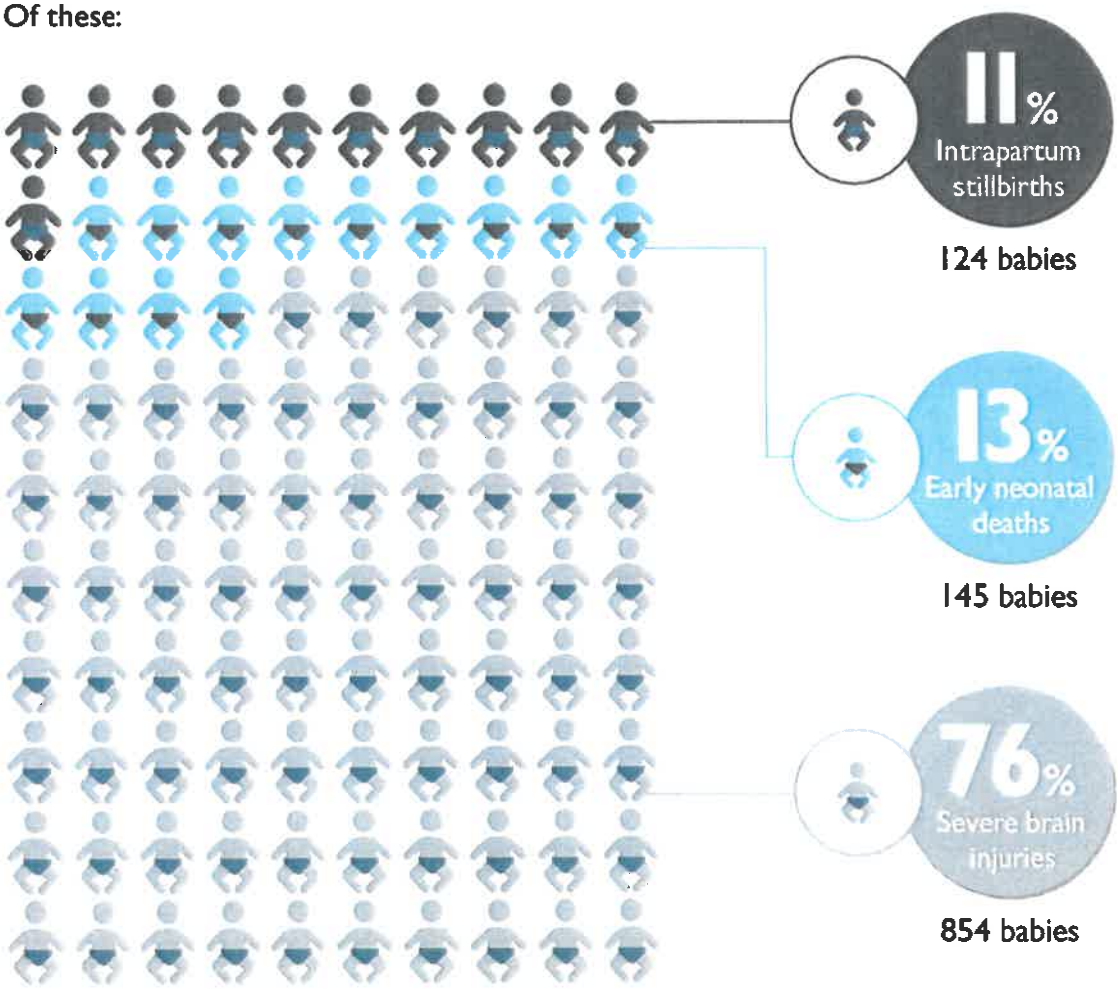
The number of babies identified as potentially reportable to Each Baby Counts through cross-checking of other national sources of data whose information was not checked by the trust or health boards' Lead Reporters was less than 1% (7 babies in total, 4 identified through cross-checking with MBRRACE-UK and 3 identified through cross-checking with

How many babies?

1123
BABIES IN 2016

The total number of babies that fulfil the "Each Babies Counts" criteria in 2016 was **1123.**

Of these:



Note: These categories are mutually exclusive. Babies with a severe brain injury who died within the first 7 days of life are classified as early neonatal deaths.

Figure 3 Breakdown of babies reported to Each Baby Counts by eligibility (*N* = 1123)

BadgerNet). The level of reporting for Each Baby Counts is therefore 99% of babies who have been identified as being potentially eligible to be reported to Each Baby Counts.

It is important to note that the Each Baby Counts definition of severe brain injury is based on information that is available within the first 7 days after birth, at which point it is not yet known how many of these babies will have a significant long-term disability as a result of the

injuries sustained during birth. However, the fact that the majority (96%) of these infants were actively therapeutically cooled – an intensive intervention requiring sedation and admission to the neonatal unit – reflects the serious clinical condition of these babies at that time.

Demographics

Table 1 presents demographic data relating to the babies born in 2016 that were reported to Each Baby Counts. All of the results presented are for term babies born following labour who meet the eligibility criteria for reporting to the Each Baby Counts programme.

Table 1 Demographics for Each Baby Counts eligible babies born in 2016

Demographic parameter		Reports with sufficient information uploaded to Each Baby Counts (*N*=955)		National average (%)
		N	%	
	Singleton birth	940	98	98.4[a]
	Twin births	15	2	1.6[a]
Admission to neonatal unit	Early neonatal death	103	77[b]	N/A
	Severe brain injury	707	100[c]	N/A
	Transferred during labour	171	18	9–45[d]
Place of birth	Obstetric unit	820	86	86.6[e]
	Alongside midwifery unit	96	10	10.2[e]
	Free-standing midwifery unit	16	2	1.6[e]
	Home	17	2	1.4[e]
	Other	4	<1	–
	In transit	5	<1	–

[a] Office for National Statistics. Birth Characteristics in England and Wales, 2016 [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales].

[b] Of the total number of Each Baby Counts babies who died within the first 7 days of life for whom sufficient information was available to assess the care provided (134).

[c] Of the total number of Each Baby Counts babies with severe brain injuries for whom sufficient information was available to assess the care provided (707).

[d] Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study; *BMJ* 2011;343:d7400 [www.ncbi.nlm.nih.gov/pmc/articles/PMC3223531/].

[e] NMPA Project Team. *National Maternity and Perinatal Audit: Clinical Report 2017 – Revised Version*. London: RCOG; 2018 [www.maternityaudit.org.uk/Audit/Charting/reports].

Analysis of local reviews

Of the 1123 eligible babies reported for 2016, the information for 1090 (97%) babies was fully completed by a Lead Reporter on the Each Baby Counts online reporting system. The other 33 reports on the system were started but were not, for a variety of reasons, completed by the Lead Reporter(s) of the relevant trusts/health boards. Of the 1090 completed reports, 1068 (98%) had had a local review of *some* kind carried out.

Quality of local reviews

Out of the 1068 local reviews that underwent assessment to determine whether enough information had been included in the investigation review to allow an assessment of the care provided, 955 (89%) contained sufficient information for the expert reviewers to classify the care provided (Figure 4). The proportion of local reviews that contained sufficient information improved significantly compared with the result from 2015, which showed only 75%[1] of completed reviews as containing sufficient information. The Each Baby Counts reviewers were impressed with the quality of many of the 2016 reports, with some examples of positive feedback received being:

- *'Excellent report with good variety of recommendations to improve service'*
- *'This high-quality report is very thorough and detailed. The review process is very meticulous.'*
- *'Truly excellent, detailed, structured and balanced review of events with learning points identified.'*

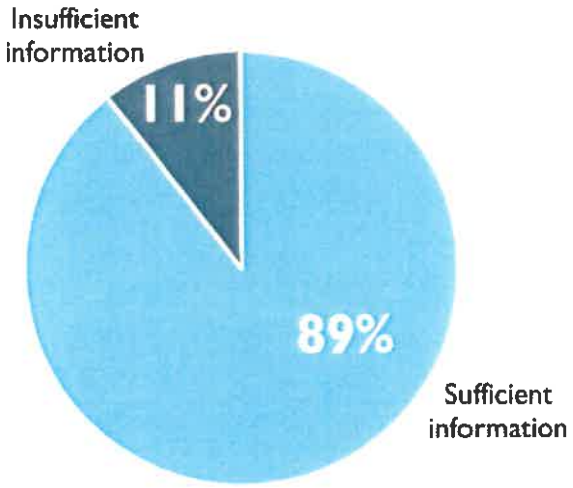


Figure 4 Proportion of completed investigation reports containing sufficient information to assess the care provided (*N* = 1068)

The reasons for classifying 113 (11%) reviews as containing insufficient information by Each Baby Counts reviewers were as follows:

- no detailed case description – 104 (92%)
- no timeline provided – 89 (79%)
- no specific tool used – 89 (79%)
- other – 89 (79%).

These reasons were not mutually exclusive, so the reviewers could list more than one reason why the information contained in the report was considered to be insufficient.

Examples of the 'other' reasons include:

- *'No cord gases, no description of any care of the baby. Obstetric findings incomplete, and no recommendations'*

- *'Timeline misses out approx. 4½ hours of care likely around the point that there was a change… Also no neonatal timeline'*
- *'There is no detailed description of the intrapartum events… I do not know how long the second stage of labour lasted and whether intervention would have been appropriate earlier to prevent the outcome'*

For the Each Baby Counts babies born in 2016, 475 reviews were assessed by Each Baby Counts neonatal specialists. These reports were those highlighted as requiring neonatal assessment by the obstetric or midwifery reviewers, as well as those sent for automatic neonatal review (reports sent for review from 1 January 2018). The automatic neonatal review of liveborn Each Baby Counts babies was implemented in 2018 following the analysis and findings published in 2017.[1] Of the 475 reports assessed, 271 (57%) were assessed as containing sufficient information about the neonatal care provided (Figure 5). The proportion of reports containing sufficient information about the neonatal care was significantly lower than the proportion of reports containing sufficient information about the maternity care. Over 85% of the 2016 Each Baby Counts eligible babies were born alive and the vast majority of those would have received neonatal care. It is therefore important that neonatal representatives are involved in reviews and that this is reflected in the information contained in reports (for example, timelines recorded during resuscitation).

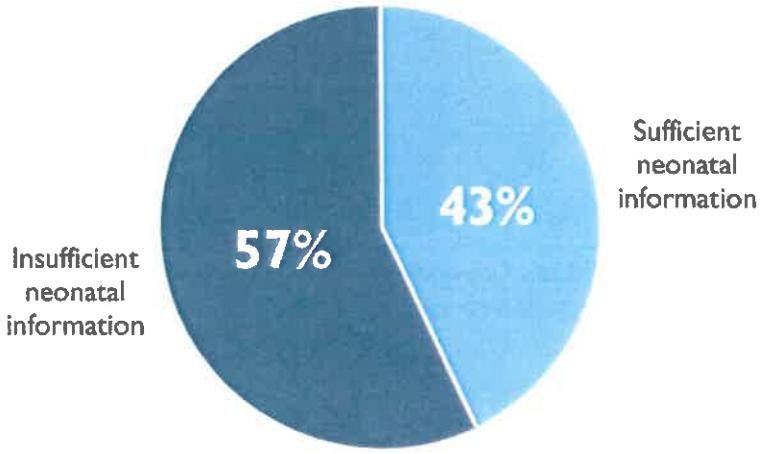


Figure 5 Proportion of investigation reports assessed by neonatal specialists that contained sufficient neonatal information to assess the neonatal care provided (*N*=475)

Tools and methodologies used in reviews

Out of the 955 local reviews that contained sufficient information, 83% (797 reviews) used a specific tool or methodology to conduct the review. The remaining 17% (158 reviews) were not carried out using any specific process. Note that the Perinatal Mortality Review Tool (PMRT) was not available in 2016.

Figure 6 shows that, of the local reviews that made use of a specific tool or methodology, the process most commonly used (65%) was root cause analysis. As local investigators may have used a range of tools or methodologies in any given review, multiple options could have been checked.

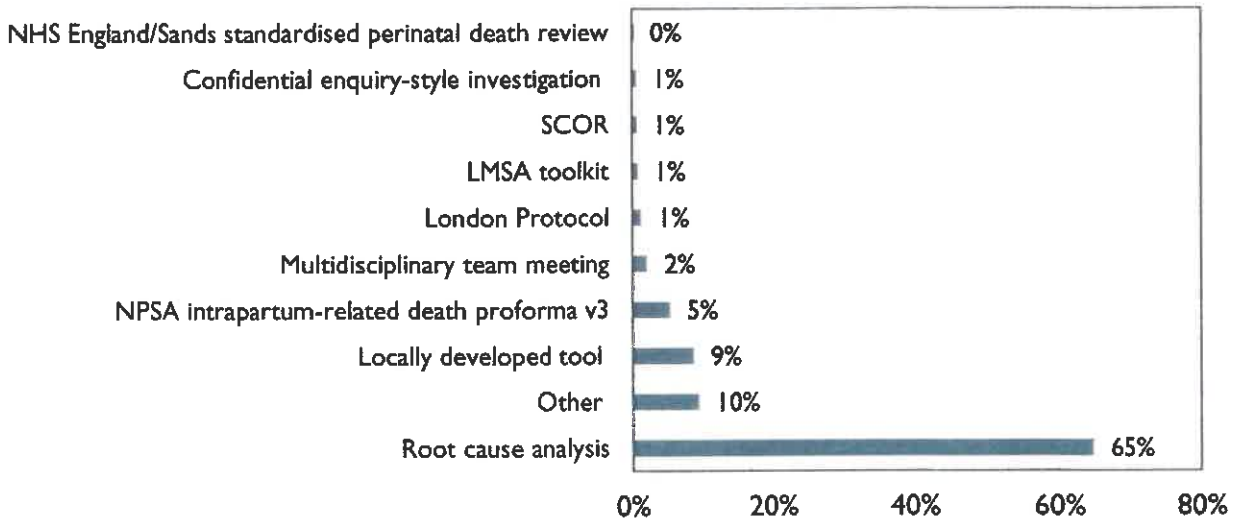


Figure 6 Tools and methodologies used in local reviews containing sufficient information ($N = 955$)

Make-up of local review panels

The analysis shows that 96% of the local reviews where the quality was sufficient to judge the care had been carried out by an MDT (i.e. a panel that contained individuals with expertise from more than one specialty). Although these results are encouraging, the Each Baby Counts project team reiterates that the composition of the panel should always ensure that individuals with all the relevant expertise according to the circumstances of the incident are involved.

As expected, midwives and obstetricians were regularly present, but participation from other specialties was lower, with senior management involved in 48% and anaesthetists involved in 13% of reviews (Figure 7).

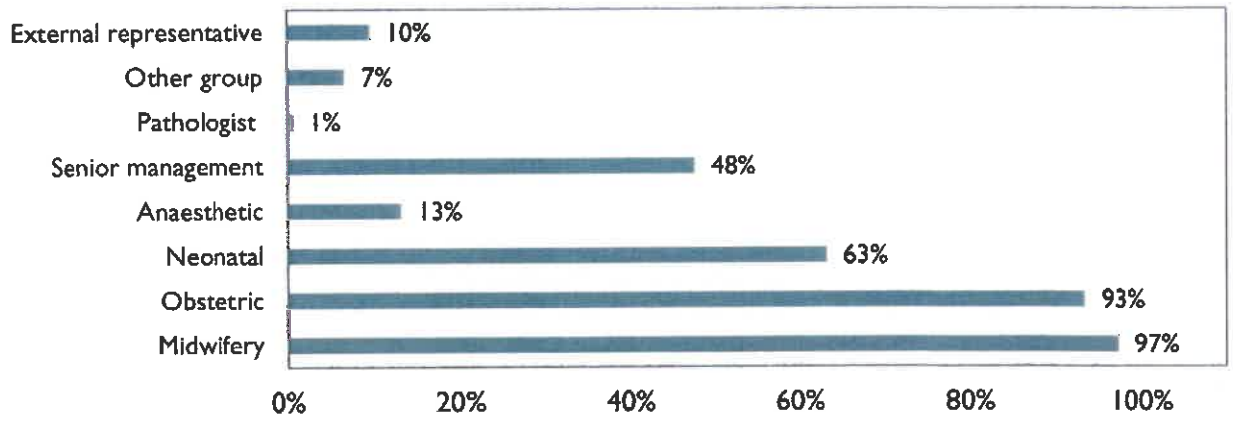


Figure 7 Contributors to local review panels for reviews containing sufficient information ($N = 955$)

Of the 955 reviews with sufficient information for the reviewers to classify the care provided, 875 concerned babies who were born alive. Neonatal clinicians in local units were involved in reviewing the care of 575 (66%) of these babies. Improving the representation of neonatal

clinicians in local review groups will ensure that expert opinions and recommendations relating to the neonatal care of the baby are included in the local review process.

Recommendation

All reviews of liveborn Each Baby Counts babies must involve neonatologists/neonatal nurses.

Following the *Each Baby Counts 2015 Full Report*,[1] the methodology for Each Baby Counts was changed to include the automatic neonatal review of reports uploaded for babies who were born alive. From January 2018, all reports sent for Each Baby Counts review are reviewed by midwifery, obstetric and neonatal reviewers. It is still possible for a midwifery or obstetric reviewer to recommend the neonatal review of a stillborn baby.

External involvement in reviews

Only 10% of panels included an external expert (Figure 7). Where external panel members were present, these were mostly midwives and obstetricians, but they also included risk managers, the Care Quality Commission or commissioners.

Recommendation

All local reviews must have the involvement of an external panel member.

Parental involvement in reviews

Parental involvement in reviews remains inconsistent and still requires improvement.

In 22% of local reviews in 2016, the parents were neither involved nor made aware that a review was taking place. In 41%, the parents were invited to contribute to the review if they wished to (Figure 8), which is a statistically significant* improvement on the 34% in 2015.[1] Although these figures are improved, there is still significant room for further improvement to ensure that all parents are invited to contribute to all local reviews.

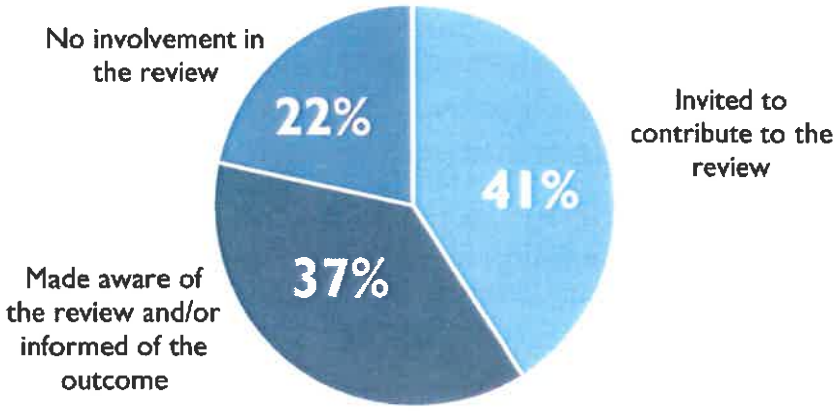


Figure 8 Parental involvement in local reviews containing sufficient information ($N = 955$)

* 34% (2015) and 41% (2016), $p = 0.003$, RR 1.21 (95% CI 1.06–1.37)

Recommendation

All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.

It should be noted that there are a number of different approaches to involving parents in reviews and a personalised approach should be followed. NHS Scotland's 'Being Open Framework'[28] presents a refresh of the National Patient Safety Agency (NPSA) Being Open framework (2009)[29] to support NHS boards in developing their approach to communicating and engaging with people who have experienced moderate or severe harm following an adverse event (predominantly category 1 or 2 in the national framework). The framework can be used to guide and inform local policy and procedures and applies across all care settings within NHS Scotland. The PARENTS study[30] has developed, implemented and evaluated parental engagement in the perinatal mortality review process. The lessons learned from the research showed practical information on how to engage parents in the review process, including recommending a point of contact and ongoing support (for example, through a bereavement midwife or nurse) or facilitating parents talking through their experience rather than completing a feedback form in isolation.

To improve parental involvement in reviews, as well as to ensure that the appropriate multi-disciplinary group is involved, the Each Baby Counts project team recommends using the PMRT[31] for all Each Baby Counts babies who die. Although this tool is currently not used to review babies born with severe brain injuries, the project team recommends that the principles of a PMRT review be applied to Each Baby Counts eligible babies with severe brain injuries.

Recommendation

All Each Baby Counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the PMRT.

Recommendation

There is an urgent need for a PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.

Would different care have made a difference to the outcome?

Where a reviewer indicates that there is enough information contained in the uploaded local review to assess the care provided, the reviewer is then asked whether different care might have made a difference to the outcome. In 29% of babies, the reviewers agreed that, based on the information contained in the local review, different care would have been unlikely to have made a difference to the outcome (Figure 9). In the remaining 674 (71%) instances, at least one of the independent reviewers considered that different care might have made a difference to the outcome.

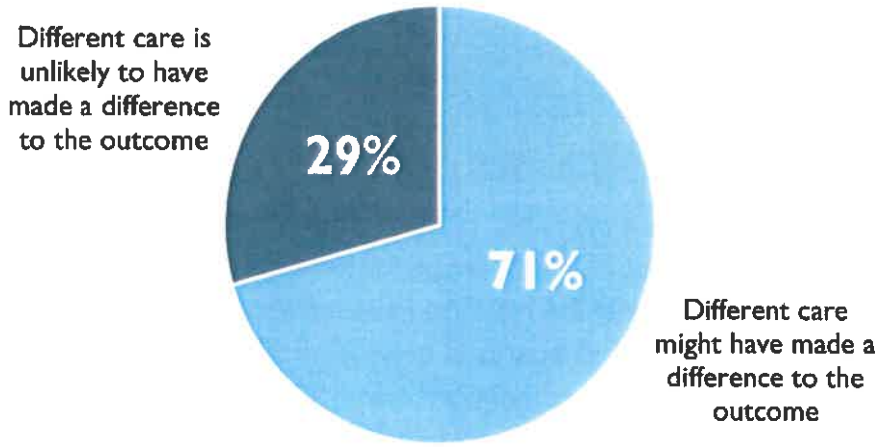


Figure 9 Proportion of babies for whom different care might have made a difference to the outcome (*N*=955)

Each Baby Counts neonatologist specialist reviewers assessed the care given to 271 babies whose reviews contained sufficient information for an assessment to be made about the neonatal care. In 124 (46%) of these reviews, the neonatal reviewer considered that different neonatal care might have made a difference to the outcome (Figure 10). In the remaining 147 (54%) reviews, the neonatal reviewer considered that different neonatal care is unlikely to have made a difference to the outcome. This result highlights the importance of neonatal involvement in reviews because, even when the need for improvements in obstetric care have been identified, there may be further improvements in neonatal care that a specialist neonatal reviewer may identify.

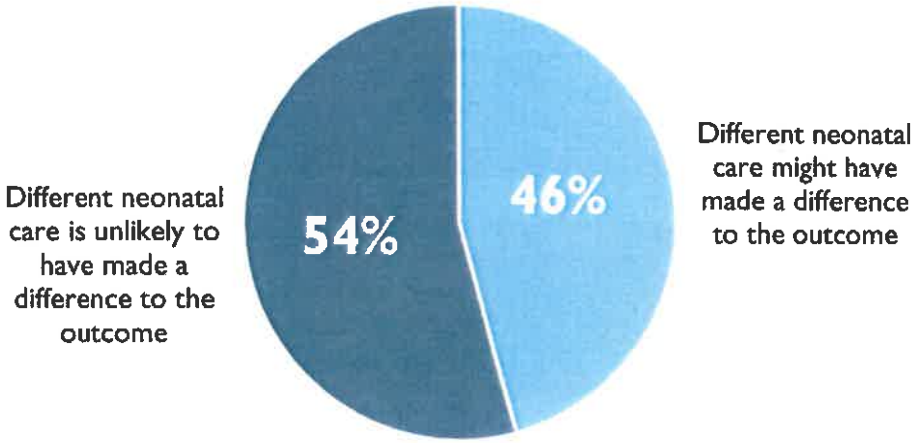


Figure 10 Proportion of babies for whom different neonatal care might have made a difference to the outcome (*N*=271)

Where a reviewer considers that different care might have made a difference to the outcome, they are asked to indicate what the critical contributory factors were in the care provided. The distribution of these critical contributory factors for babies born in 2016 is outlined in Figure 11 for all themes excluding neonatal care, which is outlined separately in Figure 12.

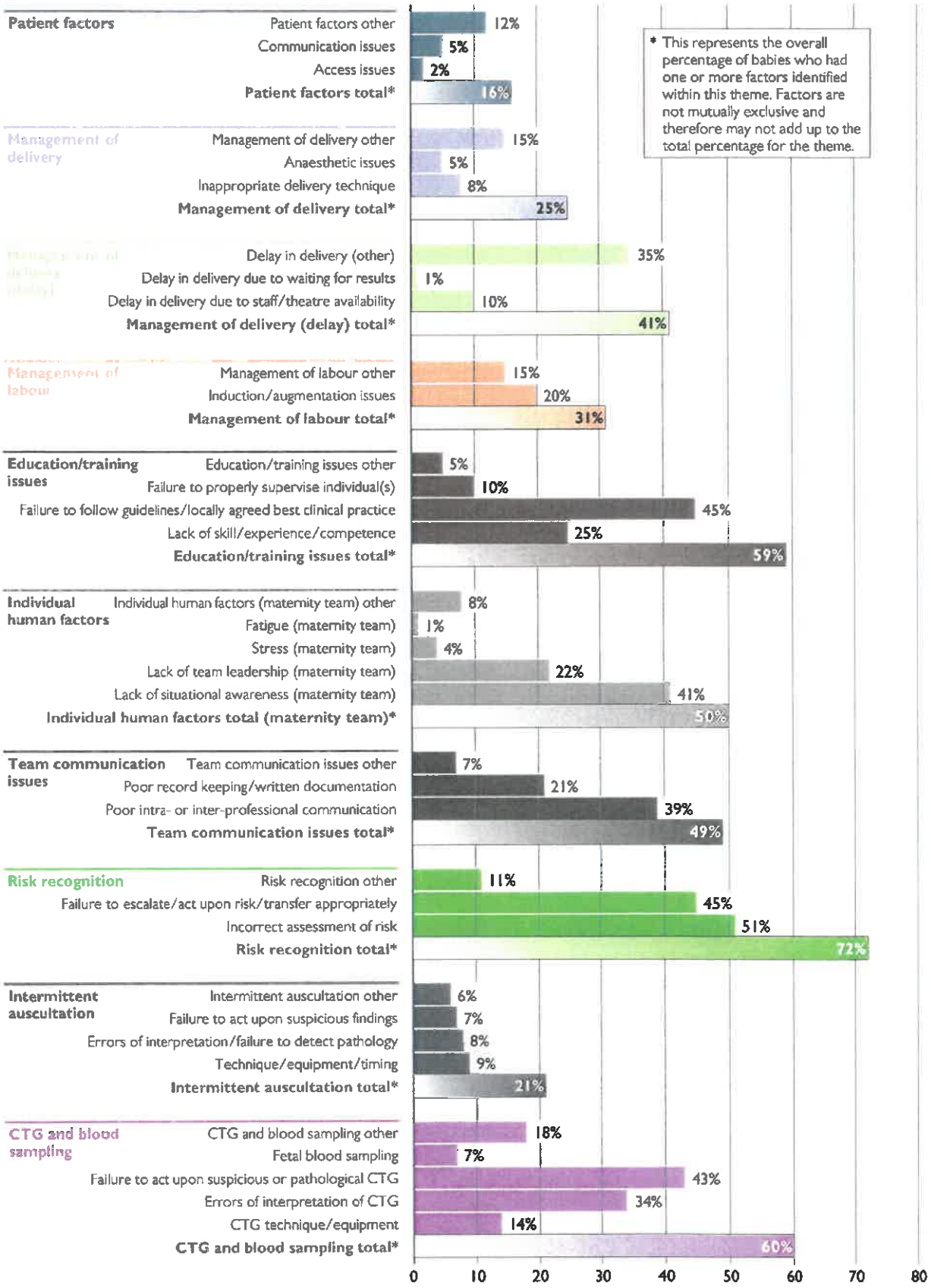


Figure 11 Critical contributory factors identified in babies for whom different care might have made a difference to the outcome ($N = 674$); note that each baby has potentially two or more reviewers identifying contributory factors and multiple factors may apply to the same baby

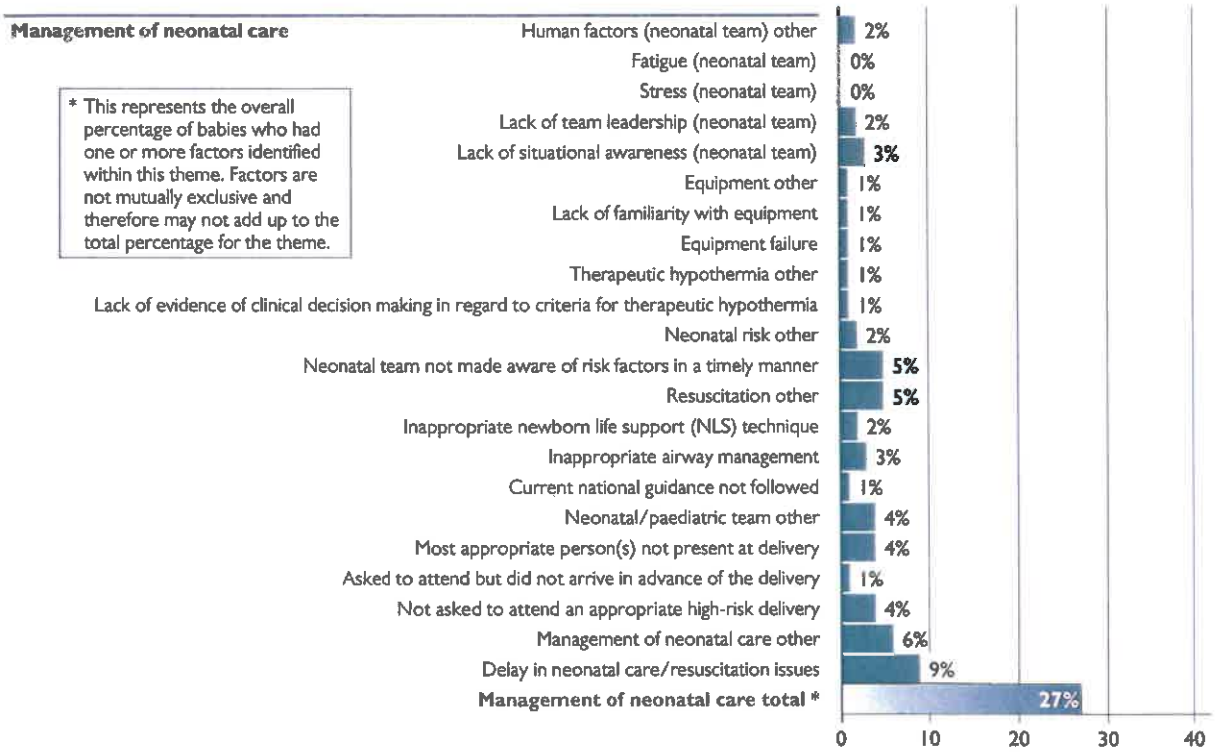


Figure 12 Critical contributory factors in neonatal care identified in babies for whom different care might have made a difference to the outcome ($N=271$); note that each baby has potentially two or more reviewers identifying contributory factors and multiple factors may apply to the same baby

The review of care for the 674 babies where at least one reviewer considered that different care might have made a difference to the outcome identified a total of over 4500 critical contributory factors. It is worth noting that each baby can have up to five reviewers from different specialties assess their care and multiple factors can be identified by each reviewer. The average (mean) number of critical contributory factors identified for each baby was 7 and this demonstrates the complexity of interactions between clinical and non-clinical factors, which can often be interrelated. The total number of critical contributory factors varied between cases from one factor identified in the care of 56 babies to 23 factors identified in the care of one baby. Figure 13 shows the distribution of the total number of critical contributory factors identified for each baby where at least one reviewer considered that different care might have made a difference to the outcome.

Each critical contributory factor is categorised under the most appropriate theme. Figure 14 shows the interrelatability of the five themes in which critical contributory factors were identified most frequently by Each Baby Counts reviewers. At least one factor in one of the most common themes was identified in the care of 618 babies. The remaining 56 babies did not have a critical contributory factor falling under one of these five themes identified in their care. Note that these 56 babies do not directly correspond with the 56 babies discussed in the previous paragraph where only a single critical contributory factor was identified in their care.

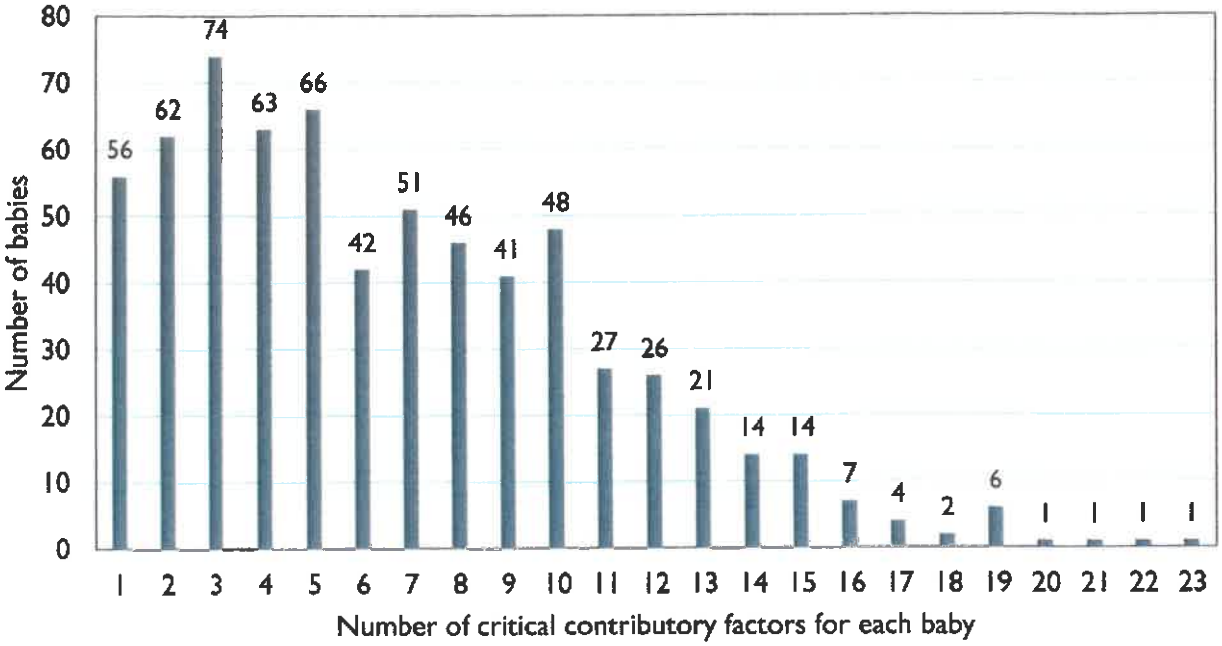


Figure 13 Distribution of the total number of critical contributory factors identified for each baby ($N=674$)

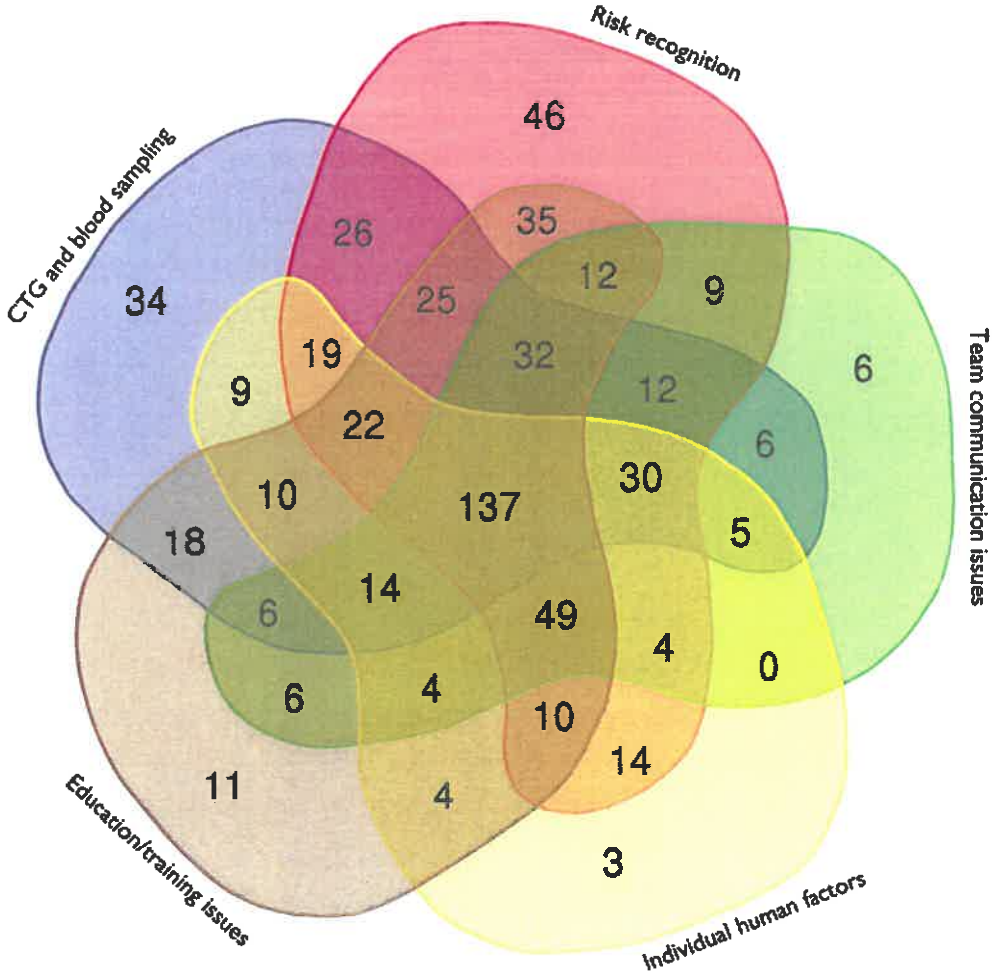


Figure 14 Interrelatability of the five most commonly identified themes ($N=618$); diagram produced using http://bioinformatics.psb.ugent.be/webtools/Venn/

What are the actions that follow local reviews?

Of the 955 local reviews that contained sufficient information for an assessment of care, 103 (11%) contained no actions or recommendations. Of the 852 local reviews that did contain clear actions or recommendations, 149 (17%) had actions or recommendations that were aimed solely at individual members of staff (for example, a requirement to attend further training). The remaining 703 reviews (83%) contained actions or recommendations that took a systemic approach (Figure 15), which is a significant improvement over the 77% in 2015.[1]

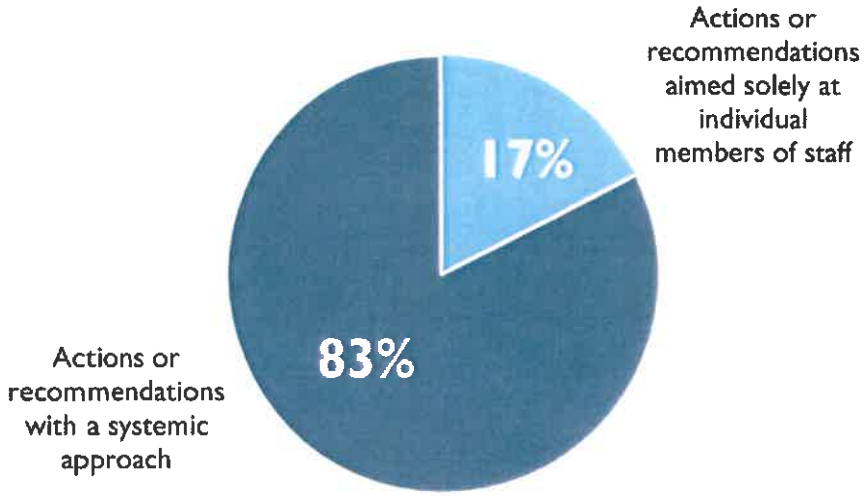


Figure 15 Recommendations and actions from the local reviews ($N = 852$)

Appendix: Additional resources

The **RCOG** is committed to understanding the workforce challenges that currently exist and through **'Supporting our Doctors'** and **Workforce Task Groups** is working closely with members through focus groups and surveys to understand the extent and nature of their workforce challenges and to develop meaningful and sustainable solutions. [www.rcog.org.uk/en/careers-training/workplace-workforce-issues/support-for-doctors-in-difficulty/]

The **Royal College of Midwives** (RCM) **'Caring for You'** campaign aims to improve RCM members' health, safety and wellbeing at work so they are able to provide high-quality maternity care for women and their families through a charter that heads of midwifery are encouraged to sign up to and implement locally. [www.rcm.org.uk/caring-for-you-campaign]

NHS Resolution's CNST Maternity Incentive Scheme introduced a series of standards that all units in England should adhere to in order to receive a 10% reduction in CNST payments. [https://resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/] The following directly relate to this report:

- Evidence of the use of the Perinatal Mortality Review Tool (PMRT) to review perinatal deaths.
- Evidence that the obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service.
- Evidence of a systematic, evidence-based (Birthrate+) process to calculate midwifery staffing establishment.
- Evidence that no more than 20% of middle-grade sessions on labour ward are filled by consultants acting down from other sessions.
- Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. Training should include fetal monitoring in labour and integrated teamworking with relevant simulated emergencies and/or hands-on workshops. The training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case-review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas. There should also be feedback on local maternal and neonatal outcomes.
- Evidence that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with board-level champions to escalate locally identified issues.

The **Healthcare Safety Investigation Branch (HSIB)** is undertaking independent investigations of all babies meeting the Each Baby Counts criteria to identify the factors that may have contributed towards death or harm and to use evidence-based accounts

to establish what has happened and why. They plan to work alongside staff in all English maternity units by March 2019, to ensure local and clinical knowledge is incorporated into the review alongside parent perspectives. [www.hsib.org.uk/maternity/]

National Maternity Safety Champions (NHS Improvement) – Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent have been appointed to work across professional groups and system boundaries to maintain the emphasis on high-quality, safe maternity care for women and newborns, and to promote learning and innovation, seeking out best practice and sharing it across the system. Maternity clinical networks were asked to designate a **maternity safety champion as local quality-improvement adviser**, coach and conduit for sharing learning from national and international research and from local investigations or initiatives. The role includes fostering relationships between maternity clinical networks and neonatal operational delivery networks. [https://improvement.nhs.uk/resources/maternity-safety-champions/]

At provider level, to promote unfettered communication from 'floor-to-board', the *Safer maternity care* action plan sets out the need for a **board-level maternity safety champion** to ensure a board-level focus on improving safety and outcomes as part of improving maternity services.

The **Maternal and Neonatal Health Safety Collaborative (NHS Improvement)** [https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/] is a three-year programme, launched in February 2017. The collaborative covers all maternity and neonatal services across England and aims to:

- improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings
- contribute to the national ambition, set out in Better Births, of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

1000 Lives Improvement is the national improvement service for **NHS Wales**. This has established the Maternity Network Wales, a group of NHS professionals and service users working together to improve the quality and safety of maternity services in Wales for anyone who uses the services or comes into contact with them. This includes the **Safer Pregnancy** campaign that highlights the importance of keeping safe during pregnancy to reduce the risk of stillbirth and aims to help expectant mothers and healthcare professionals talk about what can be done to keep safe. [www.1000livesplus.wales.nhs.uk/home]

The **Northern Ireland Maternity Collaborative** for trust obstetric services is supported by an independent Quality and Safety Forum. It is working to improve maternity safety across Northern Ireland, with many regional Each Baby Counts Lead Reporters also being members of the Collaborative. [www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum/maternity]

Being Open in NHSScotland [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/being_open_guidance.aspx] is an approach to learning from adverse events through reporting, review and the sharing of learning that:

- supports a consistent approach across Scotland to identification, review, reporting and learning from adverse events based upon national and international good practice
- promotes the sharing of learning points following adverse event reviews through the Community of Practice site, regular network meetings and the publication of an annual Learning and Improvement report featuring good practice and improvement examples
- supports a consistent approach to Being Open with people following an adverse event
- provides public assurance on the appropriate management of adverse events through progress meetings with NHS boards and engagement with NHS representatives through its adverse events network and short-life working groups

The **Maternity and Children Quality Improvement Collaborative (MCQIC)** brings together the Scottish Patient Safety Programme's (SPSP) maternity, neonatal and paediatric programmes to improve the quality of care to women, children and their families across Scotland through the use of quality improvement methodology. From 2013, MCQIC has supported and empowered NHS boards to increase local capacity and capability of quality improvement through the teaching of quality improvement methodology at national learning sessions, support visits to every NHS board and unit, WebEx sessions, networking events, data analysis and ongoing support and coaching of QI methodology. The MCQIC programme has supported a 22.5% reduction in stillbirth and 17% reduction in neonatal mortality by testing clinical changes to practice in fetal monitoring, smoking cessation and fetal movement. In addition, embracing teamwork, communication and collaboration by focusing on safety culture, team huddles and debriefs, just to name a few, has no doubt contributed to these improvements The impact of its work in reducing stillbirths can be accessed on page 11 within the ihub *Impact Report 2017-18* at https://ihub.scot/media/4029/ihub-impact-report-2018-digital.pdf.

The **Maternity and Neonatal Adverse Event Review Process** for Scotland promotes learning from adverse events through reporting. Structured review is fundamental to drive continuous improvements to deliver safe and effective person-centred care. The principles underpinning learning from adverse events in Scotland are described within the NHS national framework developed by Healthcare Improvement Scotland (HIS). To ensure consistency across Scotland, a national standardised multidisciplinary approach to the review of adverse events in maternity and neonatal services is proposed. This approach includes a clear pathway which clarifies the level of review required and the mechanisms that need be in place to support the review process, provides guidance on who should be involved at each level, and describes a system of capturing and sharing learning. This approach is being piloted currently and will be rolled out across Scotland in 2019. [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx]

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Women's Directorate Risk Register June 2019

ID	Ref	Area/Secondary/Corporate	Specialty	Handler	Manager	Title	Description	Controls in place	Further action to achieve target risk score
117	W042 - WS	Women's and Maternal Care (Secondary)	Obstetric Surgery (Secondary)	Wynne Jones, Heledd	Giraud, Mrs Fiona	Increased risk of morbidity and mortality for women due to high C/S rates	There is a risk that women will be exposed to increased morbidity and mortality due to surgical procedures during childbirth. This may be caused by higher than average C-Section rates in North Wales(Over the national recommended rate of 25%). Also variation in performance against the national standard within North Wales maternity units. The C/S rate in commissioned services at Chester are also of concern as it is higher than that of BCU. This may impact on patient outcome and satisfaction, increased complaints and damage to the reputation of the organisation.	1) Implementation of C/S 'Toolkit' to ensure keeping first pregnancy normal 2) Promoting normality to decrease intervention rates 3) Vaginal Birth after C/S (VBAC) offered on all sites. 4) Action plans developed per site to reduce rate of C/S 5) Performance monitored via the maternity dashboard at Women's QSE and Secondary care QSE on a monthly basis 6) Improvement notice served.	Consultant Midwife has been appointed to promote normality and undertake analysis of C/S rates across BCU.
128	W056 C	Women's and Maternal Care (Secondary)		Giraud, Mrs Fiona	Harris, Gill	Potential for unsafe care provision due to ineffective communication	There is a risk that patient care could be affected due to ineffective communication in the following ways: - Lack of clinical leadership - Lack of continuity of care - Suboptimal learning environment - Inability to recruit medical staff - Potential increased intervention rates. This could lead to increased complaints and litigation and reputational damage.	•Women's Directorate is working with an external company to identify and address concerns over a one year period •A cultural/leadership action plan has been developed and is monitored by Women's Directorate Board and the BCU Medical Director •Staff relocated as agreed •Implementation of PROMPT training to encourage leadership and multi-professional working	Completion of OD leadership and cultural work develops cohesion of the O&G consultant team Effective (Obstetrics and Gynaecology) team working communication to deliver safe care, compliance with professional guidance 07/02/19 Human factors training until March 2019.The service was taken out of Special Measures in February 2018.

792	CRR04	Women's and Maternal Care (Secondary)		Giraud, Mrs Fiona	Harris, Gill	Maternity Services may become unsafe due to difficulties with medical staff recruitment	There is a risk that women will receive suboptimal care or delays in care provision. This may be caused by the effects of difficulties recruiting medical staff. This could lead to reduced clinic capacity and longer waits to be seen, due to minimal availability of doctors. This could impact in the following ways; a negative effect on the quality and safety of patient care, the learning environment, public confidence and organisational reputation. The result of such impacts would be high litigation and low user satisfaction levels.	1. Detailed monitoring arrangements and escalation procedures within service structures and to Board and Welsh Government on a monthly basis ongoing. 2. Revised service model introduced, with an aim to reduce locum Consultants and middle grade Drs. 3. Cultural and leadership work commissioned, phase 1 completed. 4. Continued use of locum staff where essential to maintain safe medical staffing numbers.	1. Maintain Women's Services as a separate clinical Directorate, to ensure robust management and scrutiny. 2. Work with Medical Staffing to develop a recruitment strategy and a new model for the service. 3. Improved culture and leadership to support sustainable services in North Wales. Commissioned OD work to be completed with effect by December 2018.
600	W080 WS	Women's and Maternal Care (Secondary)	Gynaecology (Secondary)	Wynne Jones, Heledd	Giraud, Mrs Fiona	Delayed care provision for women requiring admission to Gynae wards due to escalation of EGU	There is a risk of delayed care provision for women requiring admission to Gynae wards due to escalation of EGUs. This is caused as in times of high acuity, sites utilise empty beds to reduce the site risk. There is also a risk of inappropriate outliers being admitted to Gynae wards. This is impacting on Gynae are provision, compliance with the nurse staffing Act and it has led to an increased number of falls and HAPU. This is also affecting staff morale, performance and patient satisfaction.	Nursing staff to patient ratio being monitored Medical staff reviewing patients to ensure timely discharge Risk assessment to be completed due to staffing issues which are further impacting upon care provision Women's on call managers to be consulted prior to any decision to escalate EGU beds. Inappropriate outliers to be challenged and a Datix completed if admitted. Criteria of suitable patients to be outlied has been drawn up and should be adhered to by all sites. A risk assessment should be generated and shared with the Women's on call manager when the number of beds escalated exceeds the agreed amount.	Hospital site management team to escalate into additional beds on medical wards and not into Gynae wards and EGUs.

125	W048 - WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Brown, Mrs Lesley	Giraud, Mrs Fiona	Delay in Gynae care planning and care provision due to suboptimal scan capacity	There is a risk that care planning/provision will be delayed for Gynae patients admitted out of normal working hours. This may be caused by the suboptimal scan capacity, as ultrasound scans by the main scan depoartment are not available 24 hours a day. This could effect the capacity for routine work and may result in care pathways not being followed, unsafe care provision, increased litigation and reputational damage.	Review of medical staff scanning competencies to provide service out of hours locally. All sites to hold and maintain a local register of medical staff who are competant to perform ultrasound scans within the department. Risk to be recorded on radiology risk register as well as Women's risk register. Scan capacity throughout Wales is being reviewed by WG and ACOS. Midwifery has raised BCU issue with CNO/CMO, WG.	Additional scan capacity to be provided and additional scanners made available to enable more scans locally.
1103	W106 - WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Brown, Mrs Lesley	Giraud, Mrs Fiona	Harm may be caused to unborn fetus due to lack of scan capacity as per national recommendations	There is a risk that a fetus whose growth is small for their gestational age or whose pattern of movements has changed due to distress may not be detected. This may be caused by the lack of scan capacity to comply with triggers set to perform a scan, as detailed within national recommendations to prevent stillbirth. This could impact upon stillbirth and litigation rates and could effect the reputation of the organisation.	All women attending the Maternity Outpatient Assessment Unit (MOAU) are triaged within 30 minutes of arriving and a CTG is commenced to monitor fetal wellbeing. If a scan is triggered as per national recommendations, but a scan slot is unavailable, daily CTG recordings will be performed to regularly monitor fetal wellbeing.	Increased scan capacity to meet national recommendations.

2310	W139WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Giraud, Mrs Fiona	Owen, Teresa Ann	Lack of assurance received from COCH with regards to performance based on outcome measures	There is a risk that assurance with regards to performance and outcome measures will not be received from the Countess of Chester NHS Trust, from whom we commission maternity services. The Directorate are concerned re the Provider's performance in the following key areas: Initial Assessment by 10 weeks Induction of Labour rate Caesarean Section rate 1 to 1 care in labour Lack of action plans with regards to national audits. There is a risk of increased morbidity and mortality of welsh women and their babies delivering in this Trust. This may be caused by a lack of action plans to address performance or reluctance to share the action plans. This could impact upon Welsh residents delivering in COCH and also upon current and future commissioning contracts.	The Provider , via the HB's Contracting team, were requested to provide improvement plans on the above measures and confirm their local plans in response to the recent MBRRACE Report and their benchmarking exercise against the RCOG Requirements for Services. The response received was that the Provider did not have any improvement/ plans for any of the elements of the request. To note these elements were clearly outlined and specified in the SLA which was agreed with the Provider.	Contracting colleagues are looking at serving a formal Performance Notice under General Conditions 9.6 (Contract Management Meeting) of the Contract and contacting the North West Quality Officer to raise our concerns formally. Receipt of assurance documents as requested.
2262	W135WS	Women's and Maternal Care (Secondary)		Roseblade, Mr Christopher	Giraud, Mrs Fiona	Increased morbidity for women requiring abdominal hysterectomy	There is a risk that obstetricians/Gymaecologists may not be able to maintain the required competencies for performing abdominal hysterectomy operations. This is due to to the fact that surgery is becoming more laparascopic and this operation is performed less frequently, but may be required in an emergency , massive haemorrhage incident within obstetrics. This could impact upon women/staff in such an emergency and operations delayed or suboptimal. This could impact on morbidity and mortality of women and increase litigation and could damage organisational reputation.	- National issue - Included in BCUHB action plan in response to the MBRRACE report - Discussions commenced with the RCOG with regards to availability of simulator training and how this is being addressed nationally - RCOG to review the training curriculum and training available	National simulator training opportunities to maintain competencies

2276	W137C	Women's and Maternal Care (Secondary)		Reeve, Julie	Wynne Jones, Heledd	Women are at risk of morbidity/mortality at Denbigh home from home delivery suite	There is a risk that women using the Denbigh home from home delivery suite would be unsafe in the event of a fire. This is due to the fact that there is a significant defect within the compartmentation of the original building at first floor and roof level, which did not comply with current safety regulations. As a consequent use of in-patient beds on the first floor was ceased in June and therefore the environment is unsafe to use for community births as evacuation in an emergency cannot be guarunteed.This could lead to injury to morbidity/mortaity of women using this clinical area and could impact upon reputation.	•The delivery suite at Denbigh community hospital have been ceased. Women will be able to access the Midwifery Led Unit based at YGC (Wrexham and Bangor also provide this service but it is expected that women who currently use Denbigh will go to YGC) •Opportunities for women to have home births is also available and will remain unchanged	Building to be modified to reach fire regulations.
2277	W138WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Johnson, Mrs Llio	Brown, Mrs Lesley	Mothers and babies at increased risk of morbidity as the Recovery Room in YG does not meet current standards as a safe area	There is a risk that mothers and babies at increased risk of morbidity as the Recovery Room in YG does not meet current standards as a safe area to operate on a second obstetric theatre patient. This could cause delay in care provision or suboptimal care resulting in morbidity to women and/or their babies. This could lead to increased litigation and reputational damage.	Business case in development to review alternative options for a replacement area to operate in during times where two emergencies co-incide. Minimum of essential equipment stored in Recovery and additional equipment stored close by to ensure more floor space. Skills drills in theatre recovery to ensure staff are familiar with the Recovery environment and areas of storage.	Development of a clinical area/theatre to utilise in the event of two emergencies.
2572	W148 WS	Women's and Maternal Care (Secondary)		Quarmby, Jan	Wolfe, Maureen	Risk of causing harm to 10% of BCU babies through NBBS avoidable screening repeats	There is a risk to 10% of our newborn babies safety This may be caused by an avoidable delay in identifying a number of serious conditions This delay could lead to permanent damage of the babies brain and development. This would lead to patient dissatisfaction, and potentially increased complaints and litigation.	Existing risk mitigation measures/controls in place is that from the 1st December 2018 a second checker process was introduced in order to ensure that each sample taken meets the standard set by NBBS Wales.	Further action has been taken to reduce the errors further. Further Training of all sample takers and second checkers is required for all areas including community services, maternity ward services, SCBU & NICU services and Health Visiting services.

2577	W150 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Giraud, Mrs Fiona	Owen, Teresa Ann	Delay in patient care and/or treatment due to a No Deal Brexit	There is a risk of potential staffing and medication unavailability and therefore delay in patient care and/or treatment. This may be caused by a No Deal Brexit. This could potentially result in the inability to fully staff rotas and long term provision of specific medication for Directorate patients. This could lead to a reduction in services and the need to source alternate medical supplies.	A list of essential medications has been drawn up by the Directorate and forwarded to Pharmacy. Pharmacy to liaise with WG and feedback with regards to any actions required.	Brexit to be successfully agreed with EU deal.
2690	W151 WS	Women's and Maternal Care (Secondary)	Obstetric Surgery (Secondary)	Wynne Jones, Heledd	Giraud, Mrs Fiona	Potential for women delayed recognition of women mental health problems and delayed access to appropriate support and treatment	There is a risk that there will be delayed recognition of women with mental health problems and delayed access to appropriate support and treatment. This may be caused by the lack of on-going PMH training in 2019-20, as it has been removed from the mandatory training days for midwives after 12 months to accommodate other topics required. This could lead to long term negative impact on mothers, partners and in particular infants(NSPCC, 2018). It may also impact upon BCU compliance with WG recommendation for having PMH plans in place for all women with MH issues.	Training was completed for all midwives in 2018-19. There is information for midwives on the PMH webpage on the BCU intranet along with templates for care plans for women with minor MH issues. There is a triage line for professionals to access advice and support. PMH Midwife provides education sessions to student midwives Funding to produce a physical resource for midwives has recently been sourced.	Training for midwives to be re-instated onto the mandatory training days.
2691	W152 WS	Women's and Maternal Care (Secondary)	Gynaecology (Secondary)	Harrison, Mrs Jill	Giraud, Mrs Fiona	Delay in Gynae care provision due to cessation of commissioned elective services in CoCH	There is a risk that Gynae care provision will be delayed for Women in North Wales. This may be caused by the cessation of commissioned elective services in CoCH, as communicated by the CEO for Chester. This may cause a backlog in women waiting for Gynae surgery and could affect customer satisfaction and the number of complaints received.	Utilise other commissioned services if required. Absorb the additional women into our current service and re-allocate across North Wales as required.	CoCH to restore capacity for commissioning of elective Gynae services.

2352	W140W	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Johnson, Mrs Llio	Wynne Jones, Heledd	Risk of Legionella for women birthing in YG from bath on Labour ward	There is a risk that Legionella may be present in the bath taps on Labour ward in YG due to positive swab tests in August 2018. This may be caused by limited usage of the bath on labour ward and use of the bath could result in a woman becoming infected.	Bathroom decommissioned with immediate effect Costing for replacement wet room requested Other shower rooms available for use by women post delivery	Replacement wet room installed
2353	W141WS	Women's and Maternal Care (Secondary)		Quarmby, Jan	Wolfe, Maureen	Antenatal screening Wales performance data for all Health Boards in Wales incomplete therefore risk of not understanding the num	There is a risk that there is no antenatal screening denominator data and unverified data only for Down's Syndrome and ultrasound scanning available for any health board in Wales. This is caused by the fact that the denominator data for the uptake of screening tests by pregnant women is not determinable and that the numbers of tests performed by the Down's Syndrome laboratory differs to that recorded by the health board, as do the numbers of ultrasound scans. This could lead to discrepancies in data which cannot be verified but only reviewed locally. This could lead to inaccurate reporting nationally and uncertainty with regards to the performance of all health boards against national screening standards.	A/N Screening Wales looking at solutions to remedy this lack of data WRP to be notified by A/N Screening Wales	Complete, verified data collection available to provide assurance with regards to antenatal screening uptake and appropriate health board performance against screening standards.

2487	W143 WS	Women's and Maternal Care (Secondary)	Obstetrics - PN(Out-Patients) (secondary care)	Breward, Sharon	Wynne Jones, Heledd	Women may receive inadaquate breast feeding support from peer supporters affecting the wellbeing of mothers and babies	There is a risk that women are receiving outdated information with regards to breast feeding, affecting the health and wellbeing of both mother and baby. This is caused by: Incorrect database of qualified peer supporter workers A lack of governance processes for peer support workers No provision of annual update in training for peer support workers No Code of Conduct for peer support workers Inconsistency in employment and induction processes, affecting security and safeguarding	A Task & Finish group set up and first meeting in October 2018, meeting monthly to address concerns identified. An overall action plan has been developed with named leads and set timeframes. Current actions in progress from the meetings: Scoping exercise to be completed of peer support workers working within BCUHB Review of other governance processes used in the UK (Unicef, BFI) Costing undertaken for initial training, verification and annual update. Training module reviewed to assess if amendments required Code of Conduct being developed-to be discussed at WIFN WOD and OH contacted to review employment processes. Induction process being reviewed with other voluntary services (Robins).	Completion of the action plan and actions incorporated into a revised Written Control Document.
2488	W144 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Giraud, Mrs Fiona	Owen, Teresa Ann	Women may experience poorer outcomes when delivering at commissioned services in SaTH	There is a risk that women may experience poor outcomes when choosing to deliver at SaTH. This has been highlighted by the recent concerns raised by the public and subsequent enquiries into the outcomes of several hundred deliveries at this maternity unit. Two families from Wales are part of the investigation with deliveries in 1990 and 1998.	Regular meetings have been established between the Director of Midwifery and SaTH to update re the two historic cases. Performance outcomes will be reviewed by the Women's Directorate and the commissioning team.	Knowledge of the outcome of the two investigations and satisfactory assurance re performance outcomes.

2522	W145 E	Women's and Maternal Care (Secondary)	Gynaecology (Secondary)	Harrison, Mrs Jill	Brown, Mrs Lesley	Risk of undiagnosed Gynae conditions and delayed treatment for Women in Wrexham area	There is a risk that women may not be seen and treated in a timely manner due to the fact that there is a backlog of patients caused by an inability to long term sickness absence of the nurse colposcopist and an inability to recruit to the vacancy. Therefore there is an ever increasing backlog of patients that need to be seen in Wrexham. This may cause a delay with Gynae diagnosis and could lead to increased complaints, litigation and reputational damage.	A decision has been taken to advertise 2 part time post instead of a full time post in the hope of attracting more applicants. This is also being advertised as a trainee post with training taking up to 12 months. CSW is looking at moving the borders for a period of 12 months until the recruitment process and training has been completed. CSW Informatics is currently processing this request and will advise us how many and which GP surgeries will be affected. It has been agreed that this needs to be actioned before the end of March.	Vacancy needs to be filled and backlog of patients seen.
2174	W133WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Quarmby, Jan	Wolfe, Maureen	Failure to risk assess the birth weight at birth to inform clinicians on how to base their plan of surveillance	[24/04/2018 10:15:37 the reporter] The BWC itself in reality is actually more significant than the birth weight as it is a risk assessment of the birth weight that determines whether the baby has been subject to Fetal Growth Restriction or is at risk of hypoglycaemia following birth. It also informs clinicians on the risk status of the mother for her future pregnancies. Each month we have between 30 and 40 babies born and discharged home with no BWC generated. Therefore the Health Board is running the risk that should any of these babies have a BWC <10 th centile and more specifically <3rd Centile they could become severely ill, which could lead to hypoglycaemia without apporiate care panning and assitional surveillaance having a grat impact on both baby and family. It could also in addition have an impact on following pregnancies as if not picked up at the begining on	Each Labour Ward lead is required to check the birth register on a daily basis and identify any births that have no BWC documented next to the birth weight in the register. They should then either generate the BWC or delegate this task to another midwife. Paediatricians use the population birth weight centile to assess for need for hypoglycaemic pathway. This is not as sensitive but is an accepted risk assessment tool.	A Functional modification and bespoke development specification form has been completed to requesdt that the BWC becomes a manadatory field on the Birth Registration form. An email has been sent to the 4 HOMS to ask for their support to make this change as with these 4 HOMS the request should go straight through.

2203	W132WS	Women's and Maternal Care (Secondary)	Obstetrics - AN(Out-Patients) (secondary care)	Brown, Mrs Lesley	Giraud, Mrs Fiona	Fetal Medicine consultants may be unable to maintain their competencies in amniocentesis following NIPT implementation	There is a risk that fetal medicine consultants may be unable to maintain their competencies in amniocentesis following NIPT implementation. This may be caused by the lack of requirement for invasive tests such as amnios due to the new NIPT screening test. This could lead to consultants becoming deskilled in this field and being unable to practice fetal medicine, as less consultants will be needed.	Competency register Professional standards	Review of staffing requirements as required for fetal medicine speacilists
121	W004 - E	Women's and Maternal Care (Secondary)	Gynaecology (Secondary)	Harrison, Mrs Jill	Upadhyay, Kalpana	Delayed Gynae care planning/provision due to inability to retrieve historic gynae scans	There is a risk that decision making around care provision may be affected if existing paper copies of scan results cannot be found. This is caused by the fact that Shooting Star gynae ultrasound scanner not linked to PACS system, therefore scans cannot be electronically stored. This could affect the quality of patient care and may affect the quality of defence of any legal claims.	Paper copies available and secured in notes. ANC Scanner linked to PACS but no current plan to link Gynae scanner to this system.	Align departmental ultrasound reporting to the PACS system. No further development 4/2/19 - No further development

119	W038 - WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Brown, Mrs Lesley	Giraud, Mrs Fiona	Inaccurate and untimely data collection within Women's services due to manual collection of statistics	There is a risk that information collected to inform the performance of maternity services may be untimely and inaccurate. This may be caused by human error and time spent by staff collating the information manually. There is no current maternity IT system that can collate the required data for Women's services, therefore information is not up to date or live. This may effect statutory and mandatory information requested by WG or HIW and may also result in coding errors. This may impact upon determining actual performance and reputation of the organisation.	Head of IT for BCU aware of problem. Some basic patient information available on PIMS, PAS and Myrrdin. Intrapartum data collection form developed to capture the data required by WG manually. This information is triangulated with ACE forms completed for each delivery.	The introduction of a maternity information system.
467	W070 - WS	Women's and Maternal Care (Secondary)		Wolfe, Maureen	Giraud, Mrs Fiona	Suboptimal emotional care provision available for bereaved families due to the lack of a counselling service	There is a risk that women and families may feel unsupported and may experience increased emotional distress following bereavement due to the lack of immediate counselling services available to them. This may be caused by the lack of a counselling service within the health board to offer immediate grief counselling to bereaved parents. This could lead to an increased potential for complaints and may also impact upon the reputation of the organisation.	Women are give the information of services who offer counselling; SANDS, the Miscarriage Association and Hope House.	BCU to commission a counselling service. The introduction of a bereavement midwife post. This will not provide counselling, but will offer women and their families much more support and information immediately following a bereavement.

735	W084 E	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Harrison, Mrs Jill	Brown, Mrs Lesley	Delay in care planning due to system for access, scanning and storage of Volume 8 - Maternity Notes	As per the Health Records policy, Records that we would be required to retain from more than 8 years MUST be scanned. These should be scanned if the patient has not received treatment within the past two years. This is causing issues due to the format in which the notes are scanned they are slow to load and difficult to navigate making past history from notes difficult to obtain. Scanned notes reviewed and CTG and intrapartum period and the quality of the image is poor. If asked to provide for legal purposes they would not withstand legal challenge.	- consultant to ensure that history is obtained from the patient and adequate time is available to navigate the notes. 5/8/16 - Requested Health Records cease scanning maternity records with immediate effect Health records to confirm that all maternity records (volume 8's) in East proceeding 2012 have been scanned and originals destroyed. Health records to confirm the year to which records have been scanned in Central and West Risk Midwife undertaken risk assessment Health Records to quantify number of records scanned and destroyed to date 13/11/18 Cannot store CTGs offsite due to Health Records procedure. Currently being stored in Ablett Unit, YGC. JH working with Health Records to come up with long term plan.	CG gold being installed on all machines for ANC clinics - issues with access 16/08/16 Meeting to be held with health records. Health records agreed to contact COSMOS for the following options: a) request notes to be printed with colour dividers and colour CTG b) request full set of notes to be printed in colour 30/03/17 - Met with Health Records - full set of colour notes much improved. Health records to check costing. Happy with GROW Chart. Quality of CTG not improved- Marie Edwards expressed concern from legal perspective. Health records to find out the process for storage/scanning of CTGs at COCH and

811	W090 E	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Wynne Jones, Heledd	Giraud, Mrs Fiona	Unable to perform cord blood tests as recommended nationally	Gas machine requires upgrading with Ca and lactates 13.01.17 -A safety concern was raised in our local LW forum this afternoon regarding the blood gas analyser on LW. Background: over a year ago we were informed that the analyser was due for renewal. It is used for neonatal/paediatric care, intrapartum care and for postnatal care. Gareth and I, supported by Mair, wanted the option of lactate and calcium to be reported on the new model. We met with the relevant team on VC in Avril's office to explain our case, which we understood to be accepted. Assessment: We still have not had a replacement. In the meantime there has been a pan-BCU roll out of new glucometers. We are informed that whilst this is on-going any other planned upgrades are on hold and that it may be up to 2 years before	Armstrong and POCT Coordinator aware of risk. ABG procurement currently underway for replacement of all ABG analysers at BCU 10/12/15 - Sent to David Fletcher to provide updates mitigating measures in place/planned. 13/05/16 - Resent to David Fletcher for update 16/08/16 Sent to Victoria Robinson, Pathology - response from Victoria 22/8/16 - The documentation for the procurement is ready and being progressed. All POCT resources are currently focused on implementing new glucose meters and it is anticipated procurement for blood gas will take place once this has been completed. The implementation plan for the new glucose meters is currently being finalised. Pathology Action Plan	Replacement of all ABG analysers at BCU Pathology Action Plan
1073	W104 - WS	Women's and Maternal Care (Secondary)	Gynaecology (Secondary)	Pettifor-Jones, Mrs Gail	Wynne Jones, Heledd	Intermediate life support may be compromised on Gynae wards as staff unable to complete training	•There are 69 RNs. •Of the 24 who are mentors who take priority for training, 22 are booked to attend sessions in May and June. 2 of the 24 are already trained and up to date. •The remaining 45 require ILS training will be booked as soon as training places become available. •Of this 45, 27 are compliant with Mandatory Life Support (MLS). 16/08/16 - Still issue, mandatory training sessions in September.	Training Needs Analysis Weekly updates to ACOS Nursing and Midwifery on training compliance	The 18 who are not compliant with MLS will be allocated dates to join the midwifery MLS sessions in May and June. 16/08/16 Will now attend in September

1225	W113 - West	Women's and Maternal Care (Secondary)	Obstetrics - AN(Out-Patients) (secondary care)	Ilyas, Dr Zainab	Giraud, Mrs Fiona	Delayed care for women with haematological problems in the antenatal period and for teenagers accessing Gynae services	Delayed care for women with haematological problems in the antenatal period and for teenagers accessing Gynae services. This may be caused by unclear referral pathways for Antenatal patients and Teenage Gynaecological patients. This could impact upon the care provision and treatment for these women and may result in decreased satisfaction and increased complaints.	Continued referrals issues to the Haematology Services. Dr Clark looks after the majority of women with known haematological disorders affecting pregnancy. Joint meetings were held with Dr Melinda Hamilton, to agree clear management plans. Dr Hamilton also managed numerous teenager with menstrual difficulties testing for bleeding disorders (which we have a high pick up rate) We have discovered indirectly that Dr Hamilton is no longer working locally and that the remaining team are unable to suggest a single access point to Dr Clark for planning, due to pressure of work. This presents an increased risk for these patients and an inferior service provision.	Named contact within Haematology Services to be provided
1387	W117 - WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Wolfe, Maureen	Giraud, Mrs Fiona	Fetal distress may be missed due to inappropriate CTG training package	NICE have updated their CTG guidance for midwives and obstetricians which includes different information to the current RCOG training package, therefore an urgent review of the national mandatory training requirements for staff is required. The Maternity Network is leading on a replacement package.	Current CTG documentation to be reviewed and amended in accordance with NICE Guidance	Dissemination of an appropriate CTG training package
1388	W118 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Roseblade, Mr Christopher	Giraud, Mrs Fiona	Fetal distress may not be identified by junior doctors due to their suboptimal compliance with CTG mandatory training	Poor completion rates of the CTG training package by junior doctors in obstetrics which could impact upon accurate CTG interpretation.	All clinical directors informed of issues, when able weekly CTG case discussions/teaching in clinical areas	Junior doctors to complete training

1735	W122 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Roseblade, Mr Christopher	Giraud, Mrs Fiona	Potential for inability for obstetricians to maintain their clinical competencies	The birth rate in North Wales is decreasing. If there are a reduced number of births it will be difficult for obstetricians to maintain their competencies putting services at greater risk of medical staffing issues.	Escalated to secondary care, Nigel Lee and Eric Gardiner for information, but will be maintained as a Women's Directorate risk at present.	The Directorate continues to work to attract women back to BCUHB from the Countess of Chester to repatriate associated finances.
1866	W124 C	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Tedaldi, Mr Dominico	Brown, Mrs Lesley	Delayed care and investigations for babies as WPAS unable to generate NHS number	If an NHS number cannot be generated for WPAS, then a hospital number cannot be generated for a baby. Labs decline any blood tests sent without a hospital number and therefore care and investigations are delayed which may cause harm to a poorly baby.	WPAS aware of concerns, labs informed when issues arises but may still decline to perform blood teats without correct identifiers.	Effective, efficient WPAS system
1982	W128 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Lloyd, Gaynor	Wolfe, Maureen	Morbidity/mortality caused by epidural medicines which have been administered by the	The current use of Luer connector neuraxial devices on BCU maternity units allows incorrect connection of epidurals to IV lines and IV medicines to be incorrectly	1) All epidural consumables, medicines and equipment are stored separately from intravenous (IV) consumables, medicines and equipment 2) Epidural updates are mandatory for all midwifery staff. PCA/Infusion device training is mandatory for all midwifery and nursing staff in Womens. Compliance is 100% 3) Separate pumps for epidural	Each maternity unit has developed a site specific risk assessment. It is anticipated that the UK will start using devices with the new ISO 80369-6

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1982	W128 WS	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Lloyd, Gaynor	Wolfe, Maureen	Morbidity/mortality caused by epidural medicines which have been administered by the intravenous route.	The current use of Luer connector neuraxial devices on BCU maternity units allows incorrect connection of epidurals to IV lines and IV medicines to be incorrectly administerd via spinals.	1) All epidural consumables, medicines and equipment are stored separately from intravenous (IV) consumables, medicines and equipment 2) Epidural updates are mandatory for all midwifery staff. PCA/Infusion device training is mandatory for all midwifery and nursing staff in Womens. Compliance is 100% 3) Separate pumps for epidural infusions on all labour wards in BCUHB are clearly labelled "for epidural use only" 4) All giving sets for epidural infusions in use on all labour wards in BCUHB are coloured yellow and are clearly marked	Each maternity unit has developed a site specific risk assessment. It is anticipated that the UK will start using devices with the new ISO 80369-6 neuraxial connectors from April 2018.

527	W076 W	Women's and Maternal Care (Secondary)		Johnson, Mrs Llio	PAUJON	Delay in care provision due to unavailability of Medical Records for Clinic/Theatre	Notes not being made available for clinic/theatre SITUATION Patients attending Colwyn Bay gynaecology clinics (medical or nurse led) should be seen with YG notes and admitted for surgery at YG with the same. BACKGROUND The transition from YGC notes was to have been completed by 2014 ASSESSMENT It appears that some patients have continued to have some elements of care in YG and other in YGC notes. patients are still being seen with YGC notes and no YG notes. Further patients are being seen with no notes.	Until the practice of using YG notes exclusively has been fully established, all patients being seen in Colwyn bay Gynaecology clinics require BOTH the YGC and YG notes, to ensure safe patient care. In view of the reported difficulties in liaising across the sites regarding preparation for these clinics, additional assistance on the YGC site is required urgently. staff member to review what is in the notes and refiling YG records in the YG notes	
130	W058 - W	Women's and Maternal Care (Secondary)		Johnson, Mrs Llio	Brown, Mrs Lesley	Delay in treating women/actioning women's test results due to inadaquate governance arrangements	Process for managing patients test results e.g. blood tests/Swabs etc Process is Paper copies sent to Llifon ward Dr to sign, medical notes may not be available as pt gone home. Recalling the notes may take time Pt may require immediate treatment Patients may not receive timely treatment/ management of their condition as diagnoses/ indicated in the test Potential delay in treatment for patient Recall of the medical records may take a long time no system to check if treatment/ or result acted upon been given prior to patient going home Patients GP not made aware of the need for treatment in a timely manner	Doctors sign result forms Ward clerks request notes for doctors if required Fax/phone call to inform GP if result indicates treatment is required	needs to be articulated

120	W006 C	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Gardner, Mrs Lorraine	Wynne Jones, Heledd	Potential for staff and women to be exposed to higher than recommended Entonox levels	Environmental report states entonox levels above national guidelines on delivery suite in central	To ensure entonox levels remain within the safe levels within the National Health & Safety guidelines Levels tested regularly by H&S scavenger system in each room. Staff advised to open windows when working in each room. Changed from mouth piece to masks to reduce risk Pregnant staff advised not to work on labour ward due to potential risk to baby Opportunity to seek further guidance from H@S Include Entonox material data sheet with COSHH risk assessment – MK circulated 18/10/13. Nov 13 - MK discussing with Shan Kennedy re medical gases training	16/08/16 Requested advice from Huw Williams, H&S Advisor Central 27/04/2017 Regular testing of levels on all delivery areas across North Wales to be continued. 29/8/18 meeting with Iwan Roberts from estates who is going to organise a period of monitoring of entonox levels on delivery suite.
2225	W134WS	Women's and Maternal Care (Secondary)	Gynae Surgery (Secondary)	Roseblade, Mr Christopher	Giraud, Mrs Fiona	Procedure specific consent forms are unavailable for use	There is a risk that using a generic consent form may not allow fully informed consent in relation to the specific procedure being undertaken. This is due to historic practice and may impact upon quality care provision, patient satisfaction and reputational damage to the service.	Generic consent forms being used and medical staff offering verbal informed consent. Procedure specific consent forms being reviewed and amended for implementation in Women's services BCUHB.	Introduction and use of procedure specific consent forms
1207	W110 C	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Gardner, Mrs Lorraine	Wynne Jones, Heledd	Neonatal resuscitation not meeting national standard as no piped air	No AIR wall sockets available in the delivery rooms in YGC which is a clinical need as AIR is a default for resusitaires. If oxygen hose is connected to the wall outlet with the AIR cylinder turned on the oxygen blender will bells all the air from the cylinder until empty then alarm. Empty or low cylinders at delivery and resusitaire not set up with AIR and oxygen as recommended	- Included on all safety briefings that both AIR and oxygen valves should be closed and the oxygen hose removed from the oxygen wall socket. - All band 7's aware and vigilant in the daily checks of the current solution	- Raise awareness to all staff on delivery suite and via safety briefings - Posters in the relevant rooms to highlight correction to ensure that cylinders do not empty - training of all new staff and staff transferring from other areas - to be cascaded via local intrapartum forum to the wider team

2523	W146 WS	Women's and Maternal Care (Secondary)		Brown, Mrs Lesley	Giraud, Mrs Fiona	Potential for delayed care provision due to insufficient admin staff	There is a risk for potential delays in care provision caused by vacancies within the administration structure and increased workload of current staff. This could lead to harm to women, increased complaints and litigation and may have a detrimental effect on the reputation of the health board.	Short term - Bank staff and overtime are offered wherever possible. Long term - an administration paper is in draft to mitigate the risks and service expectation however there is no funding within the operational budgets to increase the staffing and an additional pressure of 1% savings being implemented.	Fill vacancies and re-organise workload to ensure efficient administrative support services.
2719	W153 WS	Women's and Maternal Care (Secondary)	Obstetrics - AN(Out-Patients) (secondary care)	Wynne Jones, Heledd	Giraud, Mrs Fiona	Potential for mismanagement of pregnant women with Diabetes	There is a risk that the care of pregnant women with Diabetes may be mismanaged during the intrapartum period. This may be caused by the fact that the guideline has been in production since 2015, was presented to the BCUHB Medicines management group in Q4 2018/ 2019 (prior to going to Drugs and Therapeutic committee) and rejected as the appendices were not clear regarding variation in management across the three obstetric units. This could lead to harm to women with Diabetes, increased complaints and litigation.	There is local guidance available on each site with regards to sliding scale of insulin. The Diabetes team are actively involved in the management of all Diabetic women admitted.	A North Wales Women's guideline to support the reduction of variation in practice across North Wales and to support staff with quality care provision.
2576	W149 W	Women's and Maternal Care (Secondary)	Obstetrics (Secondary)	Farmer, Dave	Wynne Jones, Heledd	Risk of suboptimal perineal repair and potential for perineal breakdown	There is a risk that perineal suturing may be suboptimal and may cause perinael breakdown. This could be caused by the lack of overhead and portable lighting currently available within the delivery rooms. This could lead to increased dissatisfaction and complaints and preventable harm to women.	Portable light to be repaired ASAP Head torches available Women can be transferred to maternity theatre if required and only when theatre is available.	Adequate lighting provision in all delivery rooms

Opened	Target Risk Date Due	Date of Last Review/Update	Risk Rating (current)	Risk Rating (Target)	Risk Type	Risk Subtype	Consequence (current)	Likelihood (current)
01/07/2011	30/09/2019	27/03/2019	9	6	Tier 2 - Directorate	Quality and Safety	Moderate	(possible) Might happen or recur occasionally
01/11/2011	31/10/2018	27/03/2019	12	4	Tier 2 - Directorate	Quality and Safety	Major (high)	(possible) Might happen or recur occasionally

01/10/2013	31/12/2019	27/03/2019	8	8	Tier 2 - Directorate	Human Resources	Major (high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so
21/01/2015	31/03/2019	27/03/2019	16	8	Tier 3 - Divisional	Operational	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue

02/01/2012	31/07/2019	27/03/2019	16	4	Tier 3 - Divisional	Quality and Safety	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue
29/07/2016	31/03/2019	27/03/2019	16	8	Tier 3 - Divisional	Quality and Safety	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue

31/08/2018	30/08/2019	27/03/2019	16	4	Tier 3 - Divisional	Governance	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue
13/07/2018	30/09/2019	14/02/2019	12	8	Tier 3 - Divisional	Quality and Safety	Major (high)	(possible) Might happen or recur occasionally

29/07/2018	01/09/2019	14/02/2019	5	3	Tier 4 - Site/Service	Premises Operational Risk	Catastrophic (very high)	(rare) This will probably never happen/recur
01/05/2018	31/07/2019	22/02/2019	10	5	Tier 4 - Site/Service	Premises Operational Risk	Catastrophic (very high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so
05/03/2019	30/06/2019	05/03/2019	9	6	Tier 4 - Site/Service	Operational	Moderate	(possible) Might happen or recur occasionally

07/03/2019	30/06/2019	07/03/2019	9	3	Tier 4 - Site/Service	Operational	Moderate	(possible) Might happen or recur occasionally
10/04/2019	30/09/2019	10/04/2019	9	3	Tier 4 - Site/Service	Operational	Moderate	(possible) Might happen or recur occasionally
04/04/2019	31/07/2019	10/04/2019	12	6	Tier 4 - Site/Service	Operational	Moderate	(likely) Will probably happen/recur, but it is not a persisting issue

10/09/2018	01/07/2019	13/02/2019	8	4	Tier 4 - Site/Service	Infection Control	Major (high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so
28/09/2018	31/12/2019	14/02/2019	6	3	Tier 4 - Site/Service	Population Health	Moderate	(unlikely) Do not expect it to happen/recur but it is possible it may do so

15/01/2019	01/08/2019	14/02/2019	12	4	Tier 4 - Site/Service	Reputational, Ethics & Responsibility	Major (high)	(possible) Might happen or recur occasionally
27/12/2018	03/06/2019	13/02/2019	16	4	Tier 4 - Site/Service	Quality and Safety	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue

02/02/2019	31/03/2019	01/02/2019	15	6	Tier 4 - Site/Service	Human Resources	Moderate	(almost certain) Will undoubtedly happen/ recur, possibly frequently
24/04/2018	31/12/2019	11/02/2019	6	3	Tier 4 - Site/Service	Operational	Moderate	(unlikely) Do not expect it to happen/recur but it is possible it may do so

01/05/2018	30/09/2019	22/02/2019	6	3	Tier 4 - Site/Service	Policy Implementation	Moderate	(unlikely) Do not expect it to happen/recur but it is possible it may do so
01/02/2010	31/07/2019	04/02/2019	9	3	Tier 4 - Site/Service	Quality and Safety	Moderate	(possible) Might happen or recur occasionally

01/08/2013	31/03/2020	14/02/2019	12	3	Tier 4 - Site/Service	Management of Information and Data	Moderate	(likely) Will probably happen/recur, but it is not a persisting issue
26/06/2014	31/12/2019	07/06/2019	9	6	Tier 4 - Site/Service	Operational	Moderate	(possible) Might happen or recur occasionally

08/07/2015	01/07/2019	08/03/2019	9	6	Tier 4 - Site/Service	Management of Information and Data	Moderate	(possible) Might happen or recur occasionally

20/11/2015	01/08/2019	14/02/2019	10	4	Tier 4 - Site/Service	Operational	Minor (low)	(almost certain) Will undoubtedly happen/ recur, possibly frequently
20/05/2016	31/03/2020	13/02/2019	12	4	Tier 4 - Site/Service	Governance	Major (high)	(possible) Might happen or recur occasionally

16/12/2016	31/07/2019	11/02/2019	16	8	Tier 4 - Site/Service	Operational	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue
13/03/2017	31/12/2019	07/06/2019	12	4	Tier 4 - Site/Service	Governance	Major (high)	(possible) Might happen or recur occasionally
13/03/2017	01/08/2019	14/02/2019	12	4	Tier 4 - Site/Service	Governance	Major (high)	(possible) Might happen or recur occasionally

25/07/2017	31/03/2019	14/02/2019	12	3	Tier 4 - Site/Service	Operational	Major (high)	(possible) Might happen or recur occasionally
18/10/2017	02/09/2019	20/02/2019	16	4	Tier 5 - Operational	Operational	Major (high)	(likely) Will probably happen/recur, but it is not a persisting issue
14/12/2017	31/08/2019	11/02/2019	10	5	Tier 5 - Operational	Operational	Catastrophic (very high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so

19/09/2014	31/12/2019	22/02/2019	12	8	Tier 5 - Operational	Operational	Major (high)	(possible) Might happen or recur occasionally
01/07/2013	30/06/2019	22/02/2019	6	3	Tier 5 - Operational	Operational	Moderate	(unlikely) Do not expect it to happen/recur but it is possible it may do so

01/08/2013	31/07/2019	20/02/2019	8	4	Tier 5 - Operational	Premises Operational Risk	Major (high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so
06/06/2018	31/12/2019	14/02/2019	9	3	Tier 5 - Operational	Quality and Safety	Moderate	(possible) Might happen or recur occasionally
16/11/2016	31/07/2019	20/02/2019	9	3	Tier 5 - Operational	Quality and Safety	Moderate	(possible) Might happen or recur occasionally

01/02/2019	01/08/2019	01/02/2019	9	3	Tier 5 - Operational	Operational	Moderate	(possible) Might happen or recur occasionally
15/05/2019	31/07/2019	15/05/2019	8	4	Tier 5 - Operational	Policy Development	Major (high)	(unlikely) Do not expect it to happen/recur but it is possible it may do so
07/03/2019	31/07/2019	07/03/2019	6	3	Tier 5 - Operational	Operational	Moderate	(unlikely) Do not expect it to happen/recur but it is possible it may do so

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Maternity Services Self-Assessment

Date of final completion of this form	17th June 2019

Signed by Health Board representative as a record true to the best of our knowledge:

Name	Job title

Guidance on how to complete this self-assessment form

HIW is undertaking a national review of maternity services throughout Wales. As part of this work, we are asking all health boards to complete a maternity services self-assessment which will inform the review and subsequent inspection activity.

Your assessment will help HIW to understand the degree of insight each health board has into its own strengths and areas for improvement within its maternity services.

Please ensure you provide a written response to each question. Please *do not* simply refer to a document or policy without providing a written summary.

Please note that completed self-assessments will be published alongside HIW's inspection reports and overall national report on maternity services.

Important notes

Please ensure that your completed self-assessment form is returned to Healthcare Inspectorate Wales (HIW) electronically via the Objective Connect secure portal (see Annex A) **by no later than 17 June 2019**. If you are experiencing difficulties with Objective Connect, please contact HIW as soon as possible on 0300 062 8163.

No.	Question	Health Board response
1	Describe the process for identifying, assessing, escalating, and managing risks. In your response, please also consider: - How you actively engage and listen to staff to ensure any concerns/ issues escalated are appropriately captured - How you ensure that staff receive feedback on actions taken in light of concerns received.	There are robust governance procedures in place to ensure open reporting of incidents and the Women's Directorate has a 'MUST' list that ensures staff are aware of specific incidents that are mandate to report via Datix. The Directorate also has a Risk Management Strategy to compliment the Health Board strategy.  Women's Risk Management Guide  ACE MUST LIST docx September 2018 vers The midwifery Governance team allocates all individual Datix to a named handler at 09.00hrs each weekday morning to the identified leads. The leads will be required to investigate and action their Datix in a timely manner and currently, the Women's Directorate is reporting in real time.  CR Team v6.docx  Women's Directorate Datix Prc All incidents are also reviewed at weekly teleconference meeting, to which the Neonatal Service Manager for North Wales and a member of the corporate concerns team are invited to attend. There are also weekly Datix incident meetings on each site, when any significant issues are reviewed by a multi-professional team. All serious incidents are reviewed within 72 hours, or as soon as possible afterwards and any serious incident reporting requirement to Welsh Government (WG) is undertaken by the midwifery Governance Team. There is currently one WG incident open which is not overdue. Following a rapid review of an incident, if further investigation is required, a panel external to the maternity unit in question will be put together and as per Each Baby Counts, MBRRACE and Duty of Candour, the family invited to put forward any questions that they may have for consideration. Should the incident be that of a Stillbirth or early neonatal death (NND), the MBRRACE Perinatal Mortality Review Tool (PMRT) is completed as part of the investigation. Any significant risks will be entered onto the Women's Risk Register with the agreement of the Director of Midwifery & Nursing services. Risks for further escalation to Secondary Care or

No.	Question	Health Board response
		Health Board Registers are discussed at the relevant Governance meetings as detailed in the Committee Structure. Risk Escalation process.docx Womens committee structure amended . The Risk Register is reviewed and updated at the Women's Quality, Safety & Experience subgroup and Women's Board on a quarterly basis and then is escalated for review at all Health Board Governance meetings. Complaints are managed via similar processes and the management of concerns has significantly improved being almost real time. Monthly staff 'drop in' sessions are undertaken across North Wales by the Senior Leadership Team. This ensures staff engagement and involvement in plans for development, strategy updates and open discussions with regards to staff concerns. There has also been an action plan produced following the feedback from staff received in the 2018 staff survey report. Womens Directorate Staff Su STAFF DROP IN SESSIONS - Poster 2 The Directorate also works in partnership with the Royal College of Midwives Rep, who sits on Women's Workforce & Organisational Development Group and Women's Board. The Rep also attends the Health Board Partnership Forum and is therefore able to communicate staff concerns and Health Board/Directorate responses to and from staff. Clinical Supervisors of Midwives also report staff concerns raised within Group Supervision sessions to their line manager and the Director of Midwifery at monthly supervision meetings. Learning is shared in a variety of ways inclusive of a lessons learned template, memo's, one to one feedback and at risk, audit and perinatal mortality/morbidity meetings. Appropriate elements of learning are also escalated to BCU Board via the Governance Committee Structure. Learning is also shared nationally through various forums. There is also capacity for staff to request feedback when submitting a Datix and a screen shot of directions on how to do this, has been

No.	Question	Health Board response
		widely circulated for staff information. Following the investigation of any serious incident, any staff member who contributed to the evidence collected via a statement, will receive an executive summary of the final investigation report, to ensure they are aware of the outcome findings and lessons learned. Datix feedback.pdf what happned 44 LIR feedback NOT C(

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Maternity Services Self-Assessment

Date of final completion of this form	17th June 2019

Signed by Health Board representative as a record true to the best of our knowledge:

Name	Job title

Guidance on how to complete this self-assessment form

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No.	Question	Health Board response
2	What do you see as the key strengths and/or good practice areas within your maternity services?	The Women's Directorate has identified areas of good practice within Women's Services as follows: **Midwifery workforce planning** The Directorate are Birth Rate Plus compliant and undertake a review of birth rate plus locally on an annual basis as well as completing the full exercise every three year. All vacancies have been filled and attracted midwives nationally and from the UK. All Matrons are required to rotate across the inpatient and community areas on a three yearly basis, to ensure a fresh eyes approach for all clinical areas and for professional development and succession planning. Staff rotation is also in place, as are developmental posts. These posts offer staff the opportunity to experience working in senior posts within the Directorate on a temporary basis, enabling them to make informed choices with regards to their chosen path for career development. **Culture and Clinical leadership** Following de-escalation from special measures all senior leadership posts have been filled on a substantive basis. There has been significant investment in the senior teams with training in clinical leadership to enable strategic direction, teamwork and a positive culture. The attachment below details some of the work undertaken. The Directorate has also been allocated a named Executive Lead under the remit of Public Health. SKM_C45819060712050.pdf **Clinical Supervision for Midwives** The new employer led model of supervision has been successfully implemented and has had extremely positive results within Maternity Services. The Clinical Supervisors for Midwives (CSfM) have succeeded in embedding a supportive and coaching culture, which has become a recognised asset by all healthcare professionals within the Directorate. The CSfM Team also deliver a teaching session for staff on the introduction to enhanced communication skills, which involves listening to women, use of effective questioning, non-verbal communication and coaching skills.

No.	Question	Health Board response
		Introduction to Advanced Communi All staff are offered an immediate debriefing session following any significant incident. Should further support be identified by the senior team on duty, the matron will organise a further debriefing session with support from experts within the Occupational Health Department. **Partnership working** The Women's Directorate work in partnership with Safeguarding, Children's Services and Public Health strengthening communication and Governance processes. Public Health are currently working with Women's and Children's Services to complete a thematic review of all Stillbirths and Neonatal deaths in 2016, to monitor for trends and to ensure any learning is shared. The Directorate also work in partnership with Local Authority on the First 1000 Days projects. The Women's Directorate has also worked closely with the Information department to develop a dashboard, published via IRIS, the Health Boards Information Reporting Intelligence System. This provides a comprehensive summary of quality, safety and performance indicators with various degrees of granularity to various staff groups within the service and across the organisation. The Women's Directorate is aware of the performance of all its commissioned services and is working in partnership with the Health Board Commissioning Team, to ensure the same level care for all women, wherever they deliver **Monitoring of Women's Services Written Control Documents (WCD)/Policies** There is a WCD group that monitor the renewal dates of all North Wales WCD/Policies. The Women's Directorate forums are also used to review the draft WCD as expert panels of professionals; • Intrapartum forum • Antenatal forum The group admin support ensure all new WCD are uploaded onto the intranet and old WCD removed and archived to maintain patient safety by ensuring only the most up to date evidence is utilised by staff.

No.	Question	Health Board response
		WCD flowchart V5 amended 13.05.16.p **Governance** Significant progress has been made over the last 12 months with the management of incidents and complaints, which has been recognised and commended by the Health Board. There is currently only one Welsh Government reportable incident open, with regards to a delivery in commissioned services in England. **PROMPT training** PROMPT was introduced by Women's Services in 2017, 12 months prior to the All Wales PROMPT launch by Welsh Risk Pool. The training has improved clinical leadership, team working and situational awareness within Maternity Services. The Directorate aim to achieve 100% compliance with medical and midwifery staff training. For 2018/19. **Annual appraisals** The Directorate are achieving over 95% compliance of annual reviews for all medical and midwifery staff, ensuring support and opportunities for discussions with regards to professional development requirements. **Mandatory training** The Directorate have achieved 96% compliance with midwifery Mandatory Training and 79% compliance with medical staff Mandatory Training to date. **Fetal Surveillance Standards** The national Fetal Surveillance Standards have been implemented from 1 April 2019 and three CTG Masterclasses have been organised to provide staff with the required six hours of face to face interactive training in 2019. **Equality** The Women's Directorate have an equality statement:

No.	Question	Health Board response
		• 'Ensuring the focus on improving health and reducing health inequalities is sustained in the Programme and that the general and specific duties under the Equality Act 2010 are appropriately fulfilled and • Ensuring that Equality Impact Assessment and any other relevant assessment are undertaken in line with statutory requirements, guidance and best practice.' The Health Board have highlighted a Women's equality statement for *Help Me Quit for babies* as a best practice example on the BCUHB website:  2018-09-03HMQfor BabyEqIAV1.doc **Continuity of carer** Community midwifery is consistently achieving 80% continuity of carer for women in North Wales. **Service configuration and triumvirates** The configuration of Women's Services as a North Wales Directorate has ensured improved communication and Governance within the Directorate. The triumvirates for each site attend monthly accountability meetings with the Senior Management Team to discuss progress and risks within their area, and to receive support as requested from the Senior Management Team. **Engaging with Women** Betsi Cadwaladr Women's Directorate want all women and their partners to feel included in the planning and delivery of their maternity care and that they have the confidence in the staff to give them the best care possible. In order to make this happen 'Maternity Voices' was set up in summer 2017 and continues to meet on a regular basis in order to ensure that the voice of all of our patients are heard and that the women and their families are at the centre of everything that we do. It is a meeting which brings together those who provide maternity services in BCUHB and those who use the service. Maternity Voices hears feedback from families who attend their local listening groups which are held twice a year across BCUHB and ensure that their experiences are used to improve and enhance the service that we offer.

No.	Question	Health Board response
		There are also service users on forums within the Directorate inclusive of Women's Board. **New maternity facilities in YGC** A third bereavement Unit opened in YGC this year and refurbishments have included the Alongside Midwifery Led Unit, which is now inclusive of a birthing pool.

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No.	Question	Health Board response
3	What are the key areas you feel need strengthening or improvement?	The Women's Directorate has identified areas for improvement within Women's Services as a result of benchmarking against the HIW and RCOG recommendations for Cwm Taf and are included in the Directorate Improvement Plan: **Medical staffing** Medical staff recruitment continues to be a challenge within Maternity Services and is recorded on the Women's Risk Register (ID 792). All staff groups are monitored daily and recruitment, retention is given high attention. Reliance on locum and agency staff is also monitored on a daily basis and reported upon via the quality assurance committee structure. **Review of patients by a Consultant within 12 hours** The national target set by the RCOG is not being met by Health Boards in Wales, and both national and RCOG discussions have been held by the North Wales Clinical Lead to address this issue. However, the North Wales Clinical Lead regularly issues the role of the on-call consultant (RCOG, 2009) to remind all consultant staff of their responsibilities. good practice responsibility consu **Communication/patient experience** Communication can always be improved upon and is a theme within concerns for Women's Services. CSfM commenced delivery of enhanced communication skills sessions on the Mandatory Training days for midwives in April 2019, and once embedded into the culture, improvements should be seen. There is an external organisation working with the Directorate, Deloittes, to improve communication and the culture and this is a risk that is documented in the Women's Risk Register (ID 128). **Counselling services for bereaved parents** A Bereavement Midwife was appointed in 2018 and she has become the single point of contact for bereaved families. The Bereavement Midwife has enrolled onto a counselling course to

No.	Question	Health Board response
		improve patient experience following the loss of their baby and the risk of not being able to offer counselling is currently on the Women's Risk Register (ID 467). **Ultrasound scanning capacity** A Women's Services and Radiography Task & Finish Group are developing a Business Case to improve ultrasound scanning capacity for antenatal women in order to meet the national recommendations for reduced fetal movements and growth restricted baby's. This is a national problem and has been recorded on the Women's Risk Register (ID 1103). **Breast feeding rates** There is ongoing work to improve the rates of breast feeding within North Wales and the Health Board has a strategy and action plan for developing improvement. BCUHB launched the Infant Feeding Strategy in March 2019. This is a comprehensive document setting out a clear vision to create a supportive culture in North Wales, enabling families to make informed decisions about how to feed their babies to optimise their nutrition, and help develop close loving parent-infant relationships. The Health Board aims to reduce health inequalities and support every child to have the best start in life.  Breast Feeding Summary of action p  BCUHB_Infant_Feeding_Strategic_Plan. **Quit rates of smokers** Smoking Cessation Support Workers are now in place to improve the support available to women in primary care with quitting smoking. This is an area of priority for the Directorate.  Accountability Meeting womens su **Caesarean Section rates** The Caesarean Section (C/S) rate 27.8% remains above the national target of 25% and each site has developed an action plan for improvement, which is reviewed monthly at the Women's QSE subgroup and Board. The C/S rate is a risk on the Directorate Risk Register (ID 117).

No.	Question	Health Board response
		Caesarean Section Site Infection (CSSI) rates Over the past 12 months, the CSSI rate has risen and to address this problem, each site has developed an action plan for improvement, which are reviewed monthly at the Women's QSE subgroup and Board.  YG CSSI Action plan 2019.docx  YGC CS SSI ACTION PLAN APRIL 19 final.  Wrexham CS SSI_action_plan_Eas **Early pregnancy care** A Task & Finish group has been set up to look at early pregnancy and recurrent miscarriage services across North Wales. This will ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage. **A centralised antenatal clinic in YGC** To ensure women have access to care close to home and to provide an environment suitable for multi-professional care provision, a centralised clinic is required in the central area of North Wales, which is part of the Estates Strategy.

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No.	Question	Health Board response
4	Briefly describe and assess how women are supported with their birth choices.	A new support initiative has recently been launched across BCUHB. BRAIN (Benefits, Risks, Alternatives, Intuition and Nothing) is a simple acronym that can help women to make informed decisions during pregnancy, birth and the early parenting years. Specific BRAIN cards have been distributed to community midwives and given to all pregnant women at clinic appointments. Posters have also been displayed in all of the Maternity Assessment Units. All women are given a Birth Choices leaflet which details the four options of place of birth: • Home • Freestanding Midwifery Led Unit (MLU) • Alongside MLU • Obstetric Unit The leaflet details benefits of birth place choice and offers contact details should place of birth not be supported for pregnancy related reasons. The Consultant Midwife also delivers training to staff on their annual Mandatory Training days detailing how to promote normality for women in their care, enabling them to make appropriate choices for place of birth. In response to suggestions raised within Maternity Voices, a Birth Afterthoughts de briefing service was set up in October 2018. Following their baby's birth, all women are given an information card with details of how to contact Birth Afterthoughts should they want to talk about their experience or have unanswered questions. In the first four months the Directorate have seen over 30 women and their partners and have received positive feedback on this service. Birth Choices Leaflet PRINTERS VE Normality mandatory session 2 Birth Choice clinics have been established on all three sites to: • Enable women to discuss the benefits and risks of Vaginal Birth After Caesarean Section • Discuss their options for place of birth

No.	Question	Health Board response
		• Support women in writing birth plans The clinics are run by the Consultant Midwife and Midwifery Led Unit lead midwives and support the promotion of normality.

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5	Briefly describe how high risk women are identified and managed i.e. antenatal, intrapartum and postnatal. Please also describe the extent to which you consider these services to be adequate. If you have identified areas of service which are in need of development, please identify these and explain what you are doing to address this.	In collaboration with the woman and her family, the role of the lead professional is to plan, provide and review pregnancy care from the antenatal assessment through to the end of the postnatal period. In most circumstances, a midwife will be documented as the lead professional for all healthy women with normal low risk pregnancies following completion of a risk assessment at the booking appointment (booking risk assessment tool). However, where the midwife deems that the woman requires an urgent/early review by the Consultant Obstetric Team she will secure a consultant clinic appointment. Following the woman's review, the Consultant Obstetric Team will record a comprehensive plan of care in the AWHHN. The plan will include whether the woman is to remain Consultant Led Care for the remainder of her pregnancy, whether she can return to Midwifery Led Care or whether her care is to be shared with the Community Midwife. If the midwife is to share care, a detailed schedule of the community midwifery visits will also be detailed within the obstetrician's plan of care. A risk assessment will be undertaken by the midwife at each future appointment using the *Risk factors Identified during pregnancy* form, as per the BCU Midwifery Led Care Guideline, to determine if Midwifery Led Care / Consultant Led Care remains appropriate. The woman's risk status is documented in the All Wales Hand Held Notes (AWHHN) at each antenatal visit. The All Wales Midwifery Led Care Guidelines are also utilised to support care provision.  ML guidelines final draft 30 12 2015 PDF  MLC Revised 2019 Final Ratified QSE &  Version 1 Initial Referral-Booking Ri:  Version 1 New Risk Factors Identified D Where anomalies are identified on obstetric ultrasound scan, a woman may require referral to Fetal Medicine Services within the Women's Directorate. Should the Fetal Medicine Specialists deem the woman requires monitoring under their care, this will be clearly documented in the AWHHN and future appointments made. Should the lead professional identify past or present mental health issues, a referral to the Perinatal Mental Health Team will be made via the Single Point of Access and a care plan will be filed in the woman's AWHHN to ensure effective communication and multi-professional care

No.	Question	Health Board response
		provision. Referral may also be made in the postnatal period via the same process and a care plan be made available in the postnatal notes. The Health Board has also invested in Safeguarding Midwives and a Drug & Alcohol Midwife to further support the provision of care to these high risk women. Women who have co-morbidities such as Diabetes will receive joint care from the Obstetric Team and the relevant Medical/Surgical Team. All appointments and care plans will be clearly documented in the AWHHN and postnatal notes for the duration of the woman's episode of care, ensuring seamless care. During the intrapartum period, the named midwife caring for the woman in labour is responsible for identifying any deviation from normal. If labouring at home or in a freestanding birthing unit and there is an identified deterioration in maternal or fetal wellbeing, the woman would be transferred to the nearest Obstetric Unit via ambulance. If the woman is labouring in an alongside Midwifery Led Unit she would be transferred to Labour Ward for review by the Obstetric Team and if birthing in the Consultant Led Unit would be referred to the Obstetric Team for review and assessment. Integrated Care Pathways are used to ensure care provision for high risk women is standardised at a high standard across North Wales. 10.09.18 -V 6.5-3rd and 4th degree tear Emergency Ceasarean Section I Whilst a high standard of care is provided to high risk women and feedback is very positive, the Directorate have identified the following areas for improvement: • **The most unwell women are seen initially by a consultant within 12 hours** Currently the service is working to a 24 hours timeframe and improvement is required with resident consultant cover to meet 12 hour NCEPOD recommendation.

No.	Question	Health Board response
		• **Fetal Medicine Service** A Task & Finish Group has been established to review the current Fetal Medicine Service across North Wales to identify clinically sustainable and safe services for the future delivery of the service. • **Joint antenatal clinics** Further work is required to provide joint medical/surgical and obstetric clinics to enhance patient experience.

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No.	Question	Health Board response
6	Briefly describe and assess the level of postnatal care you currently offer to women. In your response, please also consider: - Unicef Baby Friendly Standards (skin to skin, breastfeeding support) - Baby care advice / support - Bereavement support - Mental health support.	Postnatal care is provided in the hospital and community settings. All three Maternity Units have been successful in achieving Baby Friendly accreditation and following re-accreditation of one of the Maternity Units later this year, Women's Services will be applying for the Gold Standard. The Neonatal Units are applying for accreditation this year. There are two Infant Feeding Co-ordinators in post to offer both women and staff with breastfeeding advice. The midwives also provide additional support and run a tongue-tie clinic, to further assist babies with feeding. Midwives in both hospital and community are trained to complete Examination of the Newborn, delivering Midwifery Led Care in the postnatal period and supporting early discharge home and continuity of carer. Maternity Support Workers (MSW) have been employed in both primary and secondary care and provide support and education to mothers with regards to all aspects of baby care including support with breastfeeding. All MSW and midwives also receive annual training with regards to breastfeeding and BFI standards, ensuring consistent advice and support is provided to parents. Women in Flying Start areas are able to access additional support as required with parenting skills. Provision of care for teenage mothers across North Wales is allocated to a named community midwife in each locality, with the aim of providing accessible, quality evidenced based care to all women irrespective of social circumstances. The recently appointed Bereavement Midwife is the single point of contact for bereaved families and provides extended visiting in the postnatal period to ensure families feel supported and have a familiar person who can accompany them to follow up appointments with their consultant obstetrician as required. The Bereavement Midwife will follow up any queries that families have on their behalf and will be the family's link with the midwifery Governance Team during the investigations undertaken into the care provision that they received. The environment for Bereaved families has been addressed and improvements made on each Maternity unit.

No.	Question	Health Board response
		The Bereavement Midwife also provides support to staff on bereavement care and delivers Postmortem consent training and link bereavement staff training to ensure consistent advice and information is given to families at a very emotional time. The Directorate have also developed Bereavement Pathways to further support staff and to standardise care at a high quality level.  Mat 12 Perinatal Bereavement Protoc  BCUHB Bereavement Pathw. The Health Board have appointed a Perinatal Mental Health (PMH) Team to ensure that women with identified mental health issues are referred for appropriate care. The Team have developed a PMH operational policy to support staff with the referral process and the PMH midwife provided training on the mandatory training days to all midwives on PMH and referral processes during 2018.  MHLD 0029 Perinatal Operation. The PMH Team also work in partnership with the Safeguarding and Dug & Alcohol midwives to ensure holistic care provision. Whilst a high standard of postnatal care is provided and feedback from women is very positive, the Directorate have identified the following areas for improvement: • **Communication/Handover of care** A small number of postnatal discharges from the hospital are not handed over to the community in a timely fashion and the inpatient matrons are reviewing the discharge processes locally with ward managers to prevent further occurrences. • **Breast feeding rates** There is a breast feeding strategy and associated action plan to support improved rates of breastfeeding mothers in the next three years.

No.	Question	Health Board response
		• **Counselling for bereaved families** As the Bereavement Midwife is not a trained counsellor, she is only able to offer support and referral to counselling organisations at present. To address this she has enrolled onto a counselling course commencing later this year. • **PMH training** The discontinuation of training on the Mandatory Training days for midwives in 2019 has been added to the Women's Risk Register (ID 2690). However, in agreement with the Training Group, time has been allocated for the PMH midwife to provide training to all midwives for a rolling year, every two years and in the interim year she can attend Team meetings in the community and hospital settings to update staff, as agreed with midwifery leads.

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7. Additional Comments

Strategy & Service Priorities

The Women's Service operates as a North Wales network, with priorities within the women's three year plan building upon last year's delivery plan and those identified in the Health Board's clinical strategy 'Living Healthier, Staying Well'.

The Welsh Government Maternity Strategy will be launched in July 2019 and will also influence the Service's priorities for 2019/22, which are based around three key areas:

1. Maternity Services & Community Model
2. Gynaecology & Specialist Services
3. Family Centred Care – First 1000 Days (shared priority with Children's)

Integration with other transformation / improvement groups and enablers as key to the plan as outlined below:-

The Directorate has benchmarked Services against key national documents including the RCOG's standards for providing quality care and for maternity services and more recently against the recommendations made by the Colleague following their review of maternity services in Cwm Taf. Identified areas for service improvements have informed a three year plan and the service priorities for 2019/20. Please see summary below;

Performance against the plan is monitored quarterly against key milestones by the Strategy, Partnership & Population Health Committee of the Board.

De- escalation of the Service from Special Measures & Ongoing Monitoring

Maternity Services in BCUHB were placed in Special Measures in 2015/16. The areas under scrutiny included Culture, Clinical Leadership, Workforce and Compliance with Mandatory and Statutory Requirements. Following extensive support from the Board and a HIW Unannounced Inspection of the Maternity Unit in Ysbyty Gwynedd, Services in North Wales were formally de -escalated from Special Measures in January 2018.

Following de-escalation the service has continued to be monitored closely and an assurance framework with monthly monitoring meetings have been introduced and continued within the Women's Directorate to support the internal scrutiny on services across the three acute sites and into the three community areas. The service is also held to account via the Health Board's accountability and governance framework and committee structure to the Board.

In relation to the areas that were of focus whilst in Special Measures the following serves as an update;

Culture

This remains an area of intense focus and ongoing investment. Deloitte continue to support the Women's OD Strategy as the service moves into phase3 of the overall plan (phase1 = a diagnostic phase / phase 2 = implementation of the recommendations made in phase1). Phase 3 includes ongoing developmental support specifically to the newly appointed Clinical Directors, the overall and site leadership teams, working on areas for improvement as identified in; Staff Surveys including Deanery & GMC surveys, in team 360 feedbacks and directly from staff engagement sessions.

The Directorate has also secured ongoing support from the Corporate OD Team as part of the plan who will continue to work with the senior leadership team, equipping them to manage, develop and support their teams across North Wales.

The Service continues to work collaboratively with colleagues at the University and with the RCM working on measures to continually improve the learning environment for all staff working within the service.

Medical Colleagues continue to complete the RCOG on line package in Undermining Behaviour as part of their specific training requirements and all staff including student midwives are required to attend the STOP (**S**tart **T**reating **O**ther **P**ositively) sessions which again is a collaborate piece of work which support the Women's overall OD Plan.

Progress against the Directorate's overall OD Plan and outputs is monitored at the Women's OD Monitoring Group and updates are provided to the Women's Service Board and to the Health Board via QSG and QSE Sub Committee.

Clinical Leadership

Having been de-escalated from Special Measures all interim/ temporary posts have been substantively appointed to within the Women's Leadership Structure that includes the appointment of the Clinical Director/ site and the Women's Clinical Lead for North Wales. Part of the Directorate's overall W&OD strategy is to support clinical leadership opportunities both locally and nationally at all levels within the Service. Currently we have clinical colleagues supporting several national project including the PROMPT Wales rollout, the All Wales Fetal Surveillance competency assessment work, advising and undertaking strategic roles within the Network.

Workforce

As previously noted the Service is Birth Rate Plus compliant with a low staff turnover factor and able to recruit from outside North Wales. The next full BR Plus audit and assessment is scheduled for Q2 and will inform our Workforce Planning and establishment setting in Q3/4 for 2020/21.

Whilst Medical recruitment remains a challenge for the Directorate, the reliance on medical agency and locum has significantly reduced over the past 2 to 3 years, from 55% reliance to between 8-11%, with the introduction of the Resident Consultants across all 3 sites. Reliance on agency and locum staff is monitored daily and weekly via the Maternity Workforce Daily KPI Dashboard.

Compliance with Mandatory & Statutory Requirements

This element included training and workforce governance. As previously noted the Directorate's compliance with training, PADR and appraisals is high and is monitored weekly and monthly at the Women's Workforce and OD meetings. The Directorate updates its Training Needs Analysis on an annual basis and any learning informs the process. PROMPT was introduced locally ahead of the national roll out as part of our Culture and Leadership OD plan whilst in Measures.
The Directorate is currently implementing the All Wales Fetal Surveillance Standards; having supported 1 masterclass with another two scheduled this year.

In addition to the areas identified above the Directorate has also invested in other key area;

Governance

Over the past 2 years the Directorate has strengthen its Governance structures and systems and invested in the team. The Team is led by the Clinical Risk & Governance Lead for the Directorate and includes Risk Leads, Professional Development Leads, Clinical Supervisors of Midwives, a Bereavement Lead, Improvement Midwife and Medical Risk Leads. This investment has seen an improvement in the Directorate's overall performance, with an ability to now investigate and report in real time, allowing the Service to close the loop in any learning from any events whilst able to support Women and their Families in the process.

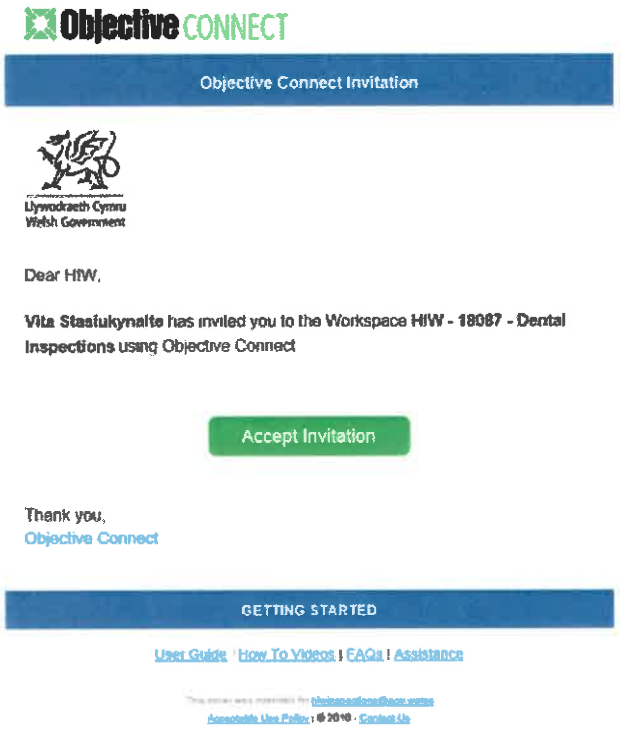
User Engagement

This is an area where again the Directorate has focused its energy with the introduction of the Maternity Voices group, working with local support groups, SANDS & the Fair Treatment for Women in Wales Group. Service user representatives sit on our numerous task and finish groups working with service leads to review, and prioritises service developments in North Wales.

In Summary the Women's Directorate with key stakeholders, including Women and their Families, strive to develop and continuously improve services to reflect local and national learning and guidance to ensure services are safe in North Wales.

Annex A

Secure File Sharing - Objective Connect - Step by step guide



Please accept the invitation received from Objective Connect and sign in with your usual user name and password

The easiest way to return your comments through Objective Connect is to:

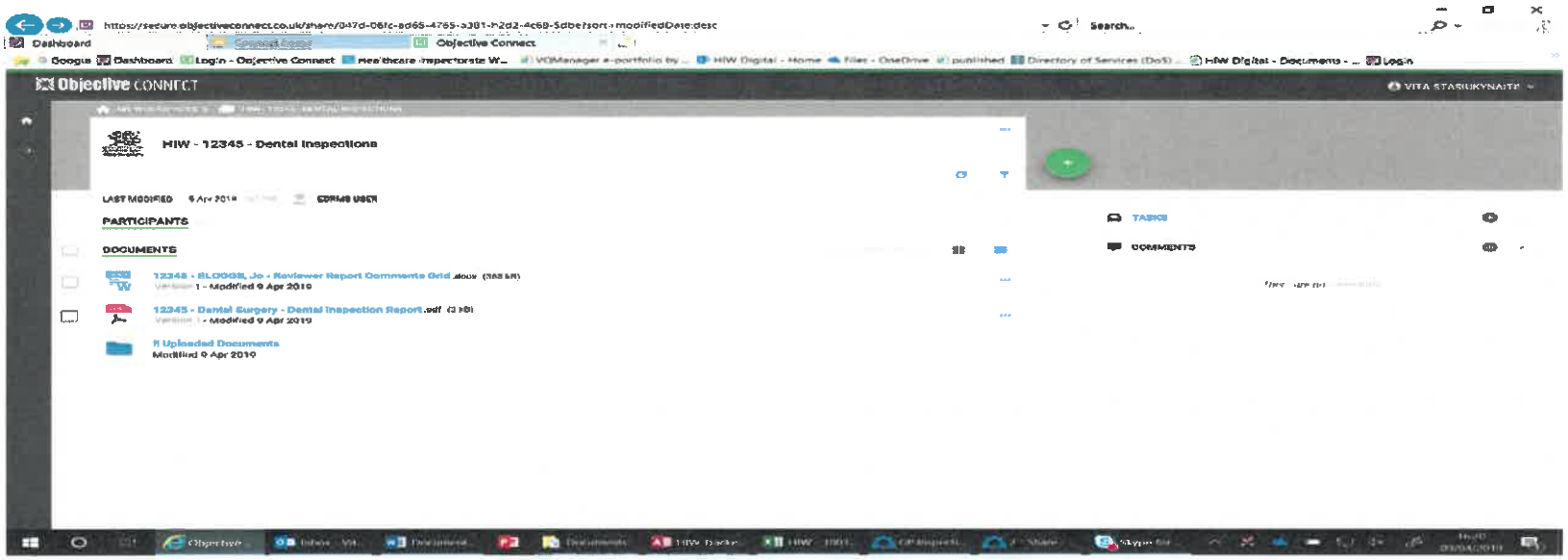
- Download the report and the comments grid
- Complete your comments grid on your device
- Upload a new version on Objective Connect

We will automatically receive a notification once you uploaded your comments.

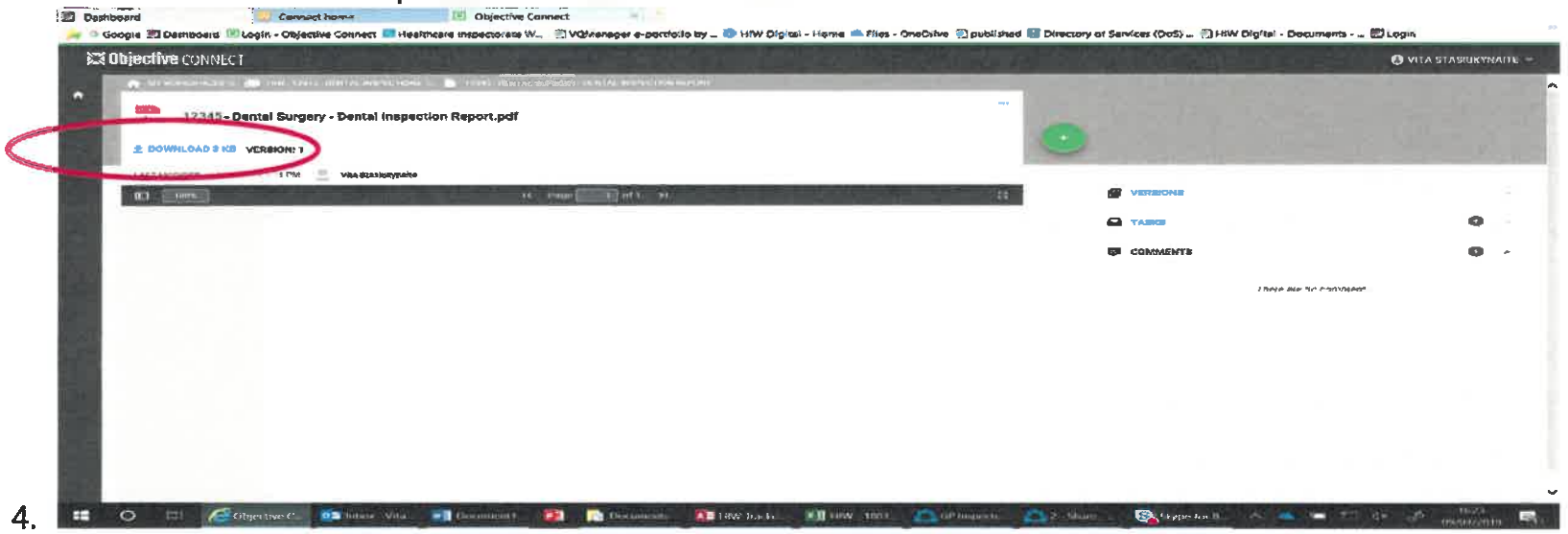
"How To" videos can be access by clicking on the attached.

Downloading documents

1. Click on my workspaces and then the workspace you want to access



2. Click on the inspection report
3. Click "Download" button at the top left



4.

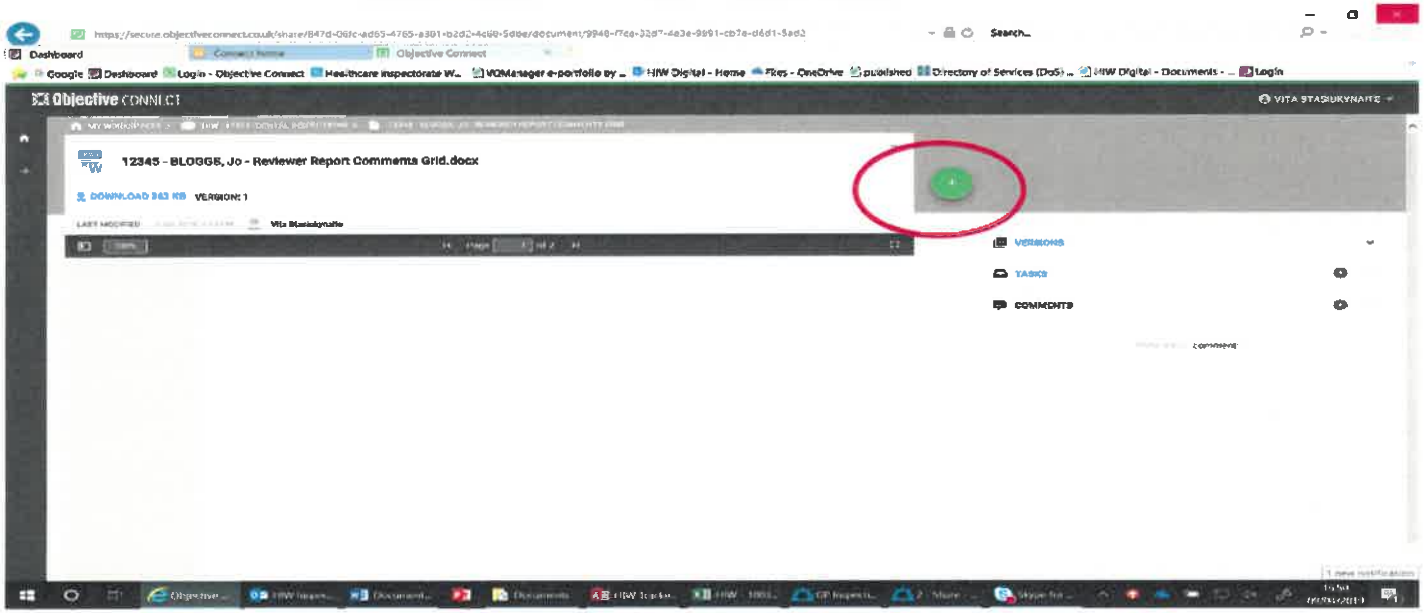
5. Click on Reviewer Comments Grid
6. Click on "Download" button at the top left

Completing your comments grid

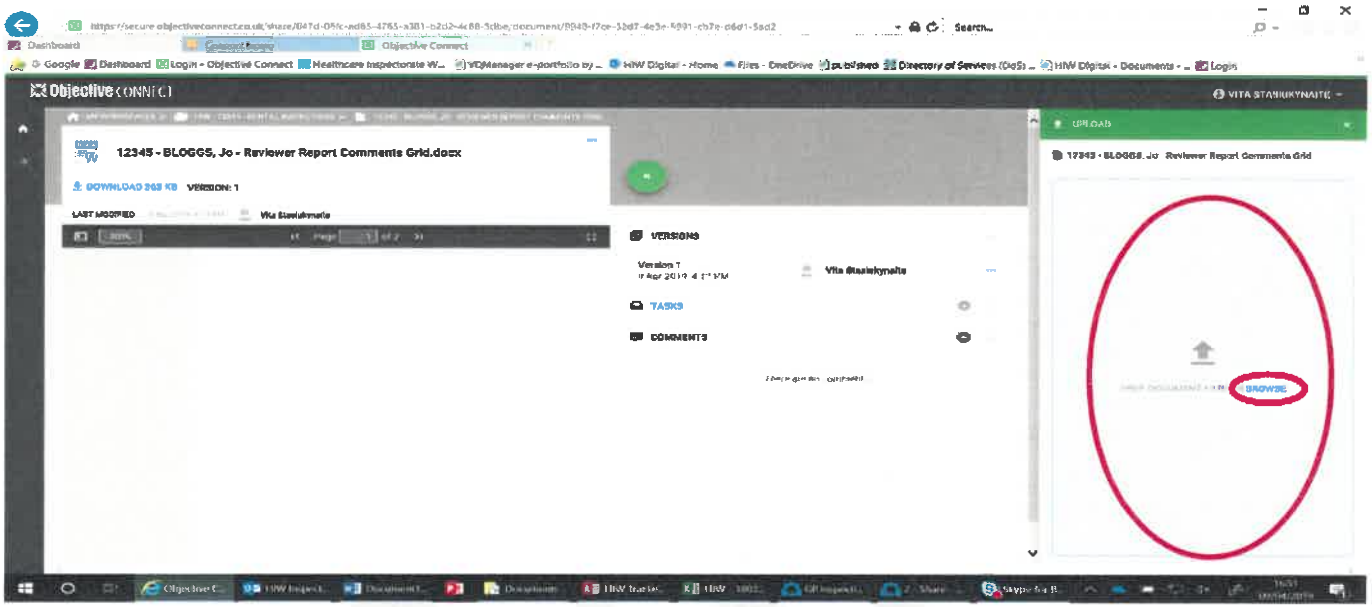
7. Go to downloads area on your device. You can now read the report and complete the comments grid.
8. Once you completed your comments grid, save it on your device.
9. Delete the report from your device. Don't forget to delete it from the recycle bin too.

Uploading a new version on Objective Connect

10. If you are not in Objective Connect, log into your Objective Connect account
11. Open the workspace
12. Click on your comments grid
13. Click green "+" button at the top right

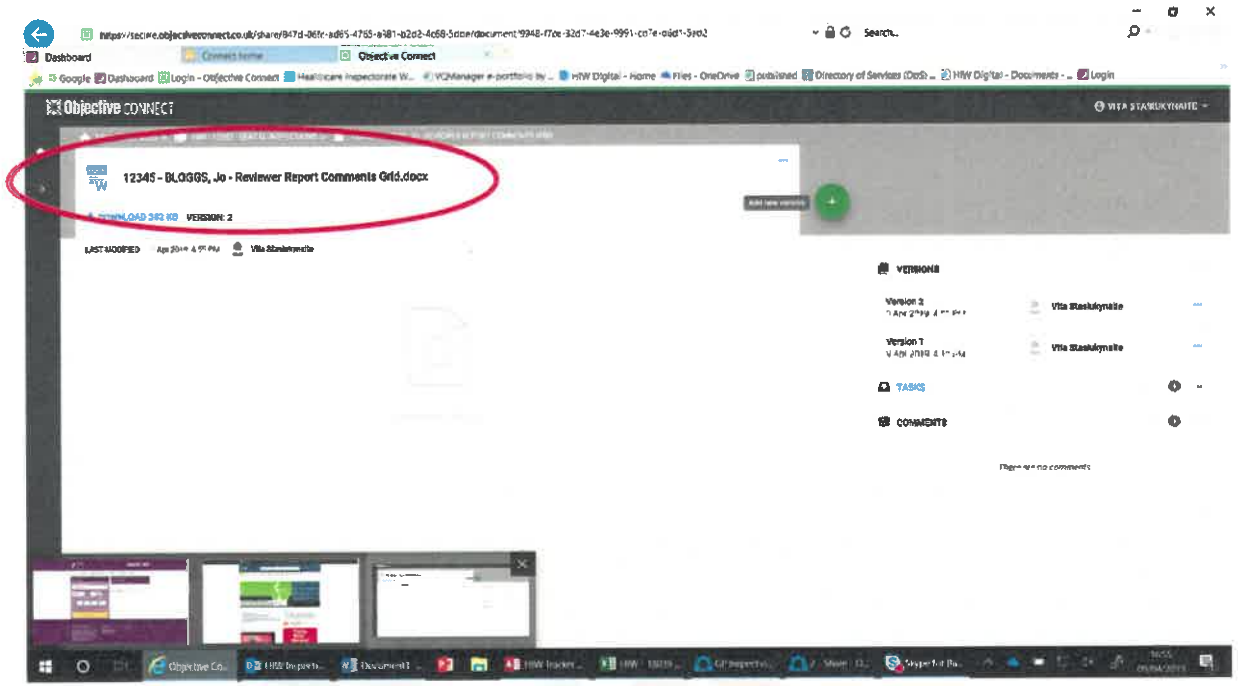


14. Drag and drop your grid to the "Upload" window or select the document by using "Browse" function



15. You have now uploaded a new version of your comments grid to Objective Connect. We will receive an automated notification.

HIW - Maternity Services Self-Assessment – June 2019



APPENDIX 3

Betsi Cadwaladr University Health Board

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

Women's Directorate Review of Concerns Pertaining to Patient Experience

Situation

Following publication of the Royal College of Obstetricians & Gynaecologist's (RCOG) report of their Review of Maternity Services at Cwm Taf Health Board in April 2019, BCUHB received correspondence from North Wales Community Health Council (CHC) informing the Board that a review of their concerns caseload found a surprising and unexpected number of concerns around patient experience. Of the twelve concerns reviewed, 11 were noted to be within the past 12 months. Twelve CHC caseload reference numbers were shared with BCUHB and on further review it was established that 11 of the 12 had been received in the Health Board and investigations completed or in the process of being completed. The Listening to Women and Families about Maternity Care in Cwm Taf, a report of outcomes from engagement to inform the RCOG Review of Maternity Services in Cwm Taf, states that in a three month period the voices of over 140 women were heard.
In Summary, of the engagement with Women and their Families in Cwm Taf it was found that Women did not feel that they;

- Had been treated with respect or listened to
- Provided with information they needed, or supported in their choices.
- Given the care and support they required – with the right level of skills and expertise.
- Offered continuity and consistency of care.
- Provided with support and bereavement counselling in an appropriate environment of care.
- Were dissatisfied with the way concerns were addressed.
- Felt that the Service was not designed around them and their families.

In light of the two RCOG Reports and concerns raised by the CHC the Women's Directorate undertook an in depth case review and analysis of the 11 concerns, to ascertain if there were any emerging themes pertaining to patient experience in BCUHB, that reflected the findings of what Women reported in the RCOG review.

Background

All concerns received in the Womens Directorate are subject to investigation by obtaining statements from clinicians and all staff involved in the care provision of patients. A weekly meeting is held, between service, the governance team and the corporate patient experience team to review open concerns with the aim of providing a timely response to the patient/ service users. Complaint responses are subject to review by Heads of Service and final sign off is provided by the Director of Midwifery.

Any themes, trends or lessons learned from concerns are shared with all clinical areas across the Womens Directorate and included on the agendas for the Quality, Safety and Patient Experience group, Risk and Perinatal Morbidity/Mortality meetings. Where appropriate lessons learned are also shared nationally, via the Heads of Midwifery Advisory Group.

Assessment

On review of the 11 cases presented by CHC the following themes/trends were identified:

- 6 suggested that the patient had experienced a negative staff attitude noting two of these related to other specialities.
- 8 of the 11 demonstrated there had been poor communication as part of the patients pathway, noting two of these related to other specialities and 4 related to inadequate handover between internal staff
- 2 of the 11 highlighted some issues with documentation, although the majority was reported as more than acceptable and two of the cases had excellent documentation.
- 1 of the cases highlighted that a placenta was not sent to the Pathologist in Cardiff despite the patient being asked to return to the unit to re-complete the documentation required for submission to Cardiff.
- 2 of the 11 highlighted poor quality of post bereavement care and support.
- 1 involved a date for an ultrasound scan being changed by the ultrasound department without communicating the amended date to the patient, therefore patient missed her appointment.
- 3 of the 11 cases were associated with dignity and respect issues with staff; 1 regarding to waiting area in the ultrasound department; 1 regarding lack of empathy from a medical member of staff and 1 pertaining to a midwife asking a lady's partner to go home when patient transferred to the postnatal ward.

Having undertaken this assessment and reflected on what Women in Cwm Taf highlighted, there are definite local themes that mirror the RCOG's findings.

They include:

- Women not being treated with dignity and respect.
- Not communicated with effectively and with empathy.
- Quality of Bereavement Care offered to Women.

In response, all staff are supported to attend STOP Session per annum. STOP – stands for **S**tart **T**reating **O**thers **P**ositively and medical colleagues are also required to complete the RCOG Dignity at Work e-session. The Clinical Director for North Wales has also issued a specific memo in relation to professionalism and dignity at work in all circumstances.

Regarding communication the Directorate has invested heavily in supporting good communication within teams, across professional boundaries and with women and their families. Clinical Supervisor of Midwives support reflective sessions and audits to review the effectiveness of communication across all sectors and support an empathetic approach in all communications.

The Directorate is conscious that there is considerable amount of work to be done to be able to support bereaved families appropriately, with dignity, respect and empathy (Please see local update on action under Recommendations).

Please note concerns pertaining to ultrasound have been shared with the department and confirmation received states that their review indicated that songraphers have followed correct procedures, and where appropriate they have taken advice from Antenatal Screening Wales. The ultrasound department conclude that there appear to be no recurrent themes with respect to ultrasound. Ultrasound are currently undertaking work to assess compliance against the Imaging Services Accreditation Schemes as the Welsh pilot site, which covers the whole of the service with

a number of domains including clinical, safety and patient experience. In addition they have recently set up a concerns tracker to look for themes and ensure lessons are learnt, and where appropriate these are shared via the All Wales Imaging Quality Forum.

In addition to the cases identified by CHC colleagues the Directorate has received the following number of concerns in the last 12months:

- Total number of concerns received: 81 of which 3 were a grade 5
- Of the above: 4 were classified as may be or actual qualifying liability and 1 proceeded to a claim.

The overall findings and lessons learnt included the following:

- Communication with patients to include explaining procedures clearly, fully and honestly to patients in a timely manner, in a language that they understand.
- Wording letters sent to patients in a more sensitive manner.
- Consistency of information shared with patients.
- Patient information leaflets to contain up to date information and staff to explain the reason for giving the patient information leaflet rather than just handing the patient the leaflet.
- Attitude of staff.
- Copy of the completed consent form should always be given to the patient.
- Staff should always ask the patient if they require pain relief prior to commencing any form of treatment.
- Appropriate and timely support should be made available for families who require advice following receiving bad news.

Patient Experience Feedback

For assurance feedback was obtained from 1775 patients across Maternity services in BUCHB during the last 12 months, majority of which was positive with patients describing staff as friendly, supportive and caring. Overall, patients stated that they felt listened to and appreciated the communication and information provided by staff and they felt as if they had received good care.

Some of the feedback was more critical and included some points which had been previously positively commented upon:

- Communication with patients and between staff.
- Waiting times for medication/pain relief.
- Patients would like extended/more flexible visiting times for fathers.
- Staff workload, patients felt that more staff was required.
- Ward temperatures and lack of air conditioning on the wards.
- Parking facilities.

All of these comments have been acted upon and escalated if not within the Directorate's ability to directly influence.

Themes from Birth Afterthoughts:

Birth Afterthoughts is a listening service, co-ordinated by a Consultant midwife available to any woman and their partner who have given birth in BCUHB. It is a confidential service and provides an opportunity to discuss and understand what happened during labour and birth. The service is promoted on the BCUHB maternity web page and through information cards given to all new

mothers by their community midwife. Consultant Obstetricians and Health Visitors are also aware of the service and can refer women. The service was set up in November 2018 and on review of the first 6 months the following themes have been identified:

- Majority of women want to piece together the narrative of their birth, usually because of escalating intervention.
- Most women want to tell the service what was great about their care and some want to suggest ways in which care could have been improved.
- It is clear that women put their trust in the midwifery and medical profession and what they want in return is to be included in the decision making process. They are asking for unbiased information.

All positive feedback is disseminated in writing to individual staff. Learning points are written up and used for discussion in staff training and midwifery group supervision and suggestions for improvements discussed with the Leadership teams.

In addition the Directorate works closely with local and national support groups, SANDS and FTWW as examples and have users as members on our service development forums, involved in the planning of services and sit on the Women's various groups and committees.

Recommendations:
Actions taken to aim to Improve Patient Engagement and Experience across Maternity Services in BUCHB in addition to those mentioned previously;

1. **Improving quality of Bereavement care and support:**
   In 2018 a Bereavement Midwife was appointed to improve the support available to women and their families during and following loss of a baby at any gestation of pregnancy. The Bereavement Midwife has become the single point of contact for women and families who experience pregnancy loss and early neonatal death and this has ensured improved communication and emotional support. It also provides direct feedback from families with regards to improvements that could be made in service provision across BCU. The Bereavement Midwife liaises with other care providers involved in bereavement services and this has improved the efficiency and effectiveness of the service as a whole. The Bereavement Midwife provides staff training in obtaining consent for post-mortem examination and the processes undertaken when bereavement occurs. As a result this has reduced the incidence of errors in documentation and may also improve the uptake of post-mortem examination in the future, as per national guidance.

   Comfortable facilities are now in place in the three maternity units for women and their families who suffer loss of a baby, to be cared for in a quiet environment that affords, privacy and dignity A Task & Finish group is in progress, consisting of service users to review patient pathways and environment for women and their families experiencing loss in early pregnancy. A report is to be completed by the autumn making recommendations from this group to improve patient experience in early pregnancy.

2. **Inadequate handover between internal staff**
   It has been identified that handover of clinical care would benefit from a robust review of the process. This work is to be undertaken by the Clinical Leads on each site.

3. **Ensuring that all women who have unplanned intervention are offered the opportunity to discuss the birth with an obstetrician and/or midwife before going**

home De-briefing prior to being discharged from the maternity units is included within integrated care pathways, which are subject to annual audit. Any areas of recommendation are included on site improvement plans and monitored by the relevant Service Forum.

In addition to the above actions, service planning for the future will need to include plans for partners to stay during the postnatal period, particularly if the baby is born during late evening and night time hours.

In conclusion, Maternity Services in BCUHB want all women and their partners to feel included in the planning and delivery of their maternity care by staff that they trust to give them the best care possible. To support this aim Maternity Voices was set up in May 2017. Maternity Voices is a multi-professional committee that brings together those who use, and provide maternity services in BCUHB. The purpose of Maternity Voices is to contribute to the development and provision of quality services which meet the physical, mental, social and emotional health of those who use maternity services in North Wales by ensuring that women and their families are at the centre of all planning. The group meet formally on four occasions per year and plan to develop user engagement to draw up November 2018 was as a recommendation of the Maternity Voices group. 'BRAIN' cards were also introduced and implemented, designed, printed and given to all women at the beginning of their pregnancy to encourage women to ask questions of midwives and obstetricians to so that care is planned in partnership.

Moving forward Maternity Voices have agreed to hold more ad hoc listening events, with particular emphasis on joining in with existing community family centred events across North Wales, Increase the use of social media to both engage with women and families and to promote services. Importantly to use birth stories and feedback from women for maternity services staff to learn lessons.

APPENDICES:

A: CE19-525 - Maternity cases - list of cases received from the Community Health Council

B: CHC review of cases - May 2019

C: Women's Directorate Concerns Summary April 2018-May 2019

D: Maternity Patient Feedback data - East (April 2018-March 2019)

E: Maternity Patient Feedback data - Central (April 2018-March 2019)

F: Maternity Patient Feedback data - West (April 2018-March 2019)

G: Review of Birth Afterthoughts (November 2018-April 2019)

APPENDIX 4

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

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

Mr Joseph Wilton
Head of Partnerships, Intelligence and Methodology
Healthcare Inspectorate Wales

Sent via e-mail:Joseph.Wilton@gov.wales

Ein cyf / Our ref: GD/DC/KKS/CE19-1460/2218
Eich cyf / Your ref:
☎: 01745 448788 ext 6364
Gofynnwch am / Ask for: Dawn Lees
E-bost / Email: Dawn.Lees@wales.nhs.uk
Dyddiad / Date: 29th August 2019

Dear Joseph

I am writing further to your correspondence received on 19th August 2019 in relation to the HIW National Maternity Review.

Firstly, please accept my apologies for the incomplete information submitted by the Health Board in relation to your previous request in June 2019. I am pleased to hear that the information which we provided has assisted you.

Enclosed are the following documents;

- **The Health Board's PMRT- Perinatal Mortality Reviews Summary Report for the period 01/01/2018 to 20/08/2019**

MBRRACE-UK has confirmed to the Health Board that the last surveillance report for births was in 2016 and this was published in 2018. The next report for 2017 births is due out on 15th October 2019, and that the local Health Boards reports generally come out just before the national report.

The enclosed PMRT Report has been generated from the MBRRACE site on 20th August 2019.

- **A Network of services flow map (included in our last submission), now accompanied by a list of Maternity Wards/Units in each site, "BCU-Network Service Flow" chart.**

I do hope that this further assists you. If you require any further information, or if you wish to discuss the documentation provided, please do not hesitate to contact me.

Yours sincerely

Gary Doherty
Prif Weithredwr
Chief Executive

Betsi Cadwaladr University Health Board

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

BCU – NETWORK SERVICE FLOW

Ysbyty Gwynedd – Flows within & into DGH

- OU - 24/7
- AMLU - 24/7
- MOAU - 24hr Assessment Unit
- Llifon Ward - In Patient Ward
- Home Birth - Gwynedd & Mon
- FMLU - Bryn Beryl, Pwllheli

Ysbyty Glan Clwyd – Flows within & into DGH

- OU - 24/7
- AMLU - 24/7
- MOAU - 24/7
- Celyn Ward - Inpatient Ward
- Home Births - Conwy and Denbighshire
- NO FMLU

Wrexham Maelor Hospital – Flows within & into DGH

- OU - 24/7
- AMLU - 24/7
- MOAU - 24/7
- Lawson Tate/Simpson - Inpatient Wards
- Home Births - Wrexham & Flintshire
  - Shropshire Border
- FMLU - Dolgellau (South Gwynedd)
  - Oswestry and Welshpool

Bronglais – Flow into DGU

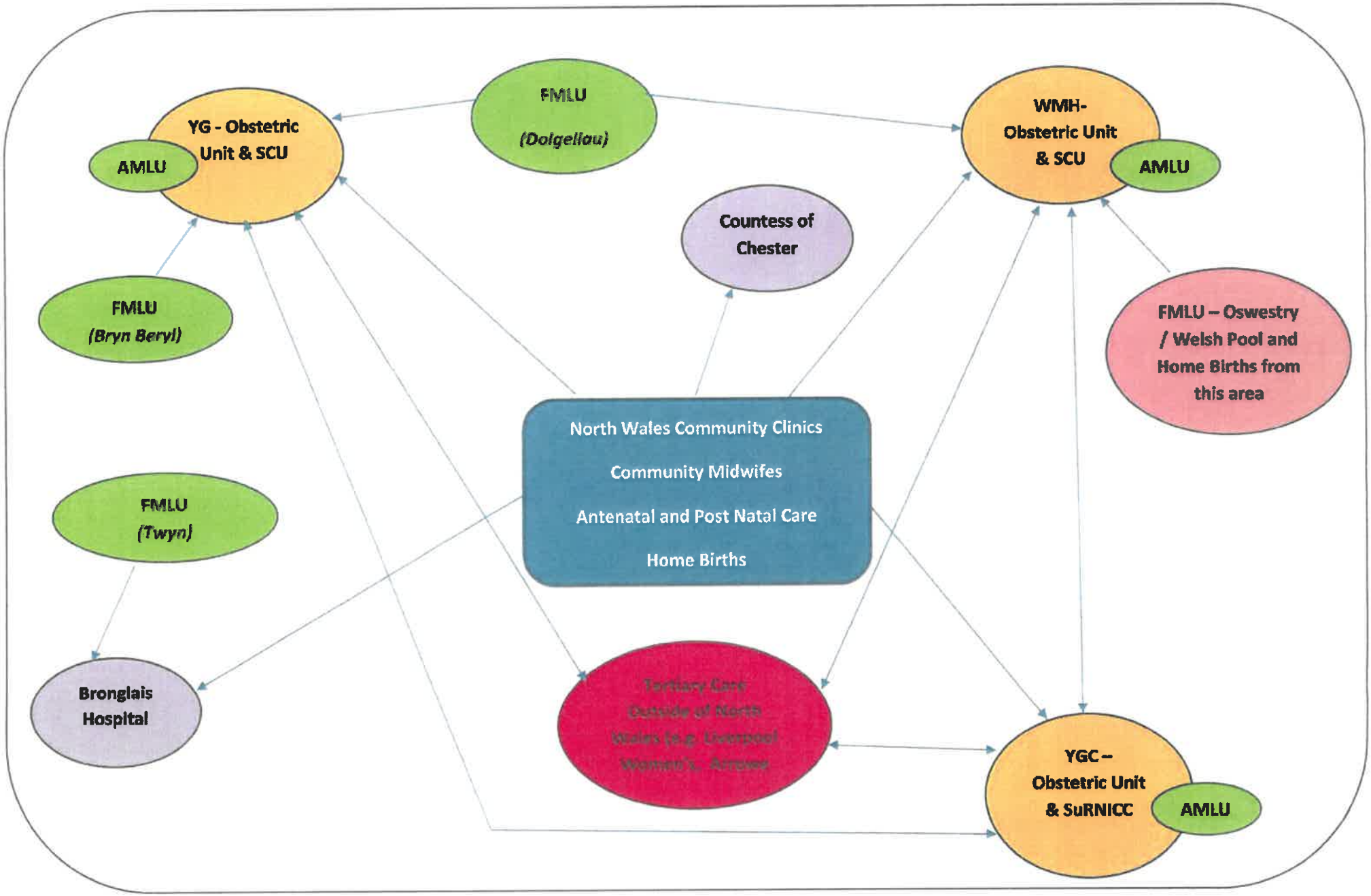
- Patients from Tywyn, South Meirionnydd

Countess of Chester – Flow into DGU

- Patients from the Flintshire Border

KEY
OU – Obstetric Unit
AMLU – Alongside Midwifery Led Unit
MOAU – Maternity Obstetric Assessment Unit
Inpatient Ward – Antenatal and Postnatal Ward
FMLU – Freestanding Midwifery Led Unit

BCUHB - Network of Services and Flow



PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Betsi Cadwaladr University Health Board

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2018 to 20/8/2019

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 57

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
56	16	7	19	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
20	2	4	7	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Report Generated by: Gaynor Lloyd
Date report generated: 20/08/2019 15:14

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 26)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	4	1	8	6	19
Antepartum stillbirths	*0*	*0*	*3*	*1*	*6*	*4*	*14*
Intrapartum stillbirths	*0*	*0*	*1*	*0*	*1*	*0*	*2*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*1*	*2*	*3*
Early neonatal deaths (1-7 days)*	0	0	1	1	0	4	6
Late neonatal deaths (8-28 days)*	0	0	0	0	0	1	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	5	2	8	11	26
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	1	1	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	1	0	1
IUGR not identified prenatally	0	0	0	0	1	1	2
Not Applicable	0	0	5	2	5	9	21
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	5	2	8	9	24
No	0	0	0	0	0	2	2
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	4	2	8	8	22
No	0	0	1	0	0	3	4
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	5	1	6	9	21
Mother transferred before birth	0	0	1	0	0	0	1
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	1	1
Neonatal care re-orientated	0	0	0	1	0	2	3

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 26)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	2	1	6	5	14
No	0	0	2	0	2	1	5
Hospital post-mortem offered	0	0	4	1	8	6	19
Hospital post-mortem declined	0	0	3	1	6	3	13
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	2	1	4
Limited and targeted post-mortem	0	0	0	0	0	1	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	1	0	3	4
No	0	0	1	0	0	2	3
Death discussed with the coroner/procurator fiscal	0	0	1	1	0	5	7
Coroner/procurator fiscal PM performed	0	0	0	0	0	3	3
Hospital post-mortem offered	0	0	1	1	0	2	4
Hospital post-mortem declined	0	0	1	1	0	2	4
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	1	0	2	2	5
No	0	0	0	0	0	1	1
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	2	1	5	3	11
No	0	0	0	0	1	2	3

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

This table has not been generated as participants in the review were not fully identified by the PMRT during the period covered by this report.

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

This table has not been generated as participants in the review were not fully identified by the PMRT during the period covered by this report.

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 26)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	2	0	2	1	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	2	1	4	2	9
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	2	3	5
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	3	0	6	5	14
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	1	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	1	0	0	1	2
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	1	0	1
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	1	1	0	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	2	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	1	1	0	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	2	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	1	1	0	4	6
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	1	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 26)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**19 causes of death out of 19 reviews**
	PM report Clinicopathological correlation: internally there was evidence of extrapulmonary sequestration at the base of the left lung. Histologically there was no evidence of cystic pulmonary airway malformation and this sequestration did not appear to be causing a mass effect. It is therefore unlikely that this has contributed to the intrauterine death. Cytogenetic testing by array CGH demonstrated a normal male hybridisation. There was evidence of hypoxic-ischaemic damage in the brain and a stress response in the thymus gland. The hypoxic ischaemic damage is likely to be the cause of intrauterine death. The placenta showed evidence of distal villous hypoplasia and this would provide an adequate explanation for placental insufficiency leading to the hypoxic ischaemic damage.
	The cause of death was undetermined
	cause of death considered to be placental abruption
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	CODAC 5 Cord conditions, diseases and events (abbrev: Cord)
	Placental abruption
	The cause of death was undetermined
	Placental abruption
	the cause of death at the time of the review was considered to be placental abruption, subsequent post mortem findings found Intrauterine infection to be the cause of death
	placental abruption
	The cause of death was undetermined
	The cause of death was undetermined
	Placental Abruption
	The cause of death was undetermined
	The cause of death was undetermined
	CODAC classification-8- Unknown, unexplained and unclassifiable causes of death. Neonatal, Antepartum, and deaths with unknown timing, in which no definite or probable cause of death has been found are coded in this category as the primary cause of death.
Neonatal deaths	**7 causes of death out of 7 reviews**
	Withdrawal of Intensive Care in view of persisting need for ventilation secondary to to HIE brain damage, this was evident on the MRI. Awaiting post mortem results to see if there were any other contributing factors to this outcome. PM report that "hypoxic- ischemic changes were not of a hyperacute to acute nature, being associated with reactive/evolutionary change consistent with an insult sustained several days to even weeks before death".
	The cause of death was undetermined
	Left hypoplastic heart
	1a Antepatum bleed 1b placental abruption 2aPROM 2bGBS 2c prematurity
	Post Mortem held 27.9.18- marks on baby's face noted which are consistent with overlaying; suspected cause of death is co-sleeping. Tissue samples obtained for analysis

	1a pulmonary hypoplasia 1b preterm pronged rupture of membranes at 16 weeks gestation 2 extreme prematurity and maternal GBS poitive
	1A BILATERAL RENAL AGENESIS
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	5	all staff to be reminded of the need to test patients who smoke
		Issue raised with Community Team Leaders -to raise awrebness with CMW's to CO monitor all women at booking.
		Contact Oswestry midwives to confirm and raise awareness that CO monitoiring should be offered at booking and during pregnancy.
		To be taken forward by Community Matron
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	4	awareness raised with bereavement service
		Awareness raised on Labour Ward
		No action entered
		Awareness to be raised, bereavement Midwife in place , will highlight issue through mandatory training
This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately	4	No action entered
		Feedback to be provided to the clinical team
		reflection has been carried out with individual midwife and clinical team
		No action entered
This mother lives with family members who smoke but they were not offered referral to smoking cessation services	4	Awareness raised with Community Midwifery Teams- memo circulated.
		awareness to be raised with the community team regarding the requiremnt to document clearly discussions held and the implications in connection with outcome of pregnancy when omitting referral
		To be taken forward by Community Matron
		BCUHB now has MAMS support workers in place to support all women in smoking cessation and their families.
The placenta was not sent for histological examination	3	No action entered
		Awareness to be raised with regards to the requirement to send all IUD placentas to Cardiff for analysis
		Awareness raised in regards to the necessity of sending all placentas for histology in the event of an adverse outcome
The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate	2	Feedback to the Neonatal team by Dr O Rackham Review and revise high flow humidified nasal oxygen guideline.
		No action entered
This mother presented with reduced fetal	2	reflection has been carried out with individual midwife and

movements and her scans and/or other investigations were not interpreted appropriately		learning package in place presented in local risk meeting discussion & reflection with relevant Dr & Midwives involved with case
This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	2	No action entered presented in local risk meeting discussion & reflection with relevant Dr & Midwives involved with case
This mother presented with reduced fetal movements but on the basis of her scans and/or other investigations an appropriate management plan was not put in place	2	reflection has been carried out with individual midwife and learning package in place presented in local risk meeting discussion & reflection with relevant Dr & Midwives involved with case
A post-mortem was performed but this was not performed by a perinatal/paediatric pathologist	1	Regardless of the jurisdiction that the PM is done under i.e. coroner or consented hospital PM the examination should always be a complete one to determine cause of death regardless of how the death occurred (i.e lawful or not).

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	5	awareness to be raised with the community midwifery team
		Awareness to be raised with the Community Midwifery teams
		awareness raised with the community midwifery team
		No action entered
		No action entered
The parents' perspectives and any concerns about their care and the care of their baby have not been sought	3	No action entered
		No action entered
		No action entered
The parents were not told that a review of their care and that of their baby is being carried out	3	No action entered
		No action entered
		No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	3	No action entered
		Pt transferred care from Arrowe Park to Wrexham due to domestic violence. She DNA x3 booking appointments
		No action entered
This mother's progress in labour was not monitored on a partogram	3	awareness raised with all midwives
		No action entered
		staff reminded via the bereavement midwife of importance of using a partogram for ladies who are in labour with a IUD
During resuscitation the baby required intubation but there were difficulties with the intubation	2	No action entered
		Identified as lessons learned for neonatal team
It is not possible to assess from the notes whether the skin care of the baby during the first 24 hours on the neonatal unit was appropriate	2	Neonatal Team to review skin care documentation
		nursing documentation to be reviewed by the education lead and changes made where appropriate. Neonatal nursing staff awareness to be raised, skincare care plan to be updated.
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	2	No action entered
		No action entered
The baby's airway was not secured appropriately during the move to the neonatal unit	1	feedback to the Neonatal Team the importance of ensuring a secure airway - issue to be raised at the Neonatal Steering

		Group meeting and consider introduction and use of check list prior to moving babies.
		feedback to the Neonatal Team the importance of ensuring a secure airway - issue to be raised at the Neonatal Steering Group meeting and consider introduction and use of check list prior to moving babies.
The fetal heart monitoring in established labour was not carried out correctly	2	No action entered
		No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Education and Training - Competence	1	This mother lives with family members who smoke but they were not offered referral to smoking cessation services
		This mother was not appropriately managed given her carbon monoxide level
		The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate
		The clotting & general haematological management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate
		The metabolic management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate
		The ongoing respiratory management of the baby on the neonatal unit was not appropriate
		The ongoing haematological management of the baby on the neonatal unit was not appropriate
		The ongoing metabolic management of the baby on the neonatal unit was not appropriate
		Referrals for scans and/or further investigations were not undertaken when required
Education and Training - Competence	1	This mother presented with reduced fetal movements at >28 weeks and the CTG performed was inappropriately interpreted
		This mother presented with reduced fetal movements and her scans and/or other investigations were not interpreted appropriately
		This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance
		This mother had abnormal fetal heart rate monitoring during her pregnancy which was not managed according to national or local guidelines
Education and Training - Supervision	1	This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately
		The interpretation of the fetal heart rate monitoring in established labour was not correct
		There were abnormalities of the fetal heart rate during established labour but these were not recognised
		Appropriate action was not taken when fetal heart rate abnormalities were identified during established labour
Staff Factors - Physical issues	1	NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened
		Symphysis fundal height measurements were not performed at correct times/intervals
		The baby was small for gestational age at birth, scans were

		indicated but had not been performed
Communication - Communication Management	1	There should have been senior escalation when this mother was giving birth but this was not instigated In view of this mother's risk factors there was not appropriately senior involvement in the management plans for her delivery prior to the establishment of labour or elective delivery Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons

Quality, Safety & Experience Committee **24.9.19**	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:	2 July 2019 (Shortened Meeting due to short notice Welsh Government Q&D meeting)

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:	**Listening and Learning report** It was advised that reportable incidents had decreased week on week and complaints had now been included in the weekly incident meetings. Complaints had failed to meet the trajectories so focussed intervention work will be taking place. The final report for the Radiology incident has now been submitted to Welsh Governance. **Patient and Service User Experience Strategy 2019-2022** Document is an outcome of a review of the service user experience work, it describes the national system, local drivers and has a more robust approach to real time capture to drive improvement. **Policies/ Guidelines/ written control documents** The group agreed the following policies: • MHLD 0043 – Restricted Items policy • BCUHB Framework undertaking patient stories policy review And Written control documents: • Health Pre-Birth Assessment (HPBA) Guidance
Key advice / feedback for the QSE:	**Risks to highlight:** <u>Secondary Care</u> - Risk to the delivery of the breast radiology service, in the interim the team are working across BCU to mitigate risk – risk score 25 - An interim solution has been secured for the paediatric

	ophthalmology issue with resources coming from Ysbyty Glan Clwyd (YGC) to Wrexham Maelor Hospital (WMH) for retinopathy Womens - Concern with the agreement with Countess of Chester (CoCH) for commissioned services – score 16 Mental Health - There is a provider in escalation which the service is working through with Continuing Health Care, they are subject to scrutiny visits from Clinical Commissioning Group and all Wales. -A number of incidents have been raised on Tegid ward similar to issues previously raised on Cefni for which a Task & Finish group has been set up to address. Pharmacy -Medicines storage – National engagement on management approach for global shortage (Brexit) is taking place to ensure all health boards work together – score 15 East -Closure of care home in Wrexham due to numerous concerns and patient safety issues. -As a result of the closure of Bromfield GP Surgery and movement of patients, it was identified that 350 referrals had not been made and a retrospective audit had identified poor record keeping. Each affected patient has been contacted and referred as appropriate. A helpline has also been set up and letters sent to all patients in the practice. Central -Sustainability of GP Practices – score 15 West -Penrhos Polish is not financially viable and there have been meetings with Welsh Government (WG) due to political issues; the home was only able to run until the beginning of 2020 Estates and Facilities -Issues regarding GP practices and the consequence of signing the

	leases over to the health board, resulting in a growth to the estate – score 16
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:	14 August 2019

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

Quality, Safety & Experience Committee **24.9.19**	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:	14th August 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:	**Mortality surveillance report – update** Weekly monitoring of inpatient acute and community results, show a seasonal variation. Deaths review process – stage 1 screening opportunity to see if more depth needed, we are at the 97% mark, more than expected are going into stage 2, completion of the review of stage 2 show low results, with one resulting in Putting Things Right (PTR). CHKS report – has been benchmarked against last year and other Health Boards, with no alerts and rate as expected, there has been a slight reduction year on year. Control chart – there is a common cause variation, with a slight slippage but no cause for concern. Staff have been asked to look into further. Pneumonia largest cause of death which is being looked into. There are no significant issues, we are looking at the process and working on Mental Health & Learning Disabilities (MHLD), community and managed practice work. **Internal Audit, Nutrition and Hydration (INCH) – Steven Grayston** Been informed that we must transition to a new nutritional screening tool (WAASP) from MUST by November 2019 for the Health Board. This is a huge piece of work and has a number of risks associated with it and potential costs, timescale is also very challenging. Meeting today to develop plan and identify work and

	costs involved. Will roll out with the electronic nursing documents, which has been brought forward. Update paper will be provided into the next QSG meeting **Policies/ Guidelines/ written control documents** The group agreed the following written control documents: • Standard Operating Procedure (SOP) – Wrexham Maelor hospital chronic pain, complex medication management clinic (CPCMM) • Acute Pelvic Inflammatory disease diagnosis an management • Discharge prescription – day case hip replacement form • MHLD 004 Rapid tranquillisation protocol for use in adults in MH inpatient of acute hospital setting • Standard Operational Procedure: Safeguarding Children and Young People Discharge Plan
Key advice / feedback for the QSE:	**Risks to highlight:** **<u>West</u>** • There is a current concern regarding a new offsite dispensing programme initiated by Rowlands pharmacy. The new process has been poorly communicated to GP surgeries and pressure has been caused by the fast introduction of the programme, there are a lot of dissatisfied patients. Group were informed that this has been highlighted to Chief Pharmacist and we are working with the pharmacy to resolve – **score 16** **<u>Central</u>** • Antimicrobial pharmacist – there is not one currently in the area for which further discussion is needed and adding to the risk register. **<u>Womens</u>** • There have been a number of clinical complex cases being seen. • Lack of scan capacity to meet national recommendations for reduced fetal movements and growth restriction in babies - **score 16** • There have been several high volume haemorrhages for which thematic reviews have been completed and the results will be presented to September QSG **<u>Secondary Care</u>** • MR scanner issue – there was a spontaneous quench resulting in scanner being out of action for 9 days, this has now been resolved but has had an impact on the delivery of waiting lists

	• Emergency Medical Services – completed a programme business case, which includes a pipeline of projects. Proposed case going to F&P and Board over the next month for agreement to start work. **East** • Childrens services – there has been progress on the neurodevelopment waiting list, and monies from WG have been obtained to improve the service • Primary care – Bromfield surgery support has challenged the resources in the team and impacted on a number of work programmes • Clinical pharmacist in Mental Health at Wrexham – **score 25**, solution found so risk will reduce • Implementation of referral triage process for Dermatology waiting lists – **score 20** **Mental Health** • The division is due to exceed their budget expenditure for 2019/20 – **score 20** • There are a number of patients under the Conwy Community Mental Health Team that are not open to the Mental Health Measure –**score 20** • Ability to deliver service due to staffing levels– **score 20** **Estates and Facilities** • Finance is an issue, have met with the recovery director and working on developing a recovery plan which will cause some delays to planned work until next year, this will have associated risks which will be quantified. • Sustainability in environmental awareness training risk has now been mitigated.
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:	11th September 2019

Quality, Safety & Experience (QSE) Committee

24.9.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Progress report of recommendations arising from HASCAS independent investigation and Ockenden governance review
Report Author:	Miss Claire Brennan, Head of Office
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress update 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 to support 3 of recommendations in order to progress the work further to deliver improvements and fully address the recommendations.
Financial Implications:	Executive Team have agreed the funding for the required additional posts to support progress of the relevant recommendations.
Recommendation:	The Committee is asked to note progress against 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, carer's, 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

Executive Summary

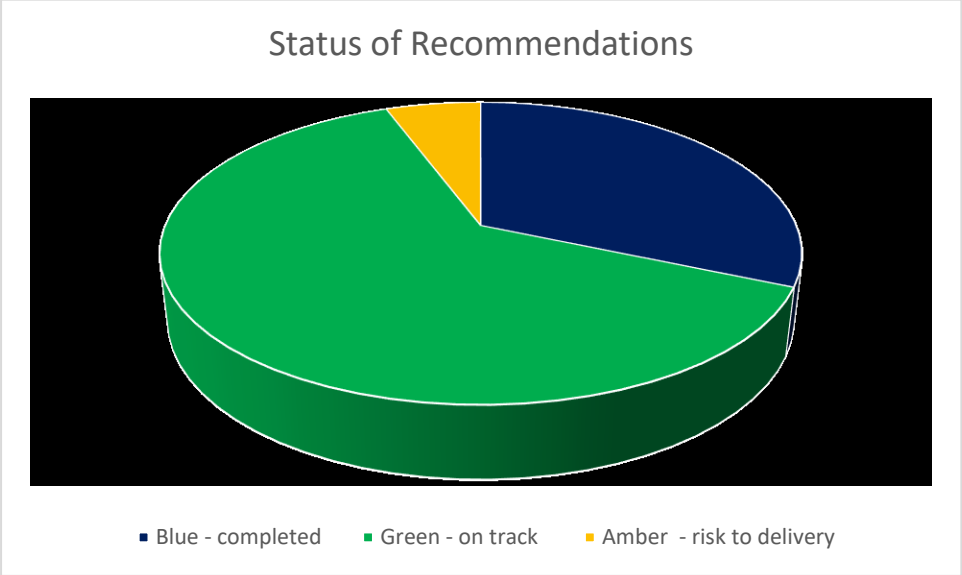
HASCAS & Ockenden Recommendations status

The Health Board meeting on 5th September received a report on the progress of the HASCAS & Ockenden recommendations, the attached report is a slightly updated version to reflect progress where this has been made for the period between the reports to Health Board meeting on 5th September and QSE committee today. This includes confirmation that a number of recommendations have progressed from amber to green status that are now on track for delivery.

The status of the total 35 recommendations for both HASCAS & Ockenden is detailed below;

- 22 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;
- 2 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;
- 11 recommendations have now been completed; these are relation to;
  - HASCAS 3: Care Homes & Service Integration
  - 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 4b & 4c: Staff Surveys
  - Ockenden 10: Reviewing External Reviews
  - Ockenden 14: Board Development and prescribed disengagement.

Graph 1 below shows the status of the recommendations as at 16th September.

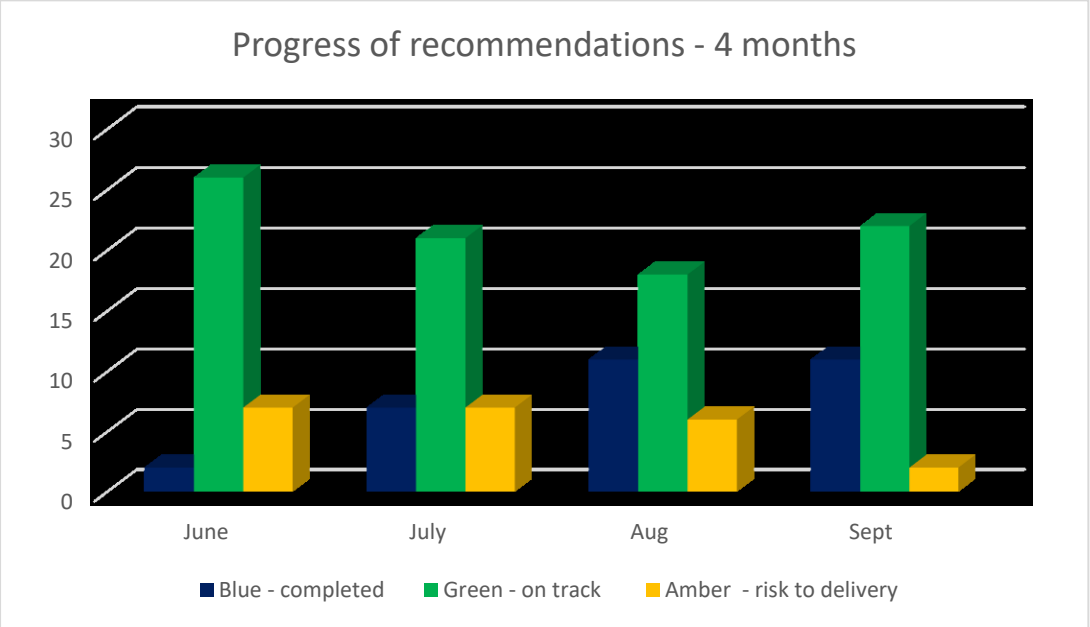


Graph 1

Graph 2 below, shows the progression of recommendations towards completion over the last 3 months. Since the progress report to Board on 5th September the following recommendations have progressed from amber to green;

- concerns management
- workforce development – including staff engagement, culture change, clinical engagement,
- anti-psychotic medications

As work continues to progress, it is anticipated that a number of recommendations will progress to full implementation over the next month, which will be formally signed off at the next Improvement Group meeting on 18th November. Stakeholders will continue to undertake tests of assurance of the actions that are confirmed as having been implemented.



Graph 2

Improvement Group

The Improvement Group continues to meet bi-monthly to monitor progress and scrutinise any risks to delivery and mitigating actions. The last meeting was held on Monday 16th September, chaired by the Deputy Chief Executive, however, the meeting was not quorate in respect of the core membership. The meeting received the monthly highlight reports and discussions took place with the operational leads present; Ockenden recommendation 2 (Integrated Reporting) was proposed as being fully implemented but as the group was not quorate this will be formally signed off at the next Improvement Group meeting on 18th November. It is anticipated that a number of other recommendations will also be considered for sign off at the November meeting.

Recommendations that are signed off as fully implemented, operational leads have confirmed that activity continues to embed and monitor the work implemented in

response to the recommendations and report any further updates or challenges if they arise. Following such discussions at the Improvement Group meeting held on 16th September, an update was provided in respect of Restrictive Practice Guidance (Recommendation 13), which advised that draft Mental Health benchmarking data has highlighted that BCUHB is significantly improving the number of restraints per 10,000 occupied bed days for both adults and OPMH. The group noted that this was a very positive development against a key performance metric.

In addition to the bi-monthly Improvement Group meetings, additional one to one meetings have been established between the operational leads and the Acting Executive Director of Nursing. These meetings enable a more in-depth review of progress and issues of each recommendation; 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 5 times since its inception in October 2018. The most recent meeting, held on 30th July, was attended by the Chairman to directly receive Stakeholder views of their experiences with the meetings held to date to review progress of the recommendations and ensure the relevant level of assurance.

The majority of stakeholders have now been in contact with the operational leads for the recommendations they expressed an interest to support, some of whom attend task and finish groups, where these have been established for specific recommendations. Contact will continue to be made with stakeholders for a couple of recommendations where this has not taken place. In addition to meetings and telephone calls with stakeholders, the following are examples of some of the activities that stakeholder members have actively engaged in, relating to the work of recommendations as follows;

- In relation to safeguarding activity, stakeholder members were invited to engage with a Level 3 Mental Health & Learning Disabilities (MHLD) training event and asked to engage with the process, attend, and provide constructive comments and feedback in relation to the event and package content. Their feedback is being reviewed and actioned and a follow up meeting with the stakeholder that attended is due to take place 5th September.
- Stakeholder member invited to engage with the revision of the Deprivation of Liberty Safeguards (DoLS) structure, consultation and review.
- Stakeholder members were invited and included on interview panels for the following posts;
    - Head of Safeguarding Adults
    - Head of Safeguarding Adults for MHLD
    - Dementia Specialist Admiral Nurse
    - Dementia Consultant Nurse (invited but not able to attend)

- Some stakeholder Group members have undertaken visits to establishments including Mental Health units and also end of life care facilities on Bryn Hesketh and Cefni.
- A member attended the first day of the 5 day aggression training course with the Positive Intervention and Clinical Support Services team.

Operational leads have formally acknowledged the valuable contribution from the engagement and involvement that stakeholders are making in supporting the progress of actions.

To date, the Stakeholder Group has received presentations 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)
- Estates Older Person's Mental Health (OPMH) including anti-ligature and Ablett Redevelopment

Stakeholder Group members agreed to identify future topics for presentation that they wished to receive going forward.

HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 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 work streams 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 took place in July 2019 with the Director of Primary Care and Associate 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. Since this approach was agreed, the Gap Analysis methodology required presentation across the region and dates set within each of the Areas/ Divisions quality meeting. A model and framework of the gap analysis has been developed and shared with all Area Nurse Directors. Each Area is expected to arrange a partnership event to undertake the analysis of their older person's services identifying what works well and not so well following the Integrated Pathway of the Older Person (IPOPs). This will attempt to identify opportunities for improvement and further integration. Further opportunities for integration is under development with the IPOPs work programme via the Regional Partnership Board. The Health Board will be integrated into this work programme, which complements the overall outcome for the Older Persons Integrated Care Pathway. Feedback is due in December 2019. • ***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 work stream 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". This specific action has been subsumed into BCUHB's newly launched 'Single Care Home Action Plan' and area teams will be responsible for the development and delivery of these pathways. This specific action has	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 Awaiting outcome of regional service gap analysis for the NW Integrated Service Model. • Work taking place with the RPB to develop the wider service model based on the IPOPs approach, which will include the findings of the gap analysis.

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Recommendation	Current position	Progress update	Risks
		now been subsumed into BCUHB's newly launched 'Single Care Home Action Plan' and area teams are responsible for the development and delivery of these pathways, with feedback due in December 2019. • ***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 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, will be overseen by End of Life Steering Group. – ***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. The West area team have now drafted version 1 of an "Integrated Pathways Supporting Access to Health Care and Dementia", consultation is underway with central and east teams for further input and standardisation. – ***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. Feedback regarding the integrated care pathways noted above due in December 2019. • ***An OPMH Improvement Hub***: This year (2019), the mental health division have successfully established a 'Quality and Workforce' group that addresses service improvements for the OPMH patient group. HASCAS recommendation 3 is just one example of how the group have embraced the 'Single Care Home Action Plan' and are in the process of addressing action no.8 which is to map out and clearly define the referral process for older persons living in care homes who require mental health services' support, across all six local authority regions in North Wales. This action is completed. • ***Audit and Reporting Schedule***: A mapping exercise of current mandatory audits that relate to older persons' services across BCUHB has taken place. However, in order to address HASCAS recommendation 1 i.e. 'an annual audit and reporting schedule for older persons and those with dementia' further consideration is needed with regards to resource implications. The outputs expected, as seen across all logic models relating to HASCAS and Ockenden (recommendations 1, 2 & 3), will provide a future benchmark in	Challenges experienced in recruiting to ANP position • Agreement confirmed to increase the hours / sessions for advertisement in addition to the possibility of a job share; to attract a suitable candidate

Recommendation	Current position	Progress update	Risks
		terms of what audits are required. In preparation for this, the Improvement Lead for HASCAS recommendations 1 & 3 is in the process of designing an audit in relation to safe discharges of older persons into care home settings. This relates to HASCAS recommendation 3 but dovetails with HASCAS recommendation 1 due to the care pathways that are under development. The audit will commence in January 2019 to allow sufficient opportunities for planning in the meantime. The Patient Experience team will be involved to capture qualitative data from a service users / carers perspective. • ***Integrated Service Model***: The findings of the older person's gap analysis, along with the five bullet points listed above, will help inform the direction and design of the service model. Whilst the aforementioned and significant work is underway, the improvement lead will continue to engage with stakeholders to consult on the various pathways, with the inclusion of the patient experience service. Engagement to date indicates that 'care outcomes' are considered central to an integrated service model and so this will feature prominently within the forthcoming safe discharge audit. • ***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 given priority at this current time.	
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).* **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.*		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. A Dementia Strategy Group for North Wales has been established with BCUHB representation. In addition, BCUHB have set up its own strategic working group in July 2019 in order to maintain oversight and governance of all Dementia work streams. • ***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. 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 the 'Dementia Therapies Action Plan' has been drafted which outlines the evidence based practice to support the need for additional therapies. A task and finish group has been	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
		established and met on the 14th of June 2019 and 3rd of September 2019. A draft plan has now been developed which highlights current resources and proposed staffing with a supportive document attached to highlight the rationale of the various therapy proposals. The plan now awaits finance department to help with costing and a phased 3-year plan is under consideration to demonstrate how the services will be delivered. This may require a new model of care and further work is ongoing in relation to obtaining stakeholder engagement. This action also dovetails with the work of HASCAS recommendation 10 to reduce the use of antipsychotic medication. • ***Performance Managed Dementia Strategy Implementation Programme***: A BCUHB Dementia Strategy Group was established in July 2019 to oversee all health board work streams in relation to Dementia, in order to avoid duplication and maintain a consistent approach. Revision of membership, ToR and organisational lead for dementia is now being led by the Deputy Director of Nursing. 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. A mapping exercise of all Dementia services across BCUHB has taken place and information shared with the project lead for the North Wales Dementia Strategy on the 6th September 2019. The programme manager and nurse consultants will develop a framework for the group on the 11th September 2019. ToR and Governance Structure remain under development, the HASCAS R.2 work-stream will be subsumed into this group by December 2019. • ***BCUHB Dementia Training Programme***: BCUHB will continue to train staff as 'dementia friends' champions and actively run sessions to support this. There are now 10 dementia friendly communities across North Wales and more will be developed; 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). The Dementia training and dementia friends needs to be progressed together as mandatory for all new starters, local areas need to ensure allocated resource available to dedicate to dementia awareness for clinical staff and map their progress utilising the Dementia Support Workers and trainers in all areas, ensuring records on ESR, all sites need to facilitate this. This has been raised as an issue as the current model is not sustainable, educational resources need to be available to support training in all areas. The progress on distressed behaviours need to be considered in the existing developed program by the BCU IPAC wide team as this is accredited and modular and already has a trust wide remit utilised predominantly in MH (previously known as violence and aggression). West Area are bench-marking the Alzheimer society work program for dementia assessments in care homes, whereby BCHBU has commissioned beds and from this,	Establishing a strategic group for BCUHB • Realigned to Deputy Director of Nursing (TH) to take forward, working up a TOR, Governance Structure and membership. Long-term clinical plan to inform the programme and its implementation under early development.

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Recommendation	Current position	Progress update	Risks
		key elements will be identified that can be utilised for care homes commissioned to look after BCU patients, develop a model to include basic antipsychotic awareness and the practice development team will deliver this, this will need replication over all areas. Also all care homes must provide a base line of training for staff and should keep records of which patients are known delirium or on antipsychotics. • ***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 2019-20 – further roll out plan 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. 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. Dementia Nurse Consultant has confirmed this is work in progress and is reliant on integration, elements of work in areas need to be merged with agreed standards across all areas that matrons can measure and also become part of ward accreditation. • ***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. A review and report on key policies moving forward has been produced, there will be a Dementia policy inclusion for all policy and procedure developers / leads which is in current draft format. It will be expected that all developers and policy reviewers consider all vulnerable groups when developing any policy or guidance, making Dementia a key consideration. This will need to go through the process of being added into the policy for polices guidance; it will be the responsibility of areas to consider this in all policy development.	

Recommendation	Current position	Progress update	Risks
		• ***Dementia Governance Framework:*** The governance arrangements that underpin 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 advertised 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 Integrated Care Fund 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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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 2019

Recommendation	Current position	Progress update	Risks
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 December 2019	• The Senior Safeguarding Structure is now being implemented with pace. The two posts for Head of Adults at Risk and Head of Adults at Risk for MHLD within the Safeguarding Structure have now been recruited to, subject to a confirmed start date. This will strengthen strategic oversight in these key areas. • The Business Support Team have successfully recruited to two vacant Band 3 posts, start dates are being worked through with one agreed for mid-October. This will strengthen the central administration function. • The Named Doctor Adults at Risk job description, implementation and engagement requires further action to progress. The Associate Director of Safeguarding has met with the Executive Medical Director who confirmed he has planned meetings with senior medical colleagues and will discuss the way forward. • As part of the organisational update, the second phase of safeguarding job descriptions is in the process of being reviewed to ensure they are fit for purpose and meet the organisations statutory Safeguarding responsibilities. • A full evaluation of the existing 2017 Organisational Change Policy Safeguarding Structure is to be finalised and reported to Quality & Safety Group in December 2019. • A 7-day on call / flexible working arrangement has been costed to support Safeguarding service delivery. Job descriptions are being refreshed to reflect this for clinical staff and will be implemented once financial approval has been gained, and the consultation complete.	Secondment to the Adult at Risk / Dementia Lead was recalled back to MH&LD, which now remains a key vacancy in the safeguarding structure. Subsequently due to the Health Board's financial constraints, there is a risk that the appointment to the Adult at Risk / Dementia Lead (Band 8a) will not be recruited to which will impact on service delivery and recruitment to full safeguarding structure. • A JD will be submitted to vacancy control panel with clearly identified risks and clarity on key role responsibilities with identified risk assessment and clarity on activities which will not be undertaken without the post.
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	• Appointment to the *Deputy Head of Health Records* post has been successful for an internal candidate and a formal start date has been agreed for 1st October 2019. • Funding for the B7 Project Manager post has been confirmed by the Executive Team. Once this post is appointed to, Mental Health services will be the priority area. The work programme for this post is expected to be completed by March 2020. • Confirmation given that responsibility for the management of all patient records is within the remit of the Executive Medical Director. • Health records policy (HR1) has been redesigned to take account of transition to digital records and is being reviewed by Head of Information Governance prior to submission to Patient Records Group for approval in November. • Following a meeting held with the Clinical Audit lead, agreement has been reached to include checks for co-mingling within the annual clinical audit of casenotes, this will be resource matched by support from within the Health Records service. This action is now complete. • The new ATHR service pilot commenced in Central in August / September which is progressing well and decision taken to advance the roll out to East during September. Existing resources within the team are conducting thorough checks for comingling prior to release, however, this is proving time consuming and early indications are that the team will need to be strengthened to ensure these quality checks can be complete when across all three sites. Comingling audit to be undertaken of ATHR requests handled by the centralised team to date and findings will be reported to the Patient Records Group. • Safeguarding also recognise the fundamental importance of good record keeping in Patient Safety. Whilst responsibility for implementing this recommendation sits with the Chief Information Officer, Corporate Safeguarding are undertaking activity which supports this, including conducting an audit of the use of purple dividers, and their application within MHLD, Secondary Care and Primary Care clinical records. • Corporate Safeguarding have requested that this activity form part of the 2019-2020 Internal Audit cycle for which a response is awaited. • Record keeping training is delivered by Safeguarding, which reflects on the importance of good record keeping, and its role in Safeguarding. This message will also be shared through the Safeguarding Bulletin and the Safeguarding Homepage.	Benchmarking work cannot commence until additional project manager resource appointed – update awaited on confirmation of funding allocation from Executive Director of Finance.

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Recommendation	Current position	Progress update	Risks
		• Corporate Safeguarding are implementing the Lead Practitioner role after an initial pilot. The Lead Practitioner role will include the oversight of the content, quality and standards of Safeguarding record keeping and documentation.	
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 audit has been completed for people with dementia on OPMH wards, in accordance with the BCUHB MM010 guidance. 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, however there is limited uptake to date. Reminders sent to secondary care MH staff to use the CAIR form for patients who have started on antipsychotics. Further audits will be undertaken to monitor completion of the forms. Discussions are underway with the Medical Director to consider embedding within core documentation. • Care Home sub group of primary care pharmacists met in July and CAIR forms have been circulated to raise awareness for care home staff. • 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. • Primary care audit for GP practices and care homes on the use of antipsychotics is underway and is expected to be completed by end of September. • Discussions to be held with the Programme Manager for HASCAS 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 HASCAS recommendation 3 (Care Homes & Service Integration). • Training plan to include training for care home staff on the use of medication for people with dementia, including antipsychotics, has been agreed and planning is in progress with the Dementia Consultant Nurse. • 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 antipsychotic medication and introduced to an approach aimed at reducing the prescribing of these medications.	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 Additional resource required to support data analysis work is awaited • This has been approved by the Executive Team
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	• The HASCAS & Ockenden Improvement Group agreed at the meeting on 31st July 2019 that all Integrated Care Pathway documentation will follow the same process as for other Written Control documentation and will be included in the new site. Office of the Board Secretary (OBS) support will be provided to prepare for transfer. • Staff continue to be reminded of the importance that all clinical Written Control Documents (WCDs) are developed using a person centred approach and that the evidence base in relation to older adults and/or those with dementia must be specified – if necessary separate clinical WCDs should be developed with input from experts. • Equality Impact Assessment mandatory requirement awareness for all pan BCUHB WCDs remains a key message • Individual and group sessions continue to be held with governance leads. • Staff are now being directed to use the new Policy on Policies (PoP) template, a period of grace was permitted from the September launch of PoP to accommodate documents on the old template that were already going through the renewal process.	Reduction in administration staff within OBS could lead to delays in transfer of policies to new site. • Following redeployment of resources for other corporate support, recruitment is now underway for additional secretarial support for Interim Acute Services Director and Interim Recovery Director.

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Recommendation	Current position	Progress update	Risks
		• The new NWIS website is currently being tested by Corporate Communications team, with whom the OBS have mapped out the basic structure of the new PoP webpage and undertaken an initial viewing to better understand the page structure, capabilities and functionality. A further meeting is required for training purposes. Once this is complete, estimated in September, depending on capacity, a test run of corporate documents will be transferred. • A desktop exercise has been undertaken to review documentation against the new Standards in terms of Welsh Language translation. • OBS have reviewed and adapted the WG Integrated Screening Tool. This will provide a one stop screening tool that encompasses all relative areas of impact (Finance, Environment, EqIA, Children, Data Protection etc). Where further assessment is required, the tool will direct the author to the applicable full screening assessment / BCUHB lead. This document will pre-empt issues and ensure all factors have been taken into consideration prior to any proposed service change. Relevant Service/Speciality leads will be consulted on the document. • Deputy Board Secretary is scheduled to attend the newly formed Executive Nursing Business Meeting on 23rd September 2019 to ensure project requirements are adequately communicated within the Nursing Directorate. • Meeting held with QSG secretariat to strengthen and improve the process and quality of documents received at QSG and QSE meetings. The OBS will provide support on initial screening prior to documents being accepted onto the agenda for QSG. Screening checks for administrative purposes are now in place however any clinical or operational content remains the responsibility of the responsible directorate. • Further discussions have taken place with the Executive Director of Workforce & Organisational Development and all Health and Safety documentation will be approved via the Strategic Occupation Health and Safety Group for final sign off below policy level. • Meeting held with the Nursing Directorate to brief newly appointed Business Manager on progress to date and agree next steps for clinical documentation transfer.	
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 December 2019	• A paper has been produced which identifies the funds and or equivalent time relating to the DoLS signatory activity. The role and responsibility of this role has previously been held by the Office of the Medical Director. A positive meeting took place on 9th September between the associate Director of Safeguarding and the Executive Medical Director who will now discuss the way forward with senior medical colleagues. • The 6th vacant Best Interest Assessor (BIA) post is to follow the recruitment process. These posts are critical due to the high activity which is both challenging and complex. • An evaluation of new working practices will be carried out including the Mental Capacity Documentation Pilot activity and the Signatories training package. This will be reported to the Safeguarding Performance Group (SGPG) on 16th October, and QSG in November 2019. • DoLs activity during the period of 2017-18 has been reviewed. Based upon the outcome of this activity and the evaluation of 2018-19 activity and action plan will be produced. An options paper to commenced discussions relating to the revised structure of the DoLs team, to reduce risk and increase activity will be completed. This will be submitted to QSG in November 2019. It should be noted that DoLS has a Tier 2 entry on the Corporate Risk Register with a Risk Rating of 16 and states that: *BCUHB is at risk of unlawfully depriving adults of their liberty due to the Case Law of Cheshire West, which widened the parameters based on the acid test. The results*	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, and 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. Formal options paper will be presented to QSG setting out the mitigations and future proposals in an attempt to reduce the risk.

Recommendation	Current position	Progress update	Risks
		extended the definition of the Deprivation of Liberty legislation and how it applies to vulnerable adults. *BCUHB has seen a continuous increase in complex activity and in specific Court of Protection Activity (COP).* The DoLS activity described above is reflected on the Risk Register as the Corporate Safeguarding team progress work to reduce the DoLS Risk Rating from 16 to 12 by January 2020.	
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*	Expected to be fully implemented by end of December 2019	• The monitoring process which commenced in November 2018 is ongoing and continues 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. • End of life case note reviews for inpatient notes were held in April and 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. Meeting between palliative care and critical care leads arranged for September to update documentation so it is fit for purpose and meets priority of care recommendations. • 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 in September.	Capacity to complete the national end of life audit • Palliative care lead established, sites have been requested to identify generalist consultants to lead site audits.
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 their 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 also 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. Two members from the Stakeholder Group visited end of life care facilities on Bryn Hesketh and Cefni in July, and their feedback from the visit provided a number of positive comments in relation to improvements noted within these environments and the importance of these facilities.	Staff not being released for training. • Training is mandated on OPMH wards for Registered Nurses.

Recommendation	Current position	Progress update	Risks
		They also made a number of observations and suggestions which were appreciated and are being actioned. • 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. An additional education session was arranged in September – a full report will be prepared around the training educational assessment for review at the next Improvement Group meeting. • 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. • Strategic and Operational Delivery Group for Palliative and EoLC is due to hold it's first meeting on 30th September 2019.	
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 end of September 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 and 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 Internal Audit plan for next year which was approved by the Audit Committee on 14th March 2019. • The audit brief has been submitted for approval and is due to commence in September. • Once the audit brief has been approved and audit commenced it was agreed that this recommendation will be signed off as fully implemented – this will be reviewed at the Improvement Group meeting on 18th November.	
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.*	Proposed as fully implemented – to be formally agreed by the Improvement Group	• Two cycles of the new health economy process were undertaken during February from which learning resulted in an amendment of the process for the second cycle undertaken in June 2019. Outcomes of the review were fed back in the form of notes, action log, decision tracker and risk log. • Q1 2019/20 review took place at the beginning of August 2019 with the mechanism expanded to include both the 3 health economy reviews and reviews for the pan-BCU services of Women's, North Wales Managed Clinical Services and review of the work on the clinical services strategy. The effectiveness of the interim accountability framework will be required post the quarter 3 reviews set for February 2020 with an intent to formalise the Performance Framework from 2020-2023 planning cycle. • The annual operating plan actions are being monitored with progress reported to committees of the Board using the peer reviewed self-assessments. On a quarterly basis a random sample of the underpinning evidence takes place to ensure consistency in rating between the Executive Lead for each Action. This was completed at the end of June 2019 and included in the July Annual Plan Monitoring Report presented to the Finance and Performance Committee for scrutiny. • Due to the significant oversight by the Board, as well as subcommittees (QSE and F&P) and also the Special Measures task & finish Group, it is proposed that this recommendation is approved as fully implemented where robust governance structures provide the relevant level of monitoring and scrutiny. This will be formally reviewed at the Improvement Group meeting on 18th November.	
Ockenden 3: Policy Review Operational Lead: Dawn Sharp, Deputy Board Secretary	Expected to be fully implemented	• 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.	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

Recommendation	Current position	Progress update	Risks
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.*	by December 2019	• 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.	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 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 where possible into the available band 5 vacancies across the MHLD Division. This process will continue as the summer months progress. • A dashboard is developed to monitor workforce performance for the MH&LD division. Improvements can be seen in areas of turnover and time to hire. • The MH&LD division also has a workforce objectives plan in development which is monitored currently through the W&OD senior leaders group which will now transfer to the newly established Workforce Improvement Group. There is an organisational improvement plan for retention, the W&OD teams are working together to improve retention in hotspot areas. Close monitoring and scrutiny of workforce processes including recruitment, time to hire vacancy rates, fill rates, retention etc is mainstreamed into the work of the workforce teams. • 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 Community Mental Health Teams (CMHT). 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 to enable triumvirates to engage with the Quality Improvement Governance Plan and produce Divisional Action Plans.	

Recommendation	Current position	Progress update	Risks
		• Since the launch of the Together for Mental Health Strategy, Local Implementation Teams (LITs) have been established across the 6 counties supported by Quality & Workforce Groups that work collaboratively to ensure vertical read across, and understanding of how the work of the LITs and other organisations and networks impact on service provision across the whole system. The Quality & Workforce Groups are tasked with developing clinical service models across secondary care.	
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 required to staff engagement across the whole of BCUHB*		• The Staff Engagement strategy approved in 2016 identified key activities and achievements required to successfully realise the strategy and the Health Board have received six monthly updates on progress and achievements since the launch. 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. – 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 2019. Cohort 2 started their Pioneer journey on the 19th June 2019 and will run until 12th December 2019 and cohort 3 is being planned for October start date and teams have been identified for this cohort which includes a number of teams from the MHLD division. • 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 treats at the end of the week which has been well received. • There has been positive engagement with the Action Learning Sets within which 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.	

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Recommendation	Current position	Progress update	Risks
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 • 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 was designed in 2015 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 commenced July 2019. • Building on the Ward Manager Leadership Development Programme the first cohort of matrons will commence the **Matron Leadership Development programme** in November 2019. • A bespoke 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.	

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Recommendation	Current position	Progress update	Risks
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.*	Expected to be fully implemented by October 2019	• 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, which is expected to be implemented in September 2019. 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 designated MH commissioning post has been appointed to and is expected to start in post in September 2019. • A paper was presented to the Strategy, Partnerships & Population Health Committee in September providing feedback from the series of engagement events held earlier in the year and confirming the proposed principles. Following discussion with Independent Members the draft strategic framework has been prepared and is being shared with third sector and internal colleagues for any further feedback and amendment prior to sign off.	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
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.*	Expected to be fully implemented by October 2019	• Work continues to progress to respond to the actions identified to better manage concerns in a timely and effective manner. • Revised trajectories that have been to deliver real time management of complaints and incidents continue to be monitored via weekly incident review meetings. The current position against trajectories is as follows; – No WG incidents overdue by end of June 2019 – 72 as at 11th September – No complaints graded as 1 or 2 overdue – 101 overdue as at 9th September – No more than 15 complaints graded as level 3 overdue – 82 overdue at 9th Sept – No more than 30 complaints graded as 4/5 overdue – 27 overdue at 9th September – No more than 5 complaints overdue by over 6 months and must be grade 5 – 1 overdue as at 9th September • The number of open and overdue incidents has decreased from 5,575 in March 2019 of which 3,508 were overdue to 4,391 in August 2019, of which 2,514 are overdue. • There has also been a decrease in the number of open Welsh Government closure forms from 419 in March 2019, of which 345 were overdue to 148 in July 2019 (of which 76 are overdue). • A revised approach to weekly scrutiny of all complaints has been implemented, led by a single lead for corporate complaints with each division including all complaints over 2 months as well as open AM / MP complaints. • 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 the next Quality Safety Experience Committee for approval. • The PTR Annual Report was approved by the May QSE committee and presented to the Health Board meeting in July. • A Standard Operating Procedure (SOP) to support staff in writing a complaint letter was launched on 1st July 2019 and a training programme is underway. • The Patient & Service User Experience Improvement Strategy 2019-2020 was approved via QSG & QSE July 2019 and has been shared with CHC for comment feedback. The draft Patient Advice and Liaison Support officers' operational model is currently in circulation for comment and feedback.	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

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Recommendation	Current position	Progress update	Risks
		• Recruitment process for the appointment of Patient Advice & Liaison Service (PALS) officers is now complete with all vacancies appointed to. • Customer care training and recording of patient stories is being delivered across BCUHB with excellent participation evaluation feedback. Quality Safety meetings have introduced patient stories as an opening agenda to address key learning, for example, staff arranging referrals for interpretation services for patients and service users. The revised patient story policy was approved at Quality & Safety Group in June 2019. A patient story library will be developed on the BCUHB website accommodating varying methods including audio, video and narrative.	
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 Work stream 1, which is 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 work streams 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. • As part of Estates and Facilities budget setting process for 2019/20, bids have been submitted for an additional £200k of recurring revenue funding to address any remaining outstanding repair / planned maintenance work within MH&LD buildings. • The project group have identified the requirement for Project Management capacity to support the project and actions required in Work stream 2 – funding has been agreed by the Executive Team for this additional resource. Work stream 2 commenced in April 2019 and is tasked with developing the Enhancing the Healing Environment (EHE) assessment across all wards within MH&LD OPMH facilities. In order to undertaken the ward assessment and additional repairs and maintenance, additional revenue funding is sought for project management capacity. • Presentation was made to the Stakeholder Group held on 30th July, which provided an overview of the progress to date for the recommendation including anti-ligature and environmental improvements as well as the redevelopment of the Ablett Unit.	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
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 will be subject to BCUHB's stakeholder and engagement groups. • ***Logic Model***: The logic model for Ockenden recommendation 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.	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

Recommendation	Current position	Progress update	Risks
		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. • ***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 over sight. 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 Consultants are currently mapping out all clinical standards / policies in relation to Dementia care. 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. The clinical standards and procedures for the Older Person will be developed via the IPOPs work programme (Gap Analysis) in partnership with the RPB. • ***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. NICE guidelines and the National Dementia Audit will be a rich source of information for BCUHB to consider. Policies for review will take place as part of the IPOPs initiative as endorsed by the Area Directors.	'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.
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.	

Blue = Fully implemented Green = on track to deliver Amber = risk to delivery

Recommendation	Current position	Progress update	Risks
		• 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 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 Strategy aims to provide assurance to stakeholders of our continued determination to focus on delivering high quality patient care and challenging ourselves to achieve the highest of standards. • 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 '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.	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 2019

Recommendations that have been signed off by the HASCAS & Ockenden Improvement Group as being fully implemented in response to required actions taken and agreed address the requirements of the recommendation as set out in the either the HASCAS or Ockdenden reports.

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.*	Fully Implemented	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 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. • ***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 with Care Inspectorate Wales (CIW) in March 2019. • ***Single Care Home Action Plan:*** The 'BCUHB Single Care Home Action Plan' was launched in July 2019 in order 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 quarterly basis. Any new and emerging BCUHB care home work-streams will be added to, and form part of this integrated process at a local level. The aim of the action plan is to bring	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.

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Recommendation	Current position	Progress update	Risks
		together all ongoing service re-design initiatives, and to capture evidence of improvements through a single framework of governance. 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. The priorities are based on the IPOP (Integrated Pathways for Older Persons) initiative with 7 key themes. 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. The above achievements were presented to the HASCAS Improvement group meeting held on 28th July 2019 where it was approved that the requirements of the recommendation is fully implemented. However it is acknowledged that there is considerable progress required to implement the actions across Health Board in the forthcoming months. The stakeholder group have also been sighted on the development of the single care home action plan. • ***Integrated Training Programme***: A long-term training schedule for BCUHB to include Care Home staff in its design and delivery, in relation to the care of older person and those with Dementia remains under development. This work stream will be completed within the remit of Ockenden recommendation 12; Long Term Clinical Plan. The improvement lead has met with Bangor University and recent undertook a scoping exercise, which identified opportunities for BCUHB to work with the University to develop specific training and education. • ***Presentations***: The Programme Manager for this work stream delivered a successful presentation to the East, Central and West Partnership Forums to raise awareness of BCUHB's progress made against HASCAS recommendation 3. 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) and in doing so illustrating the consultation process and benefits of working in partnership. The Flintshire's 50+ Action Group also warmly received the same presentation in June 2019 and a further presentation will be offered to the Carer's Strategy Group in September 2019.	
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*	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:	

Recommendation	Current position	Progress update	Risks
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.*		– 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;* • *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.*	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. – 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.	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.

Recommendation	Current position	Progress update	Risks
		• 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* • *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*	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) ▪ 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 & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 2019

Recommendation	Current position	Progress update	Risks
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 70 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 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'. An update was provided to the Improvement Group meeting held on 16th September that highlighted performance of draft Mental Health benchmarking data that demonstrated the Health Board is significantly improving the number of restraints per 10,000 occupied bed days for both adults and OPMH. The Improvement Group noted that this was a very positive development against a key performance metric	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 2019

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.	
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.*	Fully Implemented	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 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 2018 NHS Wales annual staff survey has been undertaken and the results revealed a number of positive improvements since the 2013 and 2016 survey. • The Organisational Survey has been redesigned and tailored to the Health Board's needs with additional Wellbeing and Equality & Diversity questions. The results of the first BeProud organisational engagement survey report saw a 20.29% response rate, which equates to 1400 individuals from a range of disciplines across the Health Board. These results from the first quarterly survey were presented to the Executive Team on 31st July. Plans are in place to carry out 4 surveys a year with a different random sample each time. • Draft organisational and divisional plans were approved at the Health Board meeting on 28th March 2019. Monitoring progress against the organisational improvement plan and divisional improvement plans will take place through 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. It has been confirmed that a national NHS Staff Survey will next take place in 2020. • 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 that focus 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.	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 24th September 2019

Recommendation	Current position	Progress update	Risks
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.*	Fully Implemented	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 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; • 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.	
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. Following on from this, the Executive Director of workforce & Organisational Development 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.	

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Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Ward Accreditation, Hospital Acquired Pressure Ulcers (HAPU) Collaborative & Falls Collaborative update
Report Author:	Mrs Diane Read, Head of Quality Improvement Team Lead (Corporate Nursing) Mrs Alison White, Business Support Manager, Quality Improvement Team (Corporate Nursing)
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	This report provides the Quality, Safety & Experience Committee with an update of the Ward Accreditation programme, HAPU collaborative progress and an overview of the Inpatient Falls Collaborative.
Approval / Scrutiny Route Prior to Presentation:	Quality and Safety group
Governance issues / risks:	The Ward Accreditation process highlights / flag any areas of concern, issues or risks that are shared with the ward team and senior team immediately or as part of the validation process depending upon the level of risk.
Financial Implications:	The Ward Accreditation process and Improvement collaboratives have highlighted areas requiring financial support and may highlight areas that require further financial support to improve upon as part of patient and staff safety and as the overall quality agenda. These areas may differ from one ward to another but the quality Improvement team are monitoring these areas.
Recommendation:	The Quality, Safety & Experience Committee are requested to continue to support the ward Accreditation process and implementation of the Improvement Collaboratives.

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			

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

Ward Accreditation, HAPU Collaborative and Inpatient Falls Update August 2019

1.0 Introduction:

The Health Board introduced a programme of focused improvement work that includes the Ward Accreditation Programme which commenced mid October 2018, quickly followed by the Hospital Acquired Pressure Ulcer Collaborative (HAPU) in late November 2018 and then the Inpatient Falls Collaborative in June 2019.

All key programmes of focused improvements provide an opportunity for the Health Board to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC) .

2.0 Ward Accreditation: Outcomes to Date

- At end of August 2019 there have been 60 unannounced visits / Ward Accreditations to wards.
- These 60 accreditations include Acute, Community, Childrens, Critical Care, Women's and Mental Health.
- 55 wards have been validated and scores shared with ward teams and their leadership team as follows:
    - 0 Gold
    - 23 Silver
    - 19 bronze
    - 9 White
    - 1 Red Flagged
- A new rota for the Ward Accreditation has been developed / launched to support an increase in the number of accreditations completed per week.
- Increased visibility of senior leaders at ward level and improved communication Ward to Board.

Areas reviewed during the accreditations are noted in Figure 1.

Figure 1

The scoring definition / standard used as part of the Ward Accreditation for each topic within the Ward Accreditation and for an overall score are defined below (figure 2):

Awarded Status	Definition
GOLD	Achieved excellent standards and have clear evidence of sustaining this success in data over at least 6 months
SILVER	Achieved very good standards and have some data over time to evidence this
BRONZE	Achieved good standards as expected by the Trust but have no evidence of sustaining this over time or have fallen below expected standards but are completing appropriate actions to address this
WHITE	Have not achieved the Trust minimum standards in at least one area and are not completing appropriate actions to address this issue – some additional support is required
FLAGGED	Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support

Figure 2

To facilitate the accreditations, the Quality Improvement Team (Corporate Nursing) maintain and coordinate the Ward Accreditation visit rota.

2.1 **Red Flagged Ward**:

In July 2019 BCUHB identified its first red flagged ward. The Red Flag signifies serious concerns identified during an accreditation in relation to safety or quality that require immediate and significant support. Following the red flag, the ward received immediate support from the Director of Nursing, Head of Nursing (HoN) and Matron to work on areas of concerns / improvement identified during the accreditation.

The Director of Nursing (and HoN in their absence) presented weekly updates to the senior team via the Ward Accreditation Validation Panel on a weekly basis (who meet every Monday morning at 9.15am).

The next step is for the ward to receive a second “post flag” accreditation visit – the aim of this accreditation is to provide assurance that the ward is safe following red flag interventions.

If the ward is deemed safe during the “post flag” accreditation visit, it will then be valid for a full reaccreditation within the next 12 months.

If it is deemed unsafe, the Director of Nursing, Head of Nursing (HoN) and Matron will continue to provide significant support and weekly updates will be provided to the Senior Team via the Validation panel.

2.2 Common Themes for Improvements:
The list below details themes highlighted within Ward Accreditation reports, some of which require immediate actions / spot checks by a member of the accreditation panel or Quality Improvement Team (Corporate Nursing):

- Record keeping: Risk Assessments, What matters;
- Implementation of Patient Rounding;
- Leadership;
- Recording of medication and food fridge temperature in line with Health Board standards;
- Resus trolley checks;
- Medication Standards and medication safety (incl. IV fluid storage);
- Security of CoSHH products;
- Handwashing for patients before meals;
- Using Patient Feedback mechanism and information for Quality Improvement (QI);
- Uniform Policy;
- E handbook Standards for above bed boards;
- SAFER implementation;
- Mandatory training;
- Adherence to minimum standards as defined in the E Handbooks (Environment & Multidisciplinary Team (MDT) Communication).

2.3 Celebrating Success:
Below are the areas of success highlighted by the Ward Accreditation**:**

- Staff engagement in the process;
- Providing a baseline for improvement;
- Improved consistency across BCUHB;
- Compliments SCC;
- Staff accessing, understanding and using Harms data for improvement;
- Increased visibility of Senior Leadership Team (Ward to Board);
- Boosting Team morale;
- QI projects in progress (Falls and HAPU);
- Board rounds;
- Patient and relative feedback extremely positive (but not always captured);
- Members of the MDT feedback very positive;
- Record keeping;
- Ward Leadership.

2.4 Next Steps for Ward Accreditation:

- Continue to undertake a minimum ward accreditation visit to each ward in the Health Board currently due to complete in February 2020, this date has slipped due to challenges of the rota and changing commitments of the visit teams.
- "Going for Gold" Roadshows across BCUHB in October 2019 to celebrate the successes of year 1 and engage staff in plans / requirements for year 2.
- Exploratory work commenced on developing a bespoke accreditation process for our Emergency Departments.
- Year 1 is our benchmark for development into year 2 (to review and revise standards to gain / maintain Gold, Silver, bronze, white or flagged).
- Update the Environment & MDT Communication E Handbooks for year 2 (based on lessons learnt from year 1) and develop new E Handbooks to support Ward teams suggested for Quality Improvement and Reducing Patient Harm –outputs from the collaboratives.
- Update Prompt Cards (used by the Ward Accreditation Team) for year 2 based on lessons learnt from year 1.

3.0 HAPU Collaborative:

The HAPU collaborative commenced in late November 2018, with two cohorts of wards from across BCUHB as follows:

HAPU Cohort 1 Wards	HAPU Cohort 2 Wards
• Ward 19 Ysbyty Glan Clwyd (YGC) • Bersham Stroke unit , Wrexham • Pantomime, Wrexham • Glaslyn, Ysbyty Gwynedd (YG) • Moelwyn, Ysbyty Gwynedd	• Ogwen, Ysbyty Gwynedd • Aberconwy, Llandudno • Ward 11 Ysbyty Glan Clwyd • Ward 1 Ysbyty Glan Clwyd • Wards 1 & 2, Colwyn Bay • Ceiriog ward, Chirk

Through a focused approach to Pressure Area Care (with support of an expert faculty and the application of Quality Improvement methodology) the cohorts were able to determine through testing, the standards for the Health Board for Pressure Area care in the ward setting. Effectively creating 'Always events' for pressure area care.

Early indication of the wards actively testing interventions are positive.

HAPU Launch events were held across BCUHB in May 2019 and were attended by over 130 BCUHB staff. During each of these sessions, the following improvements (as identified by the cohort wards) were presented / launched:

- Staff "know your ulcers" quiz – this will improve staff knowledge of identifying Pressure Ulcers;

- New look Tissue viability intranet page – this has provided staff with easier access to documentation and learning aids etc;
- Improve DATIX reporting including using an SBAR format in open narrative, plus the ability to report more than 1 pressure ulcer for 1 patient;
- “Are you Chair Aware” (as developed by Ceiriog Ward, Chirk) to help staff identify if patient chairs are suitable / not causing harm;
- Overview/introduction of the new Tissue Viability risk assessment Purpose T as part of the all Wales documentation standardisation.

The Quality and Safety Group are advised that there may be an increase in the number of incidents of HAPU reported following the implementation of how to report accurately on Datix, Pressure Ulcer classification and improved staff knowledge.

The HAPU Masterclasses (to launch the Purpose T and corresponding documentation) were originally scheduled for July 2019 but were postponed due to a delay in receiving the All Wales Welsh Health Circular which will confirm the All Wales launch date for Purpose T (and the package of other risk assessments).

3.1 Next Steps for the HAPU Collaborative:

Planning is underway for the postponed HAPU Masterclasses (now scheduled for October 2019) where the following will be shared:

- Purpose T assessment;
- Purpose T care plan;
- SKINN bundle;
- Purpose T interactive learning aid;
- Purpose T E Learning package;
- DATIX Root Cause Analysis;
- Non Concordant update / overview
- HB interventions that are proven to have a positive impact on reducing HAPU.

During these sessions (in collaboration the Senior Lead Nursing Informatics Specialist) the new All Wales Nutrition, Manual Handling and Continence risk assessments will also be launched alongside the Purpose T pathway due to the interlinking of these risk assessments top support safe patient care.

4.0 Inpatient Falls Collaborative:

By applying similar methodology as used with the HAPU collaborative, the Inpatient Falls Collaborative commenced in June 2019 with one cohort of wards identified through analysis of falls data as follows:

Falls Cohort Wards

- Evington Wrexham;
- Enfys YGC;
- Acute Cardiac Unit (ACU) Wrexham;
- Prysor Ward YG;
- Tryfan Ward YG;
- Menlli ward Ruthin Community Hospital;
- Bryn Hesketh Colwyn Bay;
- Cader Ward, Dolgellau Community Hospital.

The collaboratives aim is to:

Reduce falls by 15% by November 2019 and 30% by April 2020 for our cohort wards

The Faculty / collaborative aspire to achieve this aim by implementation of individual interventions for patients following an individual risk assessment.

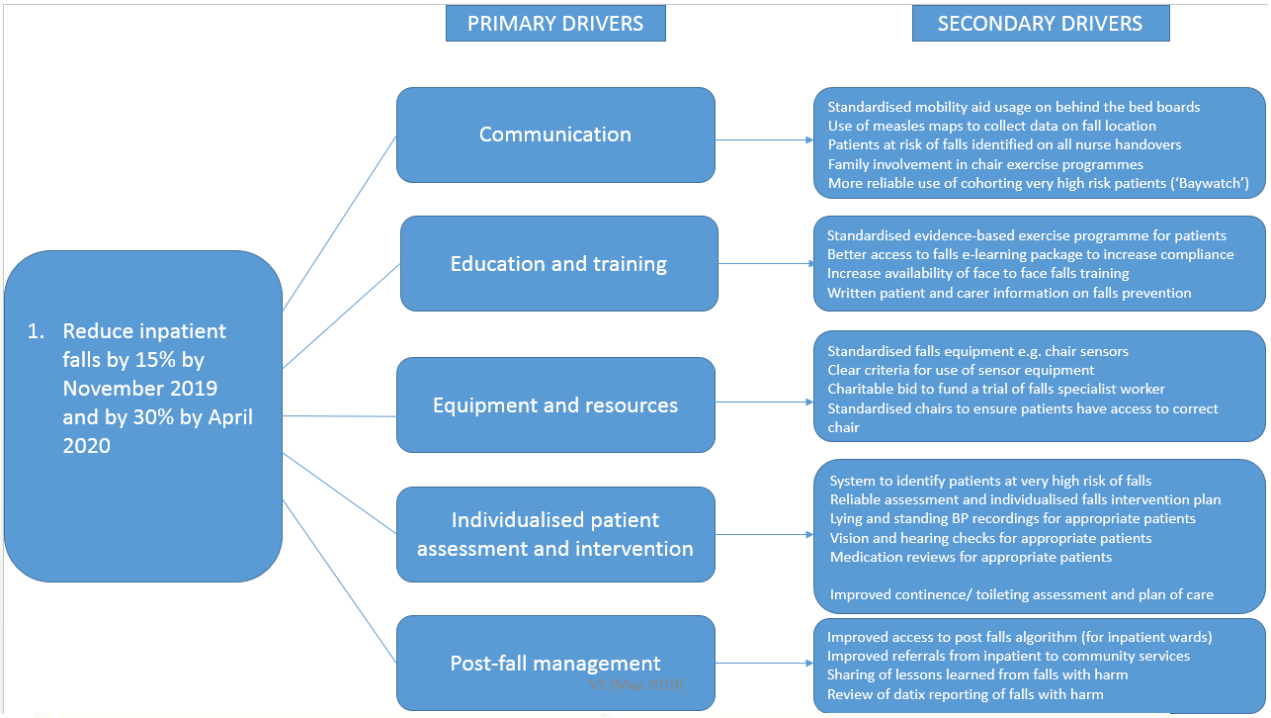
The faculty compromises of the Quality Improvement Team (Corporate Nursing) and subject experts which include Physiotherapist, Occupational Therapist, Dementia Consultant Nurse, Medical Consultant community falls lead etc with technical support from a data analyst.

4.1 Progress to date:

To date, the cohort wards have attended 2 Masterclasses during which they:

- Received Falls training from the BCUHB Falls Prevention Community Clinical Lead and Clinical Specialist Physiotherapist. This training ensured that all members of the collaborative have the same knowledge base;
- Received training around sustainability and how to ensure change is sustained post completion of the collaborative.
- Reviewed own wards (last 6 months of) DATIX incidents to identify trends / themes for areas of targeted quality improvement = PDSA 1 in the first Masterclass and PDSA 2 in the second Masterclass;

The faculty have also undertaken a review of the available literature / evidence and through a faculty workshop have developed both a driver diagram for the wards to test interventions against and the outcome / process measures as follows:



Outcome Measures	Process Measures
Total number of falls	Location of fall (using measles map)
Number of falls by severity (as reported on Datix)	Compliance with falls pathway completion
Number of falls per 10,000 bed days	Compliance with falls pathway actions being carried out by ward team
Number of falls associated with toileting	Staff knowledge of falls prevention strategies
	Number of ward staff undertaking falls prevention training

4.2 Next Steps for the Falls Collaborative:

Masterclass 3 will be held on the 5th September 2019 where the cohort wards will:

- Share progress to date;
- Receive training around creative thinking to help the cohort wards look at issues and consider ideas from various perspectives;
- Review DATIX (as per Masterclass 1 & 2) and data;
- Plan PDSA 3;
- Faculty work plan for Q3/4.

Following completion of Masterclass 3, all cohort wards (and the Falls Faculty) will attend a presentation day on the 23rd October 2019 (Wrexham Medical Institute Lecture Theatre) to present their experience and outcomes of their PDSA's. All Senior Leads / Directors will be invited to attend this event to hear the successes and issues encountered as part of the collaborative and then to determine interventions that are for HB wide implementation or for further local (cohort wards) testing to establish local evidence.

Falls Collaborative Launch events will be held across BCUHB in December to share the outcomes to date of the collaborative quickly followed by focused Masterclasses in January 2020 to share with and train staff to greater detail. .

5.0 Recommendations:

The Quality, Safety & Experience Committee are asked to continue to support the Ward Accreditation process and the improvement collaboratives.

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Health Board's Response to Healthcare Inspectorate Wales (HIW) Annual Report 2018-19
Report Author:	Mrs Deborah Carter, Associate Director of Quality Assurance Ms Erika Dennis, Business Support Manager, Corporate Nursing
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	This report provides a response on behalf of the Health Board in relation to the HIW annual report for the period; 1st April 2018 to 31st March 2019 which can be found at Appendix 1
Approval / Scrutiny Route Prior to Presentation:	Detailed presentation at Board Workshop 6.6.19 Monthly briefings submitted to Quality Safety Group (QSG)
Governance issues / risks:	The findings from inspections and reviews feed into the NHS Wales Escalation and Intervention Arrangements. If NHS organisations do not provide sufficient assurance to HIW that action has been taken to address the issues found, HIW can fine or take enforcement action.
Financial Implications:	Costs will be incurred in each Division / area and will differ depending on HIW recommendation / BCUHB action and some costs will be part of the maintenance / refurbishment programme.
Recommendation:	The Committee is asked to note the contents of the HIW Annual Report and to the Health Board's response to 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 Leadership and governance			
Equality Impact Assessment			

Disclosure:
BetsiCadwaladr University Health Board is the operational name of BetsiCadwaladr University Local Health Board

Healthcare Inspectorate Wales Annual Report: April 2018- March 2019

The Annual Report for 2018-19 acknowledges how Health Boards in Wales are balancing ongoing financial pressures and increasing health care needs from an ageing population with complex conditions.

Over the past year, the HIW have carried out 179 inspections, including follow up inspections of Primary, Community and Secondary care services. The report details the findings of those inspections in terms of good areas of practice and improvements which need to be made in line with Care Standards.

For BCUHB, the HIW carried the following inspections in 2018-19;

- 2 hospital inspections, one of which was a follow-up. *No immediate assurance issues*
- 4 mental health unit inspections. *No immediate assurance issues*
- 1 Ionising Radiation (IR(ME)R) inspection. *No immediate assurance issues*
- 5 GP Practice inspections and 1 follow-up inspection. *No immediate assurance issues*
- 21 dental practice inspections. *One immediate assurance issues*
- 1 Community Mental Health Team (CMHT) inspection. *No immediate assurance issues*

For follow-up inspections, most improvements have been implemented and sustained. There are however, some issues which remain apparent and significant challenges for the BCUHB in maintaining patient flow through the Emergency Department at Glan Clwyd, and tackling prolonged waiting times.

HIW noted that for Mental Health services, there were no immediate assurance issues and it is clear that much effort is being made to improve services. The HIW do however, remain concerned about the overall capacity of BCUHB's mental health inpatient services and the length of time some patients may be waiting for access to psychological services.

HIW reported that for BCUHB, GP inspections were positive overall. However patients consistently reported concerns to the HIW regarding the ability to make appointments at their GP Practice.

Internal Processes for HIW

The Health Board have an internal process for HIW matters. Briefings are provided to the Quality & Safety Group (QSG) on a monthly basis with a summary of all HIW actions and ongoing Thematic Reviews and / or expected inspections / reports.

Next Steps

Corporate Nursing leads will continue to work with and support local leads with the HIW inspection process, along with the implementation and monitoring of

improvements from inspections. The role of the Central Corporate Lead (Business Support Manager) will play a pro-active role.

We aim to strengthen the relationship between with Health Board and HIW, ensuring collaborative working and learning.

Additional Information:

The Corporate Nursing team would like to take this opportunity to emphasise the compliments received from HIW in relation to Health Board staff. The HIW have complimented and thanked staff for their professionalism and support with inspections they have undertaken this year so far.

HEALTHCARE INSPECTORATE WALES

Annual Report 2018-19

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Important Note about Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board

This Annual Report covers the period from 1 April 2018 - 31 March 2019 and the boundaries and names of two of Wales' health boards changed on 1 April 2019.

Following the Bridgend boundary changes, Abertawe Bro Morgannwg University Health Board became Swansea Bay University Health Board; and Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board on 1 April 2019.

For the purposes of this report, we have used the correct names of the health boards during the 2018 – 2019 reporting period.

For further details on the new boundaries, please visit the relevant health board websites: www.cwmtaf.wales and www.sbuhb.nhs.wales

In Writing

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Contents

Abbreviations used:

Abertawe Bro Morgannwg University Health Board – **ABM**
Aneurin Bevan University Health Board – **Aneurin Bevan**
Betsi Cadwaladr University Health Board – B**etsi Cadwaladr**
Cardiff and Vale University Health Board – **Cardiff and Vale**
Cwm Taf University Health Board – **Cwm Taf**
Hywel Dda University Health Board – **Hywel Dda**
Powys teaching Health Board – **Powys**

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.
We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through the reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.

Foreword

Last year marked the 70th anniversary of the NHS; founded by Tredegar-born Aneurin Bevan and still a source of pride to so many in Wales. Healthcare services have changed exponentially in this time with advances in medicine, ongoing financial pressures and increasing healthcare needs from an ageing population with complex conditions.

Balancing these pressures is a challenge for everyone working in modern health settings, and patients need to know that the healthcare they receive is safe and effective. The role of Healthcare Inspectorate Wales has never been more important.

In June 2018, we launched our three-year strategic plan Making a Difference which set out our vision and priorities to improve health and wellbeing for people in Wales and a clear mandate on how we will play our part in driving up standards in healthcare in Wales. As I reflect on this first year of our strategic plan, I am proud of the achievements so far as we strive to increase our impact, take action where standards are not met, be more visible and be the best organisation we can be.

This year we carried out 179 inspections, including follow up inspections, of hospitals, dentists, GP practices, mental health providers, independent healthcare and settings using ionising radiation.

Overall we saw a high standard of healthcare being delivered to patients, but there are some recurring themes that must be addressed.

It was clear from our hospital inspections that services continue to face significant challenges with regard to staffing levels. At a more local level, issues with appointment booking systems at GP practices were evident in many GP inspections last year with patients reporting long waits and difficulties securing on the day appointments to see a doctor.

Our dental inspections were good on the whole with some practices receiving outstanding reports with no suggested improvements at all. However in other dental practices, and indeed in most of our inspections across all settings, the safe storage and administration of medicines continues to be a problem. Care and treatment planning was poor in our mental health inspections with improvements needed to risk management in independent settings.

Following the allocation of some additional resource, we are in a position to increase our core activity within the NHS, enhance our follow up work, undertake more national and local reviews, and better respond to emerging in-year intelligence.

We have also embraced the latest digital technology into our work with the introduction of new electronic inspections and a simpler system of online payments for registration fees.

As we grow and develop as an organisation we continue to focus on delivering an effective service checking on the quality of care that people receive across Wales and taking action where standards are not met to support improvement.

If you have any comments on this report, our work or your experience of healthcare services in Wales, please get in touch.

Dr Kate Chamberlain, Chief Executive

HIW 2018 - 19 In Numbers

Hospitals

- 10 general hospital inspections
- 3 surgical inspections
- 120 patient questionnaires
- 3 follow up inspections

Dental

- 73 dental inspections
- 1803 patient questionnaires
- 5 immediate assurance letters

Offender Healthcare

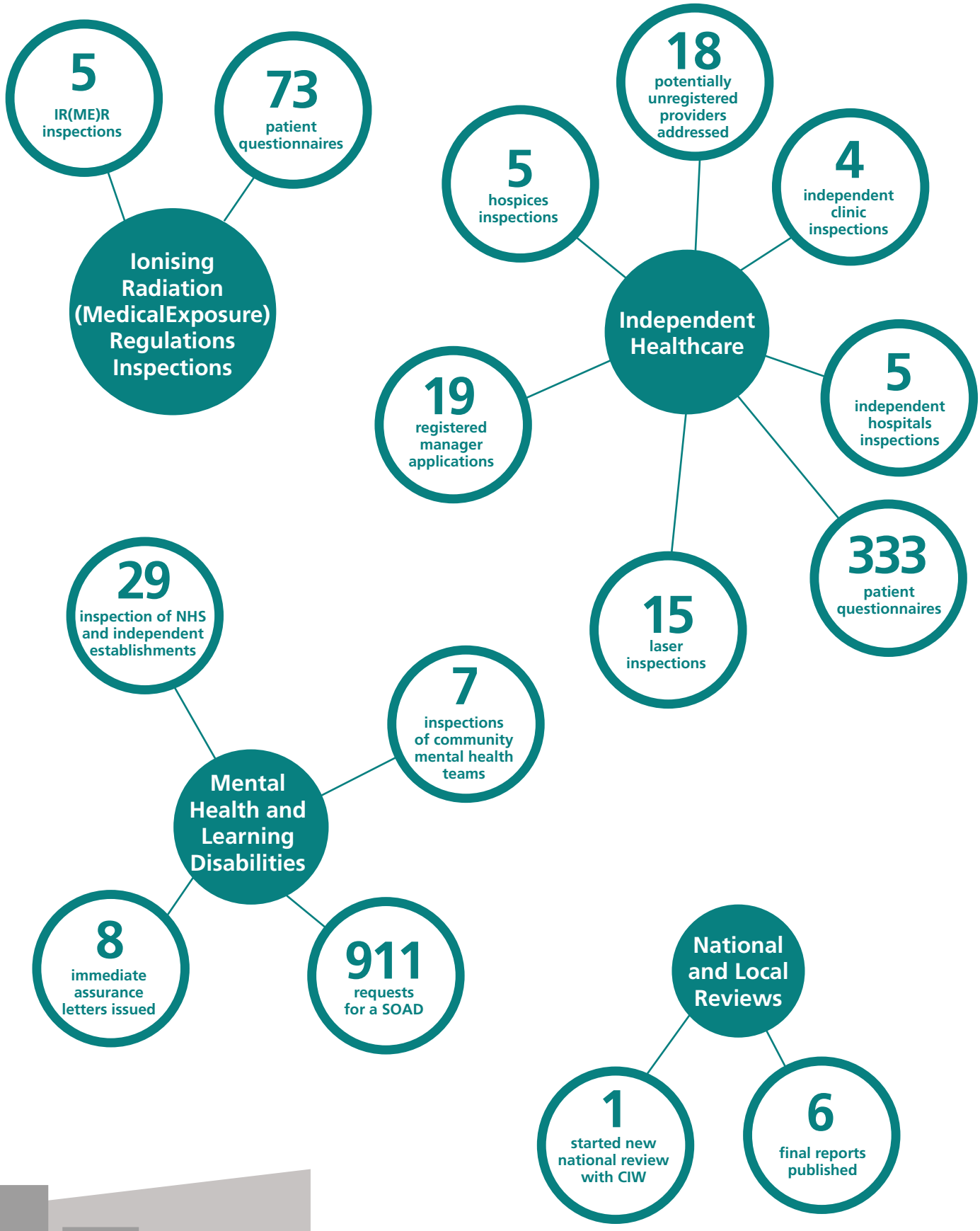
- 18 death in custody reviews
- 1 joint prison healthcare inspection
- 1 joint youth offending services inspection

Concerns

- 312 concerns from public and staff
- 37 37 were rated as 'high' risk

GP

- 20 GP Inspections
- 5 immediate assurance letters issued
- 641 patient questionnaires


5
IR(ME)R inspections
73
patient questionnaires
Ionising Radiation (MedicalExposure) Regulations Inspections
18
potentially unregistered providers addressed
5
hospices inspections
4
independent clinic inspections
Independent Healthcare
19
registered manager applications
5
independent hospitals inspections
333
patient questionnaires
15
laser inspections
29
inspection of NHS and independent establishments
7
inspections of community mental health teams
Mental Health and Learning Disabilities
8
immediate assurance letters issued
911
requests for a SOAD
National and Local Reviews
1
started new national review with CIW
6
final reports published

What did patients tell us?

As part of the inspection process we ask patients if they would like to tell us about the care they receive by taking part in a questionnaire.

Last year we received 3106 completed patient questionnaires; a small increase on the total number of responses from the previous year (3060).

We also invited staff in hospitals and hospices to complete a questionnaire and we received 327 completed questionnaires from workers.

What did patients tell us?

We have separated the figures to show patient scores in 2018-19 by the type of setting (for example. hospital, GP, dentist etc.).

Overall rating

Patients generally rated their care as good.

- On average, hospital patients scored hospitals as 9 out of 10
- 99% of dental patients rated their dentist as good, very good or excellent
- 88% of GP patients rated their experience as good, very good or excellent
- 97% of patients receiving ionising radiation as part of a diagnostic procedure or treatment rated their experience as good, very good or excellent
- 98% of laser patients rated their experience as good, very good or excellent

Cleanliness

We also asked patients to rate the cleanliness and tidiness of facilities.

- 96% of hospital patients agreed the ward was clean and tidy
- 99.6% of dental patients agreed the surgery was fairly clean or very clean
- 99% of GP patients agreed the environment was fairly clean or very clean
- 99% of independent clinic patients agreed the environment was clean and tidy

Dignified Care

Dignified care includes staff being polite and sensitive to patients' needs.

- 97% of hospital patients agreed that staff were always polite and were kind and sensitive
- 91% of hospital patients agreed that staff provided them with help, in a sensitive way, so they could use the toilet
- 89% of hospital patients agreed that when they used the buzzer, staff came
- 94% of GP patients felt that staff treat them with dignity and respect

Communicating Effectively

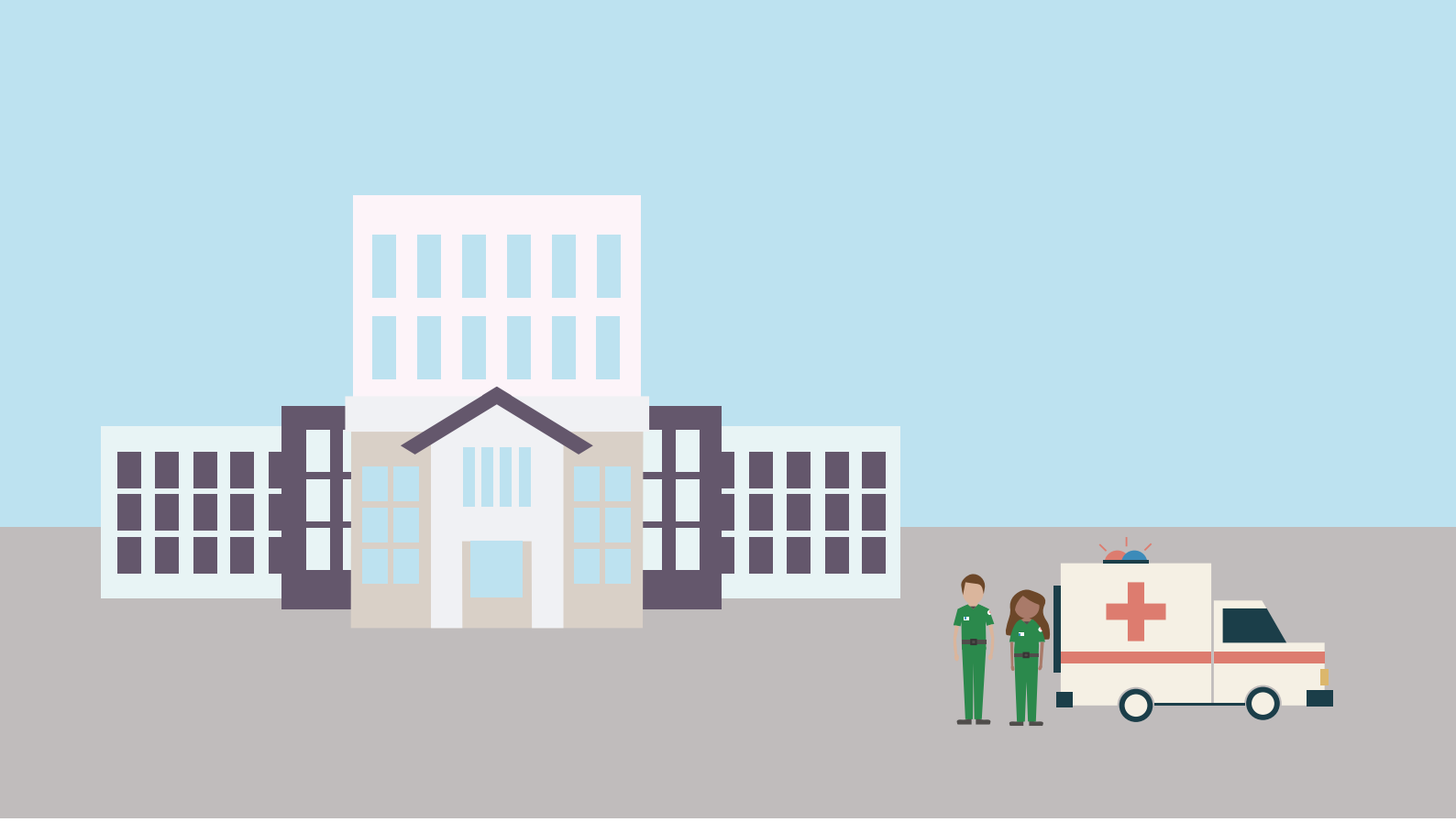
This includes how patients communicate with staff and how staff communicate with patients.

- 84% of hospital patients said they could communicate using their preferred language
- 92% of GP patients said they could communicate using their preferred language
- 96% of dental patients said they could communicate using their preferred language
- 89% of hospital patients said they felt that staff always listened to them
- 90% of CMHT patients said they felt that staff always listened to them
- 81% hospital patients agreed staff had talked with them about their medical conditions and helped them understand them
- 87% of CMHT patients believed staff had enough time to discuss their needs

Treatment options

This section covers how well treatments are explained to patients and their understanding and participation in the treatment process.

- 96% of GP patients said things were always explained in a way they understand and 91% said they felt involved in decisions about their care
- 95% of dental patients said treatment options were fully explained to them and 96% said they felt involved in decisions about their treatment
- 96% of IR(ME)R patients said they felt involved in decisions about their treatment and 96% said they were given enough information to understand the risks of the procedure
- 98% of patients receiving Laser treatment said they felt involved in decisions about their treatment and 90% said they were given enough information to understand the risks of the procedure



Cost of treatment

This section only covers treatment that is not provided free under the NHS.

- 96% of dental patients said the cost of treatment was made clear
- 98% of laser patients said the cost of treatment was made clear

Ease of access

This section looks at how easy it is to book an appointment.

- 98% of dental patients said booking an appointment was fairly easy or very easy
- 76% of GP patients said booking an appointment was fairly easy or very easy

Out of hours care

This section covers awareness of out of hours services.

- 76% of dental patients said they know how to access the out of hours service
- 63% of GP patients said they know how to access the out of hours service

Our Work

We check that people in Wales receive good quality healthcare. We put the patient at the heart of what we do, and we make sure our work promotes and protects equality and human rights for everyone. Our work is guided by the Well-being of Future Generations (Wales) Act 2015. In making decisions about the work we do, we balance the short term and long term needs of patients, working collaboratively with partners, patients and the community to support improvement.

Providing Assurance

We inspect the NHS in Wales. Our coverage in the NHS ranges from general practice to large hospitals. During 2018-19 we carried out 144 inspections in the NHS.

We also regulate and inspect independent healthcare. Independent healthcare includes a wide range of providers from full private hospitals to beauty salons who use lasers. During 2018-19 we carried out 29 inspections in the independent sector.

Dental practices rather than individual dentists undertaking private work need to register with HIW as a result of changes in the Private Dentistry (Wales) Regulations in 2017. We embarked upon a dental registration programme as a result registering practices rather than individual dentists, and by the end of 2018-19 we had completed the registration of all practices; 485 in total. We also maintained our dental practice inspection programme completing 73 inspections.

We have a specific responsibility to ensure that vulnerable people receive good care in mental health services, and we inspect mental health and learning disability settings in NHS and the independent sector. HIW considers how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We also assess compliance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011, National Minimum Standards (NMS) for Independent Health Care Services in Wales.

We completed 29 mental health inspections during 2018-19.

Our work programme ensures that we meet our statutory requirements and we review areas of concern identified by intelligence and risk. Our Risk and Escalation Committee regularly assesses the evidence and intelligence available and reviews and refines our programme of work. We use what we know about services to determine our priorities.

In addition to our risk based inspections of the NHS and independent sector, HIW also undertakes national reviews. During 2018-19 we published reports in the areas of healthcare services for young people, substance misuse, patient discharge, community mental health and the prevention and promotion of independence for older adults living in the community.

Performance

Year	2 days met	2 days missed	3 months met	3 months missed
2018 - 19	94%	6%	92%	8%
2017 - 18	100%	0%	92%	8%
2016 - 17	91%	9%	82%	18%
2015 - 16	71%	29%	75%	25%

Performance Standards

We are explicit about the standards of service we provide.

- Where immediate assurance is required following an NHS inspection, letters will be issued to the Chief Executive of the organisation within two days
- Where urgent action is required following an inspection in the independent sector, the service will issued with a non-compliance notice within two days
- We publish all reports three months after an inspection as stated in our publication policy

During 2018-19 we published 92% of our reports within three months of the inspection.

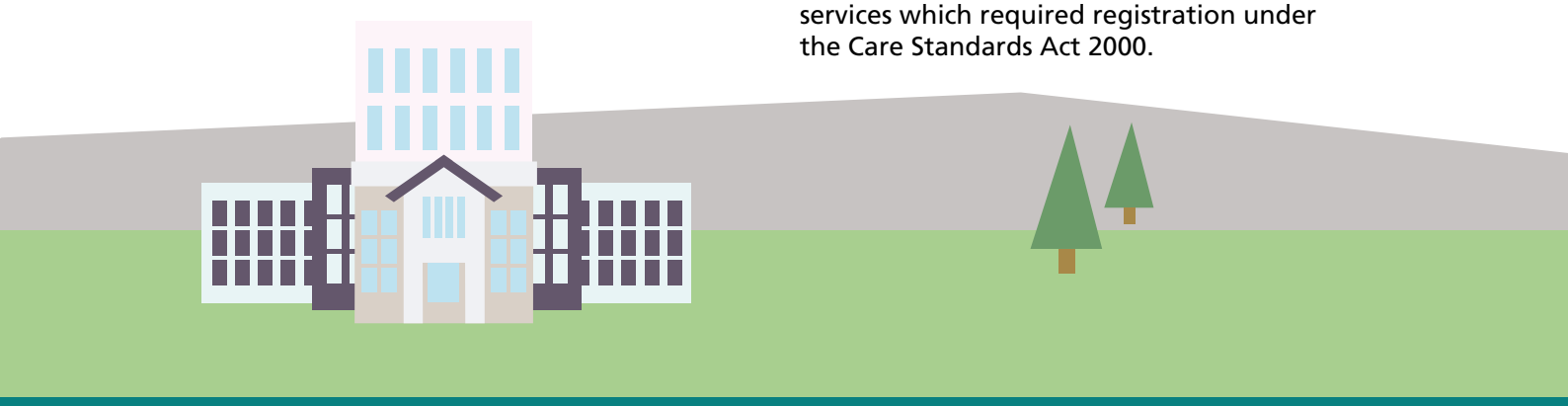
We reported 94% of issues of immediate concern within two days.

Promoting improvement

Many of our inspection and review reports contain recommendations intended to drive improvement in the quality of healthcare services. Our recommendations directly influence the actions of both service providers and health boards, and have led to improvement in the service delivered to patients. We have seen this in the majority of the ten follow up inspections that we carried out during 2018-19.

When we find that standards are not met, we make recommendations for improvement. The findings from our NHS inspections and reviews feed into the NHS Wales Escalation and Intervention Arrangements including those areas where we do not feel that sufficient progress is being made. If we do not receive sufficient assurance that action has been taken to address the issues we find in the independent sector, we take enforcement action.

In October 2018 we were successful in our first prosecution for illegally providing services which required registration under the Care Standards Act 2000.



Our Resources

Our People

The table below shows the number of posts in each team within HIW during 2018-19.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	32
Intelligence, partnership and methodology	8
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Business support (including recruitment, allocation and support of panel reviewers)	16
Total	**68**

Towards the end of 2018 we received further funding in order to build organisational capacity across our core functions. We subsequently ran a recruitment exercise to take the total number of posts in HIW to 78.

Due to timing of the recruitment process most of the extra posts were not filled until 2019. This contributed to an underspend in our budget for 2018 – 2019.

We rely on the input of peer and lay reviewers to assist in the delivery of our inspection and review programme. We currently have a panel of over 200 peer and voluntary lay reviewers and we will be expanding this pool during 2019 - 20 to meet the demand of our increased programme of inspections and national reviews.

Our peer reviewer panel consists of specialists including nurses, midwives, GPs, dentists, anaesthetists, surgeons and GP practice managers.

It also includes specialists in Mental Health Act Administration and a panel of psychiatrists who provide our second opinion appointed doctor (SOAD) service. Using peer reviewers provides a dual benefit; HIW receives specialist clinical input for inspections and reviews, and reviewers benefit from the learning provided by participation in our work and they are able to take this learning back to their own work environments.

We also have a pool of volunteers on our panel of lay reviewers who have the critical role of assessing patient experience through talking to patients and inviting them to complete questionnaires.

Finances

The following table shows how we used the financial resources available to us in the last financial year to deliver our 2018-19 Operational Plan.

	£000's
HIW Total Budget	3,934
Expenditure	
Staff costs	3,161
Travel and Subsistence	84
Learning & Development	17
Non staff costs	304
Translation	114
Reviewer costs	519
Capital ICT costs	55
Total expenditure (a)	**4068**
Income	
Independent healthcare	277
Private dental registrations	123
Total income (b)	**400**
Total Net Expenditure (a-b)	**3,668**

Working with others

In order to check that people in Wales receive good quality healthcare we work closely with a number of other organisations.

The effective sharing of information between organisations is critical in assessing the quality of healthcare being provided across Wales. During 2018-19 we hosted two healthcare summits bringing together external audit, inspection, regulation and improvement bodies to share intelligence about NHS organisations. Themes that emerge from these discussions were agreed and communicated to the Welsh Government.

We have strengthened our working arrangements with the Community Health Councils which has resulted in a more systematic sharing of work plans, emerging issues and early identification of joint working opportunities.

We continue to work closely with Care Inspectorate Wales, the Wales Audit Office and Estyn on areas of mutual interest throughout the year. Through a joint Inspection Wales presence at the Royal Welsh Show, we engage with the public and present our respective findings.

We have worked closely with the Welsh Government on new and emerging policy and legislation. Through our activities, we see how legislation, policies and standards work in practice. We feed back our findings and perspective at relevant opportunities, for example through formal consultations, evidence to National Assembly for Wales Committees and directly to the Welsh Government. We provided oral and written evidence for a general scrutiny evidence session on the work of HIW at the National Assembly for Wales' Health, Social Care and Sport Committee in February 2019.

We have also worked with other bodies to examine healthcare in other settings such as the clinical review of deaths in prison settings undertaken with the Prison and Probation Ombudsman (PPO), prisons in Wales undertaken by Her Majesty's Inspectorate of Prisons (HMIP) and reviews of Youth Offending Teams led by Her Majesty's Inspectorate of Probation.

Progress against our Strategic Plan 2018 – 2021

To maximise the impact of our work to support improvement in healthcare

HIW aims to encourage improvement in healthcare by doing the right work at the right time in the right place. In order to make the greatest impact, HIW needs to work with others in the wider health and care system and communicate its findings effectively.

Over the last year, HIW has continued to work closely with partner organisations; holding regular summits and meetings with Community Health Council colleagues on a six monthly basis. These meetings have allowed us to exchange intelligence and calibrate our views on the risks and issues present across Wales. Close partnership working has also allowed us to avoid duplication of effort, delivering work jointly where appropriate.

We have continued to refine our planning processes, making use of available intelligence in order to ensure that we use our resources effectively. Our NHS Relationship Managers have acted as the first point of contact for health boards and trusts, assessing intelligence and risk in order to define our inspection and review work programmes.

Our Thematic Steering Board supports our aim of delivering the right work at the right time, by helping us to evaluate evidence from a range of sources in order to prioritise the development and delivery of the most appropriate reviews.

With a focus on the challenges set out in the Parliamentary Review of Health and Social Care in Wales (2018), HIW has continued to work with Care Inspectorate Wales (CIW) on reviews and inspections which cross the health and social care boundary. In 2018/19 we worked closely on the publication of a national report on Community Mental Health Teams and we continue to jointly deliver local inspections in this area. In early 2019, we are supporting CIW in undertaking a national review of the prevention and promotion of independence for older adults (over 65) living in the community. CIW are also acting as a key stakeholder in HIW's ongoing work on how care and treatment is provided to elderly people who have had a fall and how falls can be prevented.

To take action when standards are not met

HIW aims to take decisive action when standards are not met, and to this end, it is imperative that our work is of a high quality and underpinned by effective processes and legal frameworks

We implemented a Methodology Panel during 2018/19 to ensure that we review, update and develop our approaches in a controlled and prioritised way. This has helped us to continue to effectively assess healthcare provision against relevant standards and take action where there is a failure to meet those standards.

2018/19 saw us strengthen our approach to enforcement in the independent sector, including our Service of Concern process. We suspended an independent provider and delivered a number of urgent, focussed inspections. HIW successfully prosecuted an unregistered provider in October 2018 and this case allowed us to reflect on the type and pace of actions we take when we receive intelligence about such providers. We are working to improve the guidance published on our website so that those providing or considering providing independent healthcare services in Wales understand their legal responsibilities.

In 2018, we continued to develop the way we follow up on recommendations made during our inspections and reviews, publishing a policy setting out our approach. This will pave the way to greater activity in this area going forward.

HIW continues to work with Welsh Government on immediate policy and legislative developments such as the introduction of a duty of candour and a duty of quality, as well as revised board governance arrangements and the introduction of a new citizen's voice body.

To be more visible

To achieve our strategic goal, we need to build on our work to improve public and stakeholder understanding of HIW's role and the work we do.

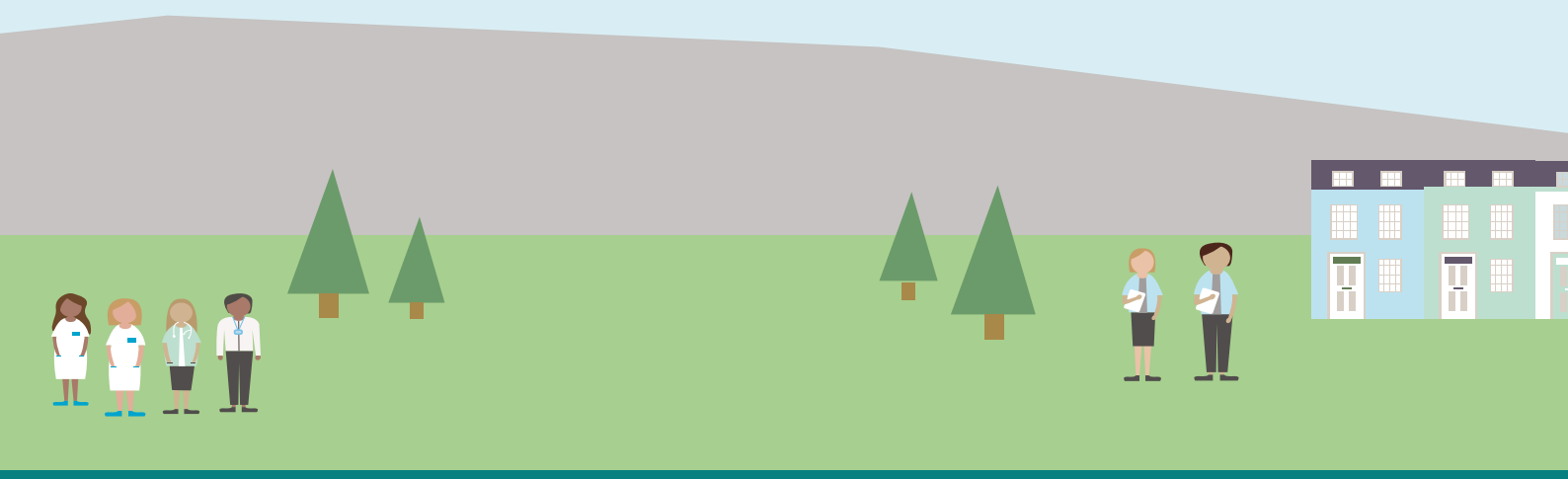
Over the course of the year we have worked to better use both digital and traditional media to communicate about our role, purpose and findings. We have worked proactively with the media and gained good coverage for our findings from a number of our reports and through a BBC Wales feature on the role of the inspectorate.

We have redesigned public facing documents to make them more relevant to the public, increased our following on social media and attended high profile events to communicate our purpose and the findings of our work. During the Royal Welsh Show in 2018 over 300 people took part in our survey on the work and findings of HIW, and we spoke to nearly 200 members of the public about their healthcare experiences.

We have also updated public facing documents, expanded our audience on social media and attended high profile events to communicate our purpose and the findings of our work.

We have started the development of new digital approaches to seeking views and perspectives from patients directly before and during inspections. This will help us to expand on the 3106 completed patient questionnaires received during the year.

We have worked closely with our stakeholder groups on new areas of work and, through our improved Healthcare Summits, we have been highly visible in providing a focal point for intelligence sharing and representing the collective views of those who scrutinise healthcare across Wales.



To develop our people and organisation to do the best possible job

HIW's greatest asset is its people. During the course of the past year the organisation has made strides forward in developing as an organisation. Our latest staff survey shows improvement across all areas.

Through our ICT change programme we have introduced new ways of working that make us both more efficient as an organisation but also improves our information management and security. Our inspectors now work digitally in the field and share information with settings through new and improved hardware, systems and processes.

Those who need to pay for registration can do so quickly and easily online and where possible we have reused existing, tried and tested government systems to reduce the costs of implementation and future support. HIW became the first organisation in Wales to adopt the GOV.UK Pay system and in doing so made the system available in Welsh paving the way for other government organisations in Wales to use it.

We have launched a three year learning and development strategy and action plan for the organisation which has improved the learning opportunities available for all of our staff and reviewers. We have also encouraged consideration of individual learning opportunities in line with personal and professional development requirements.

We have introduced and embedded new governance around our review, methodology, workforce and finance functions improving our ability to plan, manage and martial our resources to organisational priorities.

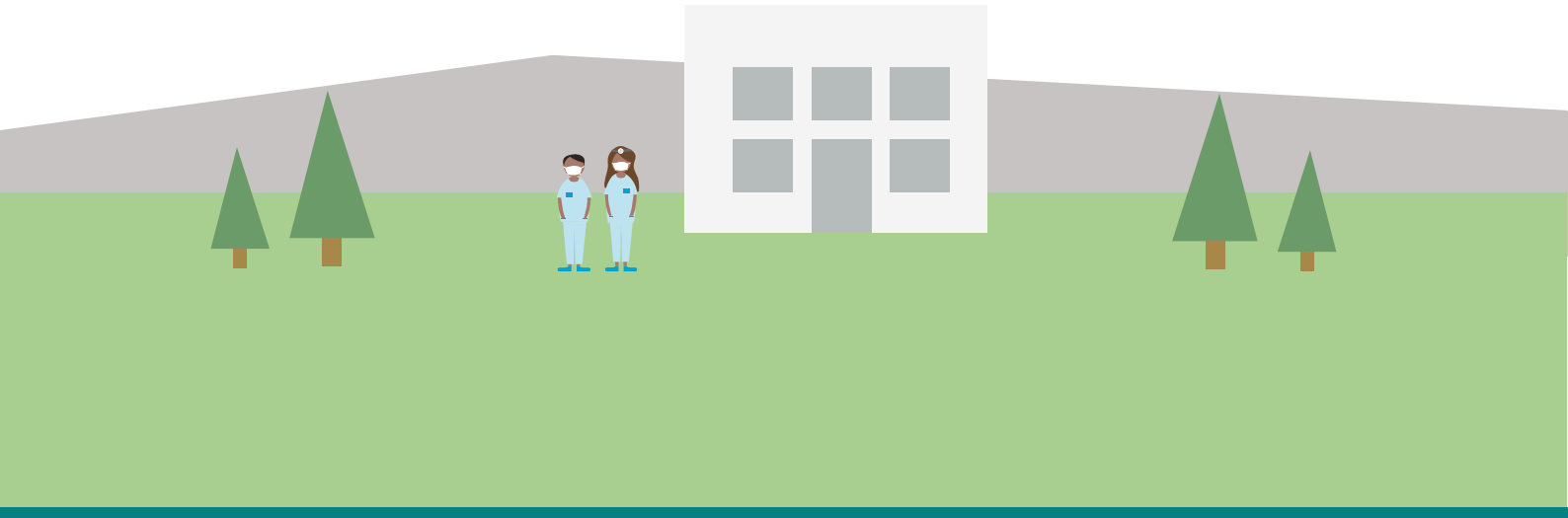
Following the in-year allocation of new resources to increase our activity across Wales, we have successfully delivered a recruitment campaign and induction programme to increase the people in our organisation by more than 10%.

National and Local Reviews

HIW delivers national reviews which enable us to examine how services are delivered across the whole of Wales. We are also commissioned to conduct independent reviews on matters of national significance.

We encourage people to tell us their views about what we should look at and we have a suggestion form on our website that can be completed by anyone who has a concern.

HIW has a close working relationship with the other inspectorates in Wales and we increasingly look for opportunities to work jointly; especially with Care Inspectorate Wales.



Substance Misuse

In July 2018, HIW and CIW published a joint review of substance misuse services in Wales. The purpose of our review was to assess the quality and effectiveness of care provided by substance misuse services across Wales.

Overall, we found people receive good care from passionate and caring staff, but access to services was limited in rural areas and generally inconsistent across Wales. Specifically, people found it difficult to get the treatment they needed from substitute prescribing (e.g. methadone), detoxification, rehabilitation and counselling services, because of long waits and a lack of capacity in services.

The review also identified weaknesses in oversight and regulation around the quality and safety of services. As such, Area Planning Boards may not be able to quickly identify, monitor and act on emerging themes and issues across all services in order to protect people's safety. Welsh Government and Area Planning Boards need to reconsider the way they seek assurance about performance of services.

Disappointingly, although some progress had been made, many of the issues identified in the report were similar to those HIW identified in its previous substance misuse report in 2012.

34 recommendations were made for Area Planning Boards and/or Welsh Government to consider.

Patient Discharge

In August 2018, HIW published a review of patient discharge from hospital to general practice. The way in which patients are discharged from hospital is critical to the effectiveness of their ongoing care in the community. The purpose of the review was to consider the quality and timeliness of discharge information provided by hospitals.

Overall, we found the quality and timeliness of discharge information was variable across Wales, with this area of the NHS requiring significant attention to ensure that safe and effective healthcare is provided.

It is clear that some parts of the NHS in Wales are making progress in the area of patient discharge but progress is far too variable across Wales. Where we saw increased usage of electronic discharge systems the quality and timeliness of information received by GPs was clearly improving.

We found that all health boards had appropriate policies in relation to discharge. However, there appears to be a lack of awareness and understanding of these processes from staff on some wards and this lack of clarity, combined with poor IT infrastructure and a failure amongst professionals to take responsibility for effective communication can put patients at risk.

13 recommendations were made for NHS Wales healthcare organisations and NHS Wales to consider as result of the findings.

Review of healthcare support for older people living in care homes in North Wales

In November 2019, we published a joint review with CIW into how we can work together to ensure the healthcare needs of older people living in care homes in North Wales are met.

We investigated how Betsi Cadwaladr UHB met the healthcare needs of older people living in residential and nursing care homes, and gathered the experiences of care home managers in accessing healthcare support for people from the NHS. We also examined how HIW and CIW can work in a more integrated way to improve outcomes for people living in care homes.

Feedback was variable across most of the service areas considered, but some common issues emerged which need to be addressed in order to provide seamless, good quality care, to individual residents and patients. Many of the issues highlighted in the report echo those found during the course of the Older People's Commissioner's review in 2014 and have a direct impact on the well-being of people living in care homes.

The report identified 16 areas for improvement which HIW and CIW are following-up.

Abertawe Bro Morgannwg University Health Board and the employment of Kris Wade

In January 2019, HIW published a review of Abertawe Bro Morgannwg University Health Board's handling of the employment and three allegations of sexual assault made against Kris Wade by patients within their learning disability service.

The review examined staff recruitment and employment, incident reporting, adult safeguarding, governance and culture, an assessment of ABM's desktop review, and learning disability commissioning arrangements between health boards.

The health board's internal desktop review identified areas of concern around safeguarding processes, incident reporting, recruitment practices and governance and culture. It also concluded that Mr Wade's actions could not have been 'predicted or prevented'.

On the limited evidence considered, the health board's own conclusions were not unreasonable, however, we believe that the conclusion that Mr Wade's actions could not have been predicted or prevented is not based on evidence to either support or refute it. What we can say, having considered a wider range of evidence, is that there was nothing in Mr Wade's training, supervision or occupational health records that would have indicated that he was unsuitable to work in a care setting.

The key themes to emerge from this review are:

- An unacceptable delay in the health board recognising and reporting the first allegation as a safeguarding issue
- The health board's investigation and subsequent disciplinary process took too long
- Whilst some improvements have been made to the health board's governance arrangements, progress in addressing these needs to be quicker.

Welsh Government should consider how the renewal of Disclosure and Barring Service (DBS) checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients. As a result of the findings from this review we made 24 recommendations to be addressed by Abertawe Bro Morgannwg University Health Board, Welsh Government and considered by all health boards in Wales.

Community Mental Health Teams

In February 2019, HIW and CIW published a joint review of Community Mental Health Teams (CMHTs) in Wales. This review is primarily a response to a report published by HIW in March 2016: Independent External Reviews of Homicides – An Evaluation of Reviews Undertaken by HIW since 2007.

The purpose of the review was to bring together the key themes to have emerged from HIW and CIW's joint-inspections of CMHTs across Wales in the last two years, as well as engagement with people who use services, carers, and the third sector.

Overall, we found that people receive an acceptable quality of care from hard working and compassionate staff. However, over the course of this review we frequently found disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams across Wales. Welsh Government, Health Boards and Local Authorities need to carefully consider and examine the areas we have highlighted and act on our recommendations so that people living with mental illness will receive equitable care wherever they live in Wales.

The key themes to emerge from this review are:

- Access to Services
- Care Planning
- Delivery of Safe and Effective Care
- Governance

23 recommendations were made for improvement for Welsh Government, health boards and local authorities to consider.

Youth Review

In March 2019, HIW published a review of how healthcare services are meeting the needs of young people, including those who need to transition from child to adult services. The purpose of the review was to consider the quality and safety of care young people receive within child and adolescent mental health services (CAMHS), general healthcare services, palliative care services and when transitioning from child to adult services.

This work was part of wider thematic work being undertaken jointly by the four inspectorate organisations that make up Inspection Wales: Healthcare Inspectorate Wales, Care Inspectorate Wales, Estyn and Wales Audit Office.

The review found that overall, young people had predominately good experiences of care within services. We also found staff working hard to provide compassionate, dignified and person-centred care. However, we are concerned about the ability of CAMHS inpatient units in Wales to accommodate people who are high risk. This means that young people are not always able to receive timely care close to where they live and may be placed some distance from their home.

It was also disappointing to find that many of the challenges young people face when moving between child and adult services are well known, but still continue to be seen. More work is needed by health boards and Welsh Government to ensure young people across Wales have smooth and effective transition to support them into adulthood.

HIW has made 37 recommendations which we expect Welsh Government, all health boards and independent service providers to address.

National Review of Prevention and Promotion of Independence for Older Adults (over 65) Living in the Community

In March 2019, we published the first of 11 separate local authority area inspections as part of a national review of the independence of older people living in the community. The pilot inspection was conducted in January 2019 and led to the undertaking of a further ten inspections in local authorities in Wales, some of which were completed in 2018 – 2019 and will be published in 2019 – 2020.

CIW and HIW are working together to focus on the experience of older adults as they come into contact with and move through social care services up until the time they may need to enter a care home and we consider the times when people experience, or would benefit from, joint working between local authority services and health board services.

The inspection evaluates the quality of the service within the parameters of the four underpinning principles of the Social Services and Well-being (Wales) Act and considers their application in practice at three levels:

- Individual
- Organisational
- Strategic

We have and will continue to consider all expectations outlined in the Social Services and Wellbeing (Wales) Act codes of practice.

Falls Review

We carried out the planning, research and reporting for a review of care pathways surrounding older people and falls in 2018 – 2019. The work aims to provide information on complex, multidisciplinary, integrated models of care involving social care, housing, independent and voluntary sector providers, as well as health. Publication of the review in the reporting year 2019-20.

The review considered the issues currently faced in effective falls prevention, management and recovery, exploring the extent to which services are seamlessly integrated and focussed on person-centred and community-based care. It depicts a picture of a whole-system care pathway so that staff and patients can understand what they should experience and expect to see over the years to come in the context of falls services.

Wider learning about how we approach inspection of these types of models of care will emerge from this in 2019-20.

NHS Hospitals

We conducted 16 hospital inspections across Wales at ten different hospitals in total including three surgical wards. Each inspection considered how the service met the Health and Care Standards under three domains: the quality of the patient experience; the delivery of safe and effective care; and the quality of management and leadership.

Findings

Patients praised the care and treatment of staff in the hospital departments that we inspected. We observed excellent interaction and communication, and a kind compassionate approach being taken with all patients.

Care is excellent - cannot think of a way it can be improved. Very grateful for their kindness and help. Always try to find food the patient likes.

– Patient – Aneurin Bevan

We saw good management and leadership in some settings, and strong examples of multidisciplinary teams working effectively and efficiently.

Our inspectors observed clean and tidy wards and good infection control policies and procedures in some but not all settings. It is positive to note that on two orthopaedic wards at the Royal Glamorgan Hospital, there had been no incidences of hospital acquired MRSA or Clostridium Difficile for the past 600 and 1,000 days.

This suggests that the ward staff are vigilant in compliance with infection prevention and control.

We saw good management and leadership in some settings, and strong examples of multidisciplinary teams working effectively and efficiently.

During my stay on the ward, the staff were really friendly and helpful. The ward was always clean and tidy and the treatment was five star. Staff really attentive and made sure I was comfortable and looked after.

– Patient, Velindre University NHS Trust

The ward team are supportive of one another and work together. The ward manager thrives on providing excellent care to patients and also cares for the staff on the ward, encouraging and supporting all members of staff. I thoroughly enjoy working as part of this team

– Staff member, ABM

There were improvements following our recommendations in some of our follow-up inspections, however, it is disappointing that in some instances improvements had not been made.

Insufficient checks and poor maintenance of resuscitation equipment was an issue in several settings. In addition, in all of our surgical inspections, we identified poor compliance with the risk assessments for venous thromboembolism, in patients requiring trauma or other orthopaedic surgery. This, along with the issues around resuscitation checks, resulted in HIW issuing immediate assurance notifications to the relevant health boards.

The majority of our inspections highlighted issues around staffing, recruitment and retention, and in some health boards it was clear that these issues were leading to low morale and concerns around the potential for patient safety to be compromised.

There is low morale and mood on the ward amongst staff due to the constant threat of moving to other areas that you are not competent to work. Often leaving your own ward short staffed

– Staff, Cwm Taf

We could deliver higher standards of care if we had the right amount of staff to meet all patients individual needs

– Staff, Cwm Taf

It is difficult to provide a good standard of care due to staff: patient ratios, high demand… can compromise care. Everyone works as hard as they can however, patient needs are not always met

– Staff, Cardiff & Vale

Staff are under a lot of pressure but still carry out duties in a professional manner

– Patient, Hywel Dda

The secure storage and administration of medicines is still a problem in many settings in spite of HIW reporting this finding as a concern over a number of years. HIW will be raising this issue with Welsh Government and other relevant bodies to encourage improvement in this area.

In terms of staff training, we saw complete and well documented examples of the delivery of training and continual professional learning in some settings. However, we found scope for improvement in this area in during many of our inspections.

When inspectors considered quality improvement, research and innovation during inspection, the findings were variable across the wards and health boards, where some sites were actively engaged with this, and other were not. During one inspection, we positively identified that on one ward, the ward staff and multidisciplinary team at Withybush General Hospital, were members of a quality improvement group. From this, a training package for the prevention and management of patient falls had been developed and implemented. This resulted in a significant reduction in the incidence of falls, and this was later shared wider across the health board.

GP Practices

This year we undertook 20 inspections of general practices across the seven health boards in Wales. Each GP inspection considered how the practice met the Health and Care Standards.

Findings

Overall, staff were polite and courteous to visitors and patients, and patients were treated with dignity and respect. The majority of practices were clean and well maintained and we observed a welcoming environment at GP surgeries.

Patients told us they were happy with the care they received, but there were numerous complaints about the processes in place for booking appointments. This included poor availability of appointments, particularly at short notice, and long waiting times to see a doctor for routine appointments.

Good practice

One practice was taking part in a trial offering out-of-hours appointments to patients one day over the weekend. This was delivered as part of the cluster where GP practices took turns in offering appointments to patients within their cluster group. This meant that patients had local access to an out–of-hours service, and did not have to travel to one of the three primary care centres across Cardiff and the Vale of Glamorgan. We found this to be of noteworthy practice, and staff told us that patient feedback was positive about the service. The trial was shortly due to end, and it would be evaluated to determine whether to continue with this

Great surgery. Difficult to make an appointment. Waited two weeks
– Patient, Cwm Taf

It is impossible to get an answer at 8:30am and then when the line is clear appointments are very scarce
– Patient, Hywel Dda

It can take 20 mins to answer a phone! [We need a] dedicated phone line. Time keeping on appointments needs looking at
– Patient, Aneurin Bevan

We saw evidence of good leadership in practices with cohesive and inclusive management teams in place. Some examples of good communication between practice teams was evident, and we identified good cluster working including a pilot for out of hours GP access in one health board.

Inadequate staff training records were noted in some practices with improvements required to ensure mandatory training is completed by all staff, and training renewal dates are not missed.

During some inspections, it was identified that not all practices recorded the Hepatitis B immunity status for all clinical staff. This meant that the practice could not produce evidence that all clinical staff had sufficient immunity to the virus.

We observed good examples of patient record keeping in many practices. Where it was necessary to make recommendations in this area, our recommendations generally related to consistency in the level of documentation within clinical records. On a number of occasions we also recommended that audit arrangements be reviewed in order to improve the quality of patient records.

We found that improvements were needed to processes for recording and considering concerns and complaints, including displaying information about the NHS Wales Putting Things Right process.

Dental Practices

In 2018-19 we continued our programme of inspections of general dental practices in Wales. This year we inspected 73 practices, including one follow up inspection. We issued immediate assurance or non-compliance notices following seven of these inspections where we identified immediate action was required to address serious patient safety concerns. Overall this is an improvement on the previous year when 13 immediate assurance letters were issued following inspections of 104 practices. We also found that practices responded appropriately when these issues were brought to their attention.

Some practices offer private only dental treatment, some offer a combination of NHS and private dental treatment and others provide NHS only services. During these visits we explored how dental practices met the standards of care set out in relevant legislation and guidance, including the Health and Care Standards and the Private Dentistry (Wales) Regulations.

This year also saw HIW complete the registration of all dental practices offering private dental treatment under the Private Dentistry (Wales) Regulations 2017; in total 485 practices were registered. This was a significant task undertaken with minimal additional resources and at times required the whole organisation to work together.

Overall practices engaged positively with the registration process but the quality of applications and supporting documentation submitted was variable.

There were also some additional benefits of the registration project; by contacting every practice in Wales over a time-limited period we were able to increase our awareness with dental teams.

We are seeing an increase in the number of patients contacting us with dental concerns which suggests that HIW's role is more visible in practices.

Another of HIW's key goals is to increase its follow up activity. During the registration process we were able to request updated improvement plans from all practices that had been inspected prior to their registration being granted, to seek assurance that actions had been taken to address all the recommendations we had made.

Excellent dentist, always compassionate, caring and professional. Practice staff are excellent, particularly the Practice Manager.

- Patient, Aneurin Bevan

Findings

We inspected dental practices in every local health board in Wales and the findings were generally very good. However, where we did identify areas for improvement they were similar to those found in previous years.

Patient experience was once again very good overall, with patients telling us that they are very happy with their care and treatment. Our inspectors often commented in reports that staff are friendly, professional and patient focussed.

We find that most practices are now actively engaging with patients to obtain feedback on the service provided. However, we regularly advise practices to display results of questionnaires or surveys and inform patients of actions taken to respond to their feedback and improve the service provided. Taking such an approach helps demonstrate to patients that their views are listened to.

I have always had complete faith in the dentists that have offered me dental care. I have had proceedings explained in depth & time to reflect on whether I wish to proceed. I have recommended the practice to others

– Patient, Betsi Cadwaladr

The care and service is the best I have ever received compared to other practices I have been with in the past

– Patient, Hywel Dda

In general, practices were well equipped and maintained to high standards of cleanliness. During many inspections, we also observed appropriate arrangements for the safe use of X-rays. However there were a small number of instances where significant improvements needed to be made regarding overall cleanliness, infection control and decontamination of dental instruments.

The quality of patient records was variable with excellent record-keeping in many practices and areas for improvement elsewhere. Issues arising most often were the need for:

- Correctly recording and updating medical histories and allergies
- Recording patient consent
- Recording of treatment options discussed with the patient and the justification for the treatment performed
- Cancer screening examinations where appropriate
- Secure storage of patient records

We found that many practices demonstrated good leadership and management and had a range of effective policies and procedures in place to support overall practice management. However, the application process for dental practices to register under the Private Dentistry (Wales) Regulations 2017 required the registered manager to sign a declaration that the policies and procedures required by the regulations were in place.

Despite this, at some inspections, we found examples of particular policies not actually being in place. This is very disappointing and does not reflect well on those practices. With the dental registration project now complete this provides a timely and relevant example to remind practices that they have a legal responsibility to comply with the regulations.

Arrangements for training and continued professional development is an area of strength for the vast majority of practices. However, we continue to identify that staff have not always received training in key areas such as, safeguarding, resuscitation training, fire safety and appropriate employment checks (Disclosure and Barring Service).

Overall, compliance with standards and regulations at dental practices is improving year on year. HIW is making fewer recommendations overall and the number of immediate patient safety issues is also reducing.

Mental Health and Learning Disabilities

HIW continues to undertake its responsibilities to monitor the Mental Health Act 1983 on behalf of the Welsh Ministers who have specific duties that they are required to do in law. These duties include formulating a report on how the Act is being implemented in Wales and ensure individual health boards and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales.

During 2018 - 19 we undertook 17 independent healthcare inspections including one learning disability hospital.

Four of these visits were made to the same independent provider due to significant concerns from our inspections, and an additional two visits were made to another independent provider.

As part of these visits HIW monitored the use of the Mental Health Act, the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS) and the Mental Health (Wales) Measure 2010.

Findings

During the visits HIW identified many positive areas including; the respectful manner that staff communicated with patients, good team working and a motivated workforce. We also found that some services were working hard to reduce restrictive practices and that a good range of therapies and activities were available.

HIW made a significant number of recommendations to the individual health boards and requirements for the registered independent providers of care. We continued to identify many failings in the maintenance and refurbishment of wards and in some cases this was having a detrimental effect on patient care, privacy and dignity and patient safety. Some of the issues identified included; fire doors being wedged open, a lack of a nurse call system, lack of sanitary bins, lack of maintenance of garden areas, lack of sufficient alarms for staff and environmental issues impacting on patient privacy and dignity.

We also identified out of date policies and procedures and a lack of a comprehensive range of patient information available on the wards. There was also a lack of care and treatment and risk management plans, and a lack of staff training in some key areas, for example basic life support.

Issues with effective medicines management were again identified this year. This included; a lack of policies and procedures, inadequate completion of medicines administration charts, medicines cupboards not locked when not in use and medication on the wards, for patients, that had been discharged.

Other issues included a lack of bed capacity for acutely ill patients in the health boards. In contrast some of our independent health care providers had surplus capacity in some of their wards.

We continued to identify many good practices with the implementation and documentation of the Act and it was apparent that there was a good level of scrutiny and audit. Files were generally well organised and contained the necessary detention information.

We did however identify some issues with the administration of the Act including:

- Section 17 leave forms not being clearly marked where they were no longer valid (which could lead to confusion with the current section 17 leave entitlement of patients)
- Some recording issues in relation to the rights of patients under section 132
- A lack of detention papers in current patient records
- Delays in some reports being submitted for patients' appeals against their detention

Independent Healthcare

Our inspections of independent healthcare settings, other than mental health, seek to ensure that services comply with the Care Standards Act 2000, the requirements of the Independent Health Care (Wales) Regulations 2011 and to establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales. We aim to inspect these services at least every three years, but may visit more often if required as a result of intelligence or service change.

Findings

Independent Hospitals

Overall our inspections of independent hospitals this year have been very positive; on one particular inspection we did not identify any improvements that were required. We have also seen a reduction in the number of immediate patient safety issues identified resulting in the issue of a non-compliance notice. Only one was issued in 2018-19 due to a service not being able to demonstrate Hepatitis B immunity for a single member of staff.

It was also positive that on all inspections:

- Patients told us that they were happy with the service they had received
- We observed staff demonstrating a caring and courteous approach to patients
- We found clear lines of responsibility and accountability on all inspections.

In the main, patient records were maintained to a high standard. However, we did identify some issues with legibility, staff not signing their designation, and care plans needing to be more individualised including ensuring they reflected action to be taken should an emergency arise.

Medicines management was an area where we made a range of recommendations; key issues identified were:

- inconsistent use of pain management tools
- not recording temperatures of medication fridges and rooms in which medication is stored
- regular checks of emergency drugs not being undertaken
- the need to maintain a medication stock list for the whole service.

Leadership and management was an area where very few recommendations were made. However, again this year we had to remind registered providers of their responsibility to undertake regular monitoring visits. Given that this has not improved since last year, we will be reminding providers more formally of their responsibilities.

My husband and I both feel this is a very warm and welcoming place. Staff are knowledgable and informative. You can tell they all enjoy their roles here.

- Patient, Independent Hospital, Cwm Taf

Hospices

On all five inspections we witnessed staff interactions with patients that were kind, caring and professional. We also observed that the services were well maintained, welcoming and offered a good range of facilities and activities appropriate for the patient group.

Overall, management of the services we inspected was good with positive multidisciplinary team working being evident on all inspections.

In the main, we found care plans to be patient centred, however, we did need to remind registered providers that care plans must be individualised and should be written from the perspective of the patient. In two services this was done particularly well and we could clearly see how the patient and carer had been involved in developing the plans for their care and treatment.

All of the hospices we inspected were conducting an appropriate range of audits. However, we often found that the results of audits were not displayed and actions arising from the audits were not documented.

The prevention and management ofpressure ulcers is a key risk that hospices need to address. We made some recommendations in this area around the use of repositioning charts and the need to ensure pressure ulcer risk assessments are undertaken when patients are admitted.

Medicines management was an area where we often made recommendations for improvement; key issues identified were:

- Staff not signing for medication immediately after administering it
- Staff not witnessing patients taking their medication
- Recording of medication fridge temperatures.

We did observe some good practice in this area, for example, where service nurses wore red tabards during medication rounds to discourage other members of staff interrupting them when carrying out this task. This helps the risk of making errors when administering medication by not being distracted.

Independent Clinics

As with other independent services we inspected this year we found that patient satisfaction was high for our registered clinics; this aligned with us observing caring, friendly and professional staff working at them. Overall, we saw that appropriate information was available for patients receiving treatment, however, the actual information provided to patients was not always recorded in their notes.

The use of chaperones was identified as an issue in all but one of our clinic inspections. Registered providers need to be clearer in recording the offer and use of chaperones.

The need to make better arrangements for people with hearing difficulties was also raised in 75% of our inspections.

Record keeping was the area under which most recommendations were made; key issues included:

- Records not clearly describing the treatment provided and by which practitioner
- Insufficient detail recorded in patient medical histories
- Verbal consent to examination or treatment not being recorded in patients' notes
- Care records not being signed and dated after each consultation.

In addition we identified that key documents such as the statement of purpose and patients' guide were significantly out of date. Registered providers must ensure that these documents are reviewed regularly and kept up to date at all times.

Class 3b/4 lasers and Intense Pulsed Light

Our findings in these types of inspections are very similar to previous years. On a positive note this means that we continue to see services that:

- Provide comprehensive information before treatment that enables patients to make an informed decision about treatment choices
- Are clean, tidy and well maintained
- Are committed to providing a positive experience for patients including appropriate arrangements for actively seeking feedback
- Store records appropriately
- Have arrangements to uphold the privacy and dignity of people receiving treatment.

However, rather disappointingly, we continue to find that key documents such as the Patients' Guide and Statement of Purpose are not kept up to date and do not include all information required by the regulations. We regularly find that:

- HIW's contact details are incorrect
- A summary of patient feedback is not included in the Patients' Guide
- The complaints process is not adequately described
- The Patients' guide is not available for people to take away
- Consent to treatment is not consistently recorded, especially when recording consent (verbal or written) at each treatment point within a course of treatment sessions
- Medical histories are not reviewed at each treatment point within a course of treatment
- Safeguarding policies need updating to include details of the local authority safeguarding teams. Also, staff need to undertake training in the protection of vulnerable adults and the protection of children
- Treatment registers do not always contain all of the information required by the National Minimum Standards.

Reassuringly, the number of non-compliance notices we issued this year was very low, but as with our overall findings, the reasons for doing so were similar to last year and related to services not having a contract with a Laser Protection Adviser (LPA). This meant that key policies and procedures such as the local rules and risk assessments had not been reviewed as required by the regulations and the service's conditions of registration.

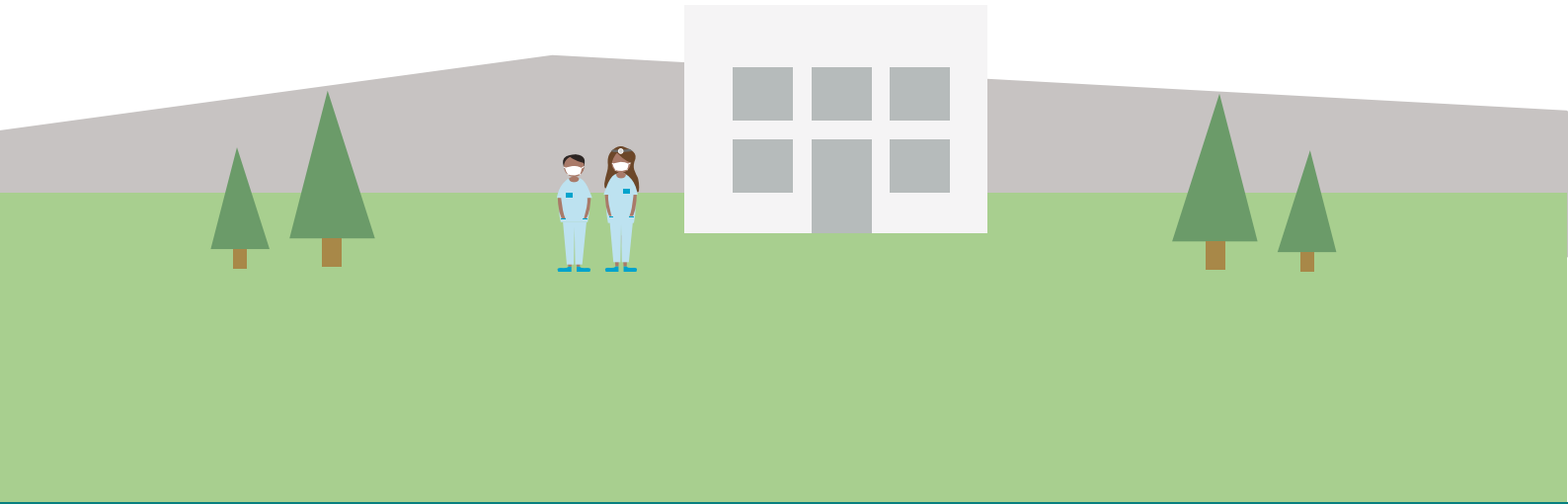
We also found one registered provider who could not demonstrate that the laser machine had been serviced and maintained as per the manufacturer's instructions. Both the appointment of an LPA, and regular maintenance of equipment, are vital to ensuring laser/IPL equipment is safe to use and registered providers are reminded that cost cutting in these areas is not acceptable and can lead to enforcement action being taken.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017. The regulations are intended to protect people from hazards associated with ionising radiation.

During 2018-19 we completed five IR(ME)R inspections including an inspection at an independent hospital. These inspections checked that services were compliant with IR(ME)R and also looked at whether care and treatment was being provided in line with the Welsh Government's Health and Care Standards.

The inspections also covered all three modalities of medical exposures: Radiology, Diagnostic and Interventional Imaging, and Nuclear Medicine.



The service provided for me today was excellent. The nurse with me was really lovely. Very helpful"

– Patient, Hywel Dda University Health Board

Findings

On all of our inspections we asked patients to rate their experience; the vast majority said they would rate their experience as either excellent or very good. When asked what improvements could be made comments were varied. However, the availability of parking was an issue that was raised frequently.

It was also positive to see, on all inspections, staff being kind and respectful to patients. However, we found that improvements were required to the environment in two hospitals we visited to further promote the privacy and dignity of patients.

2018-19 was a year of change for employers with the new IR(ME)R 2017 regulations introduced in February 2018. Overall, employers had responded well to the changes, but we did identify the need to develop employer's procedures in more detail in all of our inspections. In two cases we identified that the employer did not have a procedure for a quality assurance programme for equipment; this after identifying in previous years that ageing and inefficient equipment was impacting on the timeliness of patient care. In addition, we identified that employers needed to do more to make information available for patients to ensure that the risks and benefits of exposure to ionising radiation were made clear.

2018-19 saw HIW issue its first Improvement Notice due to serious concerns identified at Prince Charles Hospital. We identified that National Diagnostic Reference levels were being exceeded and that the establishment of Local Diagnostic Reference Levels was inconsistent. Fundamentally these concerns arose because of a lack of governance and oversight of IR(ME)R by the health board and we would ask all IR(ME)R employers to reflect on whether the profile and focus of IR(ME)R compliance in their organisation is appropriate.

Offender Healthcare

Reviews of deaths in custody

The Prisons and Probation Ombudsman (PPO) is required to undertake an investigation of every death that occurs in a prison setting. HIW contributes to these investigations by undertaking a clinical review of all deaths within a Welsh prison or Approved Premises. This arrangement is defined within a Memorandum of Understanding between the PPO and HIW.

Our reviews critically examine the systems, processes and quality of healthcare services provided to prisoners during their time within a prison or Approved Premises. From 1 April 2018 to 31 March 2019 we were commissioned to complete 19 clinical reviews on behalf of the PPO.

Generally our death in custody reviews concluded that the care provided to prisoners in Wales was equitable with the expected level of care in the community.

We noted good relationships between prison healthcare staff and staff from health boards. We made recommendations for improvement in the standards of documentation of prisoners by health and medical staff including:

- Where care plan templates are used within the electronic clinical record, these should be accompanied by an individualised assessment of the person's needs and accompanied by specific and tailored interventions to meet these identified needs
- Training in relation to record keeping ensuring that there is consistency across all healthcare staff

Prison Inspections

HMI Prison Inspections of prisons in Wales are undertaken by Her Majesty's Inspectorate of Prisons (HMIP). There is a Memorandum of Understanding in place between HMIP and HIW, and we are invited to attend the HMIP inspections of Welsh prisons. These mechanisms enable us to share our learning from clinical reviews of deaths in custody and also to consider the governance of prison healthcare.

During 2018-19, we attended one HMIP inspection at HMP Berwyn near Wrexham. The inspection found good practice in regard to the health assessment of new prisoners, good mental health services, and the positive inclusion of a member of the pharmacy team. The inspection also identified some areas for improvement particularly in the areas of:

- A prison-wide strategy to support health promotion
- Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs
- Suitable occupational therapy equipment and adaptations be provided and installed promptly
- There should be a formal and robust procedure to follow up patients who miss medicine doses
- Pharmacists should carry out medicines use reviews with patients
- Prisoners should have access to dental treatment within community-equivalent waiting times

Youth Offending Services

We continue to work in partnership with Her Majesty's Inspectorate of Probation in the review of healthcare provided within Youth Offending Services. These reviews also involve a range of other partner agencies including Estyn and CIW.

In March 2019 HIW participated in an inspection of Western Bay and considered the healthcare that young people received. Several issues were identified with young people not receiving an adequate level of healthcare and we contributed to the final report produced by Her Majesty's Inspectorate of Probation.

We noted that there were very limited health services to meet the physical, sexual, emotional and mental health needs of children and young people, and this was highlighted as an Area for Improvement in the report which can be viewed on HMI Probation's website.

Aneurin Bevan University Health Board

Overall, patient feedback was positive on all inspections. Patients felt they were treated with respect by staff, and the quality of the care they received was of a good standard.

We were pleased to find evidence of effective multidisciplinary working in some of our inspections, particularly in our GP and Mental Health inspections.

Engagement from the health board was good throughout 2018-19, with prompt responses provided to our requests for improvement plans. The health board also responded promptly to any concerns we received through our concerns process.

Unfortunately, we found that action is not always taken as a result of previous HIW inspections, and this has been particularly evident across the two mental health inspections conducted in 2018 - 2019.

Despite raising our concerns regarding the lack of shower facilities at St Cadoc's Hospital during our previous inspection in October 2016, there remained only two showers for up to 22 patients on the Adferiad ward when we inspected again in November 2018. Both showers had stained flooring and walls, as well as evidence of fungus around the window frames.

In addition, a number of issues identified at our inspection of County Hospital in 2017 were identified again at an inspection in 2018. We found that Care and Treatment Plans (CTP) were still not being fully completed and that the personal alarm system was not fit for purpose.

We issued three immediate assurance letters to the health board in 2018 – 2019 and we received sufficient assurance on the issues raised. This meant that the improvements had either been addressed or progress was being made to ensure patient safety is protected.

There are issues across the health board with regards to training being provided and kept up to date, as well as the overall standard of record keeping.

Hospitals

We inspected two hospitals: Ysbyty Aneurin Bevan (two wards) and Royal Gwent Hospital (surgical)

- ✓ Patients were highly complementary of the staff involved in their care and treatment
- ✓ Patients were appropriately supported and monitored at mealtimes
- ✓ Strong management and leadership within both hospitals
- ✗ Issues with staffing levels at both hospitals
- ✗ Improvements required relating to training for staff

Mental Health

Two mental health inspections in St Cadoc's Hospital and County Hospital

- ✓ Patients were treated with respect and care Good access to indoor and outdoor activities
- ✓ Effective communication between staff and teams
- ✓ Good use of meetings to plan and handover
- ✗ Issues with Mental Health Act application and documentation
- ✗ Recommendations from previous inspections not actioned
- ✗ The alarm systems at both hospitals were not fit for purpose and did not provide a safe setting for staff and patients

Dental

We inspected 14 dental practices

- Patients told us they were very happy with their care and treatment
- Patients being treated with dignity and respect
- Appropriate arrangements for the safe use of X-rays
- Patient records are not always maintained correctly and securely stored
- Staff are not consistently completing relevant training
- Patient information and the distribution of patient leaflets could be improved

GP

We inspected two GP practices

- Positive patient comments about the service
- Staff were polite and courteous to patients and visitors
- Good communication between practice teams
- Improvements to patient records and maintenance of staff training records to ensure renewal dates are not missed
- Increased promotion and usage of the chaperone service

IR(ME)R

We completed one IR(ME)R inspection at the Royal Gwent Hospital

- Patients reported a positive view of services provided by the department
- Patients felt involved in any decisions about their care
- Staff had a good awareness of the risks associated with ionising radiation and their responsibilities in this regard
- The health board must ensure it maintains the dignity, privacy and safety of patients who are transported to the holding bay of the department's in-patient area
- Aspects of the employer's (IR(ME)R) procedures need to be updated, developed and formally adopted
- Staff training and entitlement records need to be completed correctly, signed and dated by the trainee, and countersigned by the trainer for verification purposes

Community Mental Health

We undertook one Community Mental Health Team inspection – North

- Service user feedback was generally positive about their care and treatment
- Staff were committed to providing a positive experience for service users in a difficult environment
- Service user assessments were completed in a timely manner
- We saw evidence of good team working between professional disciplines.
- The environment for service users
- Information for service users, including advocacy and complaint processes and procedures
- Some areas of health and safety, including a ligature point risk assessment
- Elements of recording in care records, to ensure a consistent high standard is met across the team
- Managerial processes and procedures to improve integrated working

Abertawe Bro Morgannwg UHB

Following the Bridgend boundary change, Abertawe Bro Morgannwg University Health Board became Swansea Bay University Health Board on 1 April 2019. For the purposes of this report which covers the 2018 – 2019 period we have used the former name of the health board.

In general, our inspections have shown that patients have been treated with dignity and respect and were happy with the healthcare provided. Many service areas have also demonstrated good leadership and management.

There were, however, some areas that required improvement including, record keeping and medicine management in some settings. The management and maintenance of resuscitation equipment must also be up to date, and staff must be appropriately trained in the equipment.

The way serious incidents are investigated is also inconsistent.

Historic governance was scrutinised in detail last year in relation to the health board's handling of the employment and allegations made against Kris Wade. Our review found that the issue of line of sight between the Board and operational services has been a recurrent theme since 2014. The current Board has accepted our recommendations and is maturing with a focus on improvement.

We also made a number of recommendations for all health boards in Wales as noted in our National Reviews section, and in more detail in the full report on our website.

Hospitals

We conducted an inspection at the Neath Port Talbot Minor Injuries Unit and a surgical services inspection at Morriston Hospital

- ✓ Patients were treated with dignity and respect in both hospital inspections
- ✓ Good infection control procedures
- ✓ Good systems in place to promote patient safety
- ✓ Good management of controlled drugs
- ✗ Timely management of trauma and orthopaedic patients
- ✗ Concerns about the management of theatre lists at the unit were expressed by staff
- ✗ Safety checks in theatre need strengthening
- ✗ Concerns over the number of never events
- ✗ Key equipment, resuscitation checks and audit arrangements need to be improved (NPT). These issues have been found in the minor injuries unit on previous visits
- ✗ Risk assessments for blood clots (Morriston)

Mental Health

We inspected the Tawe Clinic at Cefn Coed Hospital

- ✓ Patients were treated with kindness and compassion
- ✓ Information about advocacy was prominently displayed
- ✓ Efforts had been made to make the entrance and outside areas pleasant for patients to use
- ✓ Visible and supportive leadership
- ✓ Good compliance with health board mandatory training
- ✗ No call system for patients in bedrooms
- ✗ Lack of furniture in bedrooms
- ✗ Inadequate checking of emergency equipment
- ✗ Aspects of record keeping need improvement
- ✗ Information about how to raise a concern should be clearly visible
- ✗ Care and treatment plans need to be in line with the Mental Health (Wales) Measure

Dental

We inspected 13 practices

- Patients reported a friendly, professional and patient-focused service in 10 out of 13 practices
- Good leadership in 8 of the 13 practices visited
- Safe use of x-rays in 5 practices
- A good suite of policies and procedures in five practices

- Improvements need to be made in clinical record keeping in most practices – recording of medical histories, allergies, health promotion advice, treatment justification, consent and cancer screening.
- Gaps in staff training in safeguarding, resuscitation training, and fire safety.
- Improvements needed in the management of equipment including emergency equipment

GP

We inspected three GP surgeries

- Patients were treated with dignity and respect
- Surgeries were clean and accessible
- Evidence of engaged managers and good leadership

- Provision and checking of emergency equipment in two settings
- Policies and procedures needed updating in all practices
- Mandatory training gaps-resuscitation, safeguarding, infection control
- Website requires updating in two practices
- Provision of a working hearing loop at two practices

Community Mental Health

We inspected the Neath Port Talbot Community Mental Health Team

- Dedicated staff
- Patients treated with dignity and respect
- Evidence of supportive treatment plans for patients

- Environmental risks-such as ligature points (the service received an immediate assurance letter in relation to the environmental risks)
- Poor culture of incident reporting
- Discord between leaders leading to a poor culture at a senior level

Betsi Cadwaladr University Health Board

Our inspections of the health board over the past twelve months have been broadly satisfactory. Some of our visits have been a follow-up to previous inspections, and it is positive to report that most of the improvements had been implemented, and importantly, sustained.

One of the key challenges for the health board, noted during our inspection, is in maintaining patient flow through the emergency department at Glan Clwyd Hospital and tackling the prolonged waiting times for patients.

Whilst it was encouraging that none of our mental health inspections resulted in us issuing an immediate assurance letter, and it is clear that much effort is being made to improve services, we remain concerned about overall service capacity.

The health board must ensure that there is sufficient capacity in mental health inpatient services to meet the needs of its population. We are also concerned about the length of time some patients in the community may be waiting for access to psychological services, with some waiting up to two years. This is not acceptable and steps need to be taken to address this.

Whilst the GP inspections were positive overall, we were consistently told by patients of concerns regarding the ability to make appointments at their practice.

Overall, whilst it is positive to note some of the improvement across our inspections last year, it is clearly imperative that these are sustained and built upon by a health board that remains under special measures.

Hospitals

We inspected Bryn Beryl Hospital and Ysbyty Glan Clwyd Emergency Department

- ✓ Good evidence of person-centred care and staff engagement
- ✓ Effective risk assessment, auditing and reporting
- ✓ Clean ward environment and good infection control arrangements at Bryn Beryl Hospital
- ✓ Effective multidisciplinary working and a visible management team at Glan Clwyd Hospital
- ✓ Glan Clwyd was a follow-up to the visit in November 2016, and it was positive to note that the majority of listed improvements had been implemented and sustained
- ✗ Some issues found at the previous Glan Clwyd inspection were still present, in particular, patient identification arrangements and inconsistent usage of fluid charts
- ✗ At Bryn Beryl we noted issues in regards the provision of arranged activities for patients and the fact there was no television, radio, or a lounge for them
- ✗ A more dementia friendly environment is needed at Bryn Beryl
- ✗ At Glan Clwyd, patient concerns regarding waiting times and patient flow
- ✗ Whilst it was positive to see lots of new staff at Glan Clwyd, recruitment to vacancies is still a challenge

Mental Health

We inspected the North Wales Adolescent Unit

- ✓ Staff engage with patients respectfully
- ✓ The facilities and environment at the Child and Adolescent Mental Health Service (CAMHS) Unit in Abergele were found to be good
- ✓ Established governance arrangements were in place
- ✓ Good multidisciplinary working and coordination with community paediatric teams
- ✗ The external and internal environment required attention at the Hergest and Ablett Units
- ✗ Systems for maintaining the safety of patients and staff in the North Wales Adolescent Unit required improvements
- ✗ The health board faces challenges in ensuring that mental health services have enough capacity to meet the needs of its population

Dental

We inspected 21 dental practices

- Patients were able to make informed decisions about their treatment
- Services were well run and staff were committed to providing a high quality service
- Surgeries were well equipped and clean, with appropriate arrangements for safe use of x-ray equipment

- The need to strengthen the implementation of a range of clinical audits was found to be an issue
- Fire training required improvement at several inspections
- Wall mounted sharps bins not installed
- Steps to implement clinical peer review and self-evaluate using the maturity matrix dentistry tool

GP

We inspected six GP surgeries

- Good record keeping and internal communications in most inspections
- Professionalism of practice staff and good staff support services
- Cohesive and inclusive management teams in place

- Issues with appointment systems in all 6 inspections
- Inadequate training records were noted at several inspections
- Audits and data security were in need of improvement across many of the practices

IR(ME)R

We undertook one IR(ME)R at Wrexham

- Staff treated patients with dignity, respect and kindness
- Good compliance with theregulations
- The health board has been proactive in creating new procedures to meet the requirements of the new regulations

- Health board to consider how written patient information can be made more accessible and consistent
- Information on how patients can provide feedback or raise a concern about their care and treatment needs to be clearer
- Level of detail needs to be improved within the delegated authorisation guidelines for the justification of exposures

Community Mental Health

We conducted one cCommunity Mental Health Team inspection at Nant-y-Glyn

- Positive feedback from service users and a person-centred approach
- Auditing, reporting and escalation processes good at the CMHT
- Team managers to be both accessible and supportive

- The health board faces significant challenges in ensuring timely access to psychology and psychotherapy services, with delays of up to two years
- The physical environment of the CMHT required significant attention
- Problems with integrated ICT and lack of joint access to electronic records

Cardiff & Vale UHB

Inspection findings within the health board were generally positive. Where improvement was required, all services have responded constructively and engagement from health board leadership has also been positive.

Re-inspection of services by HIW has revealed improvement in many areas and it is clear that the health board sees external and internal scrutiny as a positive means of learning and improving.

Further work is required in general practices and some hospital settings to ensure that patients are aware of how that can raise a concern about the care they received.

HIW's inspection of the emergency and assessment unit at University Hospital revealed a number of issues which were impacting on the safety and dignity of patients. The health board must reflect on its own assessment of the arrangements that were in place prior to HIW's inspection and why more action was not taken in relation to issues of which it was aware.

Hospital

We carried out two inspections at St David's Hospital and the University Hospital Wales

- Broadly positive findings in relation to our follow up inspection of St David's hospital, with action having been taken in relation to previous findings
- A number of positive findings relating to our inspection of the emergency and medical assessment units at University Hospital of Wales.
- Training and induction provision appeared to be excellent
- We also observed excellent interaction between staff and patients in the emergency and assessment units with a kind compassionate approach being taken with all patients
- A number of immediate patient safety issues following our inspection of the emergency and medical assessment units at University Hospital of Wales
- Inadequate arrangements for treating and monitoring patients in the assessment unit and failure to regularly check resuscitation equipment and medicine to ensure that it could be used safely in the event of an emergency
- Further work is required in relation to the safe administration of medicine (St David's)
- Scope for greater involvement of social workers and speech and language and occupational therapy input (St David's)

Mental Health

We carried out one mental health unit inspection at Hafan y Coed in Llandough Hospital

- Peer review checks were being carried out with staff from other areas of the hospital to check the quality of care as a means of driving up standards and sharing good practice
- HIW's peer reviewers were impressed by the comprehensive needs assessments being carried out to develop patients' care and treatment plans
- Health and safety audits, including ligature audits, were thorough and up to date
- Whilst the health board has effective arrangements for managing the risk associated with 'patients sleeping out' of the unit this appears to be a common occurrence
- Garden areas in the Hafan y Coed mental health unit are dirty and unkempt. The unit relied on the staff to clean and maintain these areas, which they rarely had time to do. As the only outside space available to detained patients, the condition of these facilities has a significant impact on patient experience

GP

We carried out three GP inspections this year

- Patients were positive generally about their experience and in 2 of the 3 practices inspected they found it easy to make appointments
- There were some examples of good cluster working, including an out of hours pilot
- All practices were well maintained and clean
- All practices were considered to be safe and effective, although 2 required improvements to fully meet the health and care standards
- Practices were generally well led
- An immediate assurance letter was issued at 1 practice due to issues around checking drug fridge temperatures
- A range of improvements were required around administration of Putting Things Right, including better recording of complaints and provision of information to patients (all inspections)
- Scope for improvement in the quality of record keeping, including consistency of recording the reasons for prescribing or significant diagnoses (in 2 practices).

Dental

We inspected 11 dental practices

- Patients were happy with the care they received in all inspections
- The standard of record keeping was high or good in 7 of the 11 inspections completed
- We noted positive management and leadership in most inspections
- Most practices had appropriate arrangements for use of X-ray
- In general, practices were clean with few minor environmental issues requiring rectification
- Issues with frequency of checks, storage or location of emergency equipment in 6 inspections
- A number of practices should increase the levels of audit and quality improvement activities carried out

Community Mental Health

We inspected the West Vale Community Mental Health in Barry

- Safe and effective care was being provided with positive feedback from users, improved access and timeliness
- Consistently high standards of record keeping at the CMHT, including Mental Health (Wales) Act documentation
- Good, multi-disciplinary, approach in relation to service user assessments, care planning and reviews
- The CMHT service was in a period of substantial change which impacted upon processes, procedures, meetings and management structures
- Staff morale was affected as a result and there was a need for clarification with regards to these arrangements

Cwm Taf University Health Board

Following the Bridgend boundary change, Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board on 1 April 2019. For the purposes of this report which covers the 2018 – 2019 period we have used the former name of the health board.

We noted a somewhat mixed picture from our inspections in 2018-19. Across our inspections, patient feedback was generally positive and we found patients were treated with dignity and respect.

We were pleased to find evidence of effective multi-disciplinary working in some of our hospital and CMHT inspections. We saw truly integrated working between health and social care staff in our CMHT inspection in Merthyr and we believe other CMHTs across Wales could learn from this good practice.

However, we identified significant concerns in a number of our inspections. Of particular concern were the findings from our inspections in maternity services and surgical services in Royal Glamorgan Hospital, follow-up in elderly mental health wards in Royal Glamorgan Hospital, IR(ME)R in Prince Charles Hospital and dental inspection.

Our inspections across Royal Glamorgan Hospital have highlighted concerns around staffing levels, skill mix of staff and low staff morale.

Across our work, we have identified a lack of evidence of organisational learning from previous inspections. For example, during our surgical services inspection we highlighted issues regarding the checking of resuscitation equipment, it was therefore disappointing to find the same issue in our maternity services inspection within the same hospital a few weeks later.

We were particularly disappointed that our follow-up inspection of the elderly mental health wards in Royal Glamorgan Hospital identified that not only were the actions from the last inspection not completed, a number of new issues were identified, including concerns around medicines management.

During last year's mental health inspections we found issues with maintenance and the improvement of service environments. Again this year, we found environmental/estates maintenance issues in Royal Glamorgan Hospital and Tŷ Llidiard.

In our maternity services inspection, we were concerned about the sustainability, resilience and ability of service to provide care and treatment in a safe and effective way. We found significant staffing issues which impacted on delivery of safe and effective care in a number of ways including staff well-being, reviewing of incidents and concerns, mandatory training and clinical audits.

We also found a disconnect between a number of professional groups across the service which impacted on multidisciplinary team working. We continue to closely follow the progress of the health board in responding to these issues.

In our IR(ME)R inspection in Prince Charles Hospital, we found the service was non-compliant in respect of the assessment, monitoring and recording of patient radiation doses and the need to strengthen the employer's response to reports provided by the external radiation protection service. This meant that patients could have received exposures that were not as low as reasonably practicable or consistent with the intended diagnostic or therapeutic purpose.

We will be closely monitoring the findings from our programme of work in 2019-20 to gauge whether we are seeing better evidence of organisational learning and improvements being embedded and sustained across services. As part of this work, Healthcare Inspectorate Wales and the Wales Audit Office will be conducting a joint governance review within the health board.

Hospital

We conducted three hospital inspections: the acute stroke unit at Prince Charles Hospital and maternity and surgical services within the Royal Glamorgan Hospital

- Patient feedback generally positive and patients were treated with dignity and respect
- Effective care in relation to preventing pressure sores, falls and nutrition and hydration arrangements (with some areas for improvement)
- Evidence of effective management at ward level
- Evidence of effective multidisciplinary team working at 2 of the 3 inspections.
- We were not always assured that care was safe and effective and issued immediate assurance letters in two of three inspections
- To a greater or lesser extent each inspection identified issues with staffing
- Improvements needed to patient and carer information on how they may provide feedback, raise a concern (complaint) and how they may contact the local Community Health Council
- Of particular concern, we identified the following issues in two of three inspections:
- Issues with the checking of resuscitation equipment within different areas of the same hospital. HIW issued an immediate assurance letter on each occasion. This showed a lack of learning following inspections
- Issues with staffing levels and skill mix
- Staff told us that morale was low amongst the workforce
- Issues with availability of equipment for staff to carry out their duties
- Issues with security of medication and the recording of fridge temperatures
- Issues with pain assessment recording and patient pain monitoring

Mental Health

We conducted two mental health inspections: a CAMHS unit at Ty Llidiard and a follow-up inspection elderly mental health wards in Royal Glamorgan Hospital

- Patients felt safe and were treated with respect and kindness by the staff team
- At Ty Llidiard, we found innovative use of technology to engage and encourage patients to provide feedback about their experiences
- We saw good record keeping practice within the sample of Care and Treatment Plans and observation records we reviewed
- Some aspects of the environment had been addressed from the last inspection
- At Royal Glamorgan, we found good compliance in relation to mandatory training and annual appraisals
- Environmental changes must be completed in a timely way to support the needs of patients
- At Ty Llidiard, risk assessments had been completed to promote patient safety and wellbeing but no written plans had been developed setting out how these risks would be managed
- At Royal Glamorgan Hospital, we found the majority of identified improvements identified at HIW's previous inspection in 2017 had not been fully completed. The health board needs to be accountable for ensuring that any improvements identified are reviewed and monitored to ensure the service provides high quality, safe and reliable care
- At Royal Glamorgan Hospital, we also found significant medicines management concerns which resulted in HIW issuing an immediate assurance letter to the health board

GP

We inspected one GP surgery

- Patients were treated with dignity and respect and spoke positively about their relationship with staff
- The practice had its own ultrasound scanner and this had proven valuable in ensuring timely diagnosis of symptoms
- GPs triage patients for appointments to ensure highest priority need is dealt with on the day
- Improvements needed to clinical details within patient records, general record keeping and audit arrangements
- Staff needed recruitment and periodic employment checks, including Disclosure and Barring Service checks
- Improvements to the arrangements for oversight and accountability for any new medication added or changed to patient records

Dental

We inspected one dental surgery

- Commitment to providing a positive experience for patients
- Good range of policies and procedures in place
- The practice was non-compliant in a number of areas relating to decontamination and infection control, environment, resuscitation equipment and security of patient records and information. This resulted in HIW issuing a non-compliance notice to the practice
- We did not see evidence of good leadership or support of staff
- Improvements were needed to ensure all clinical staff receive up to date training relevant to their role and appropriate employment checks (Disclosure and Barring Service checks)

IR(ME)R

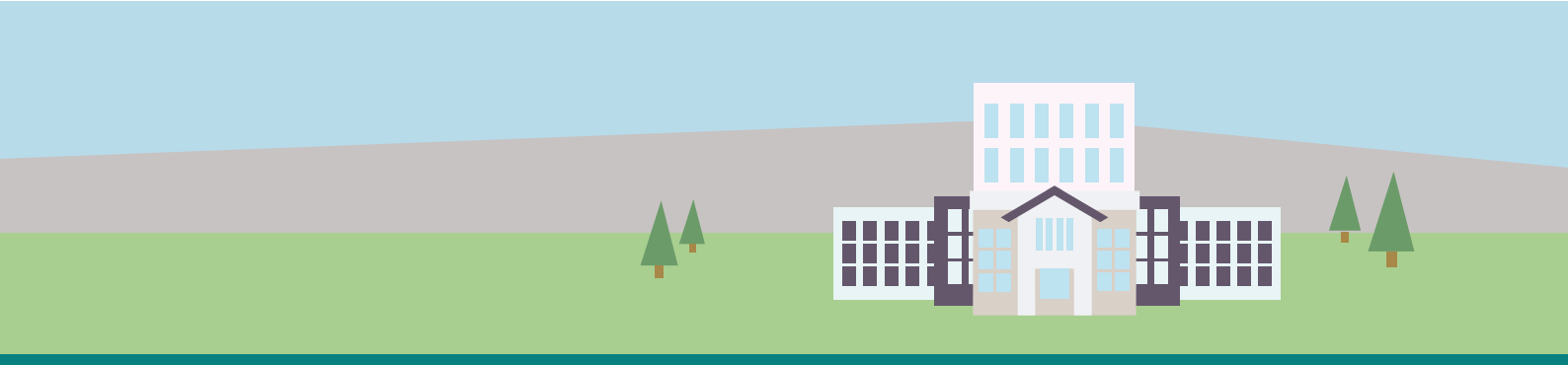
We conducted one IR(ME)R inspection at Prince Charles Hospital

- Staff who spoke with us were happy in their roles. Radiography students and new members of staff said that they felt supported by their colleagues
- Staff were respectful, professional and kind toward patients throughout our inspection
- Most patients said that they had received clear information which helped them to understand the risks and benefits of their X-ray procedure/treatment
- The service was non-compliant in respect of the assessment, monitoring and recording of patient radiation doses and the need to strengthen the employer's response to reports provided by the external radiation protection service
- A non-compliance notice was issued due to the seriousness of the issues identified
- Aspects of the content of a large number of employer's IR(ME)R policies and procedures need to be updated and provide more detail for staff to follow
- Improvements needed to ensure patients are fully aware of their right to raise concerns about their NHS care or treatment

Community Mental Health

We inspected Merthyr Community Mental Health

- Care was planned in a way that was person centred and response to the needs of service users
- Care and treatment plans and statutory documentation for service users detained under the Mental Health Act were detailed and completed to a high standard
- The service was a good example of truly integrated working between health and social care staff
- We saw effective management and leadership of the service and a positive culture in the team
- Improvements needed to compliance with mandatory training, including in safeguarding
- Staff reported the need for better engagement and understanding between GPs and the CMHT
- There needs to be progress and solutions to ensure the IT systems are fit for purpose and enable the right information to be available to the right staff at the right time



Hywel Dda UHB

We received positive responses from patients regarding their care and treatment in all inspections at Hywel Dda University Health Board in 2018 – 2019.

In three out of the four hospital inspection it was noted that staff undertook their duties in a professional, kind and sensitive manner when delivering care to patients.

However, standards and comprehensive completion of patient documentation was noted as an issue in all of the hospital inspections.

Unfortunately medicines management is still an issue in all of the hospital inspections despite us highlighting similar issues in the previous year. This is disappointing and the health board must address this problem.

The environment of care at the community mental health team inspection and mental health units required maintenance to promote patient, staff and visitor satisfaction.

It is pleasing to note that no immediate assurance letters were issued in regards to dental, CMHT and IR(ME)R inspections.

There were further positive findings in our dental inspections with two of the five dental practices we inspected receiving no recommendations for improvement.

Hospitals

We carried out four hospital inspections; in Glangwili, Withybush, Bronglais and Amman Valley Hospitals

- Staff were professional, kind and sensitive when delivering care to patients (3 out of 4 inspections)
- Ward based management was supportive and enabling (3 out of 4 inspections)
- Good staff engagement with inspection and focus on improving standards in all hospitals
- Palliative care and treatment was delivered to a high standard (Amman Valley)
- Good pain management (Withybush)

- Medicines management is still an issue in all settings
- Improvements needed to care planning, updating and safe storage of patient records
- Improvements to mandatory and specialist staff training
- Communication between healthcare professionals and patients or family members required improvement
- Patients unaware of what was going to happen next regarding treatment or discharge in one setting
- NHS Wales Putting Things Right information was not readily available for patients to read and take away (2 of the 4 inspections)

Mental Health

We inspected two mental health hospitals; Cwm Seren in St David's Hospital and Bryngofal at Prince Phillip Hospital

- Patients were treated with respect and kindness
- Patients' nursing records completed to a good standard
- Suitable arrangements in place for assessing, meeting and monitoring patients' nutritional needs
- Dementia friendly ward environment at Bryngofal

- Ward and external environment required some redecoration and maintenance
- Medical staffing levels need to be improved and more support for newly qualified nurses
- Complete and comprehensive statutory detention documentation
- Storage of chilled medication and administration of controlled drugs
- Information available for patients, carers and relatives should be consistent

GP

We inspected three GP practices

- Care and treatment provided in a dignified and courteous manner
- Information within patient records was of a good standard (2 out of 3 inspections)
- A useful system to monitor patient referrals and communication with the out of hours service had been introduced in one of the inspections
- Leadership and support for staff

- Immunisation status of all staff working at the practice must be collated
- All staff need to complete mandatory training, and job specific training for staff needs to be identified
- Some improvements needed to security of emergency equipment and drugs
- Some improvements needed to concerns and complaints arrangements

Dental

We completed five dental inspections

- Strong management and leadership
- Surgeries were maintained to a high standard
- Patients were happy with the service provided
- Good active engagement with patients to obtain feedback on the service provided

- Patient records must always be maintained in accordance with regulatory professional standards for record keeping
- Staff to complete mandatory training
- Equipment must be decontaminated in line with national guidance

IR(ME)R

We completed one IR(ME)R inspection at Bronglais Hospital

- Fully compliant with the regulations
- Patients received clear information to understand the risks and benefits of their treatment options

- Improvements to patient awareness of how to provide feedback about their experiences or raise a concern about their care and treatment
- Develop and implement a written procedure for quality assurance of medical exposures equipment

Powys Teaching Health Board

In 2018 - 2019 we inspected two general practices, an independent dental practice and a community mental health service as part of our national review of Community Mental Health Teams.

Overall we found that patients across primary care services received good quality care and treatment. Patient and staff interactions were good, demonstrating courtesy and dignity at all times. Staff told us they were well supported by colleagues within the practice and the appropriate supportive structures were in place.

Areas that could be improved included, information provision regarding the complaints process and, in a practice recently taken over by the health board, it was found that the sharing and learning from serious incidents or patient safety issues needed to be formalised.

Our only dental inspection here in 2018-2019 was Yvonne Wood Dental Hygiene, an independent practice in Welshpool. This was an outstanding inspection with no areas of improvements identified.

During our inspection at the CMHT building at The Hazels, Llandrindod Wells Service user feedback was very positive about the whole team. Staff were involved in the formulation of care and treatment plans and Service user assessments were conducted in a timely manner. We did, however, find that the building was in a very poor state of repair, and was in need of significant work to ensure it was fit for purpose. We also found that integrated working between the health board and local authority was fragmented which impacted upon the day-to-day working of the CMHT and was in need of improvement.

Community Mental Health

We inspected The Hazels Community Mental Health Team, Llandrindod Wells

- Service user feedback was very positive about the whole team
- Staff were involved in the formulation of care and treatment plans
- Service user assessments were conducted in a timely manner
- Staff were committed to providing a positive experience for service users in the difficult working environment
- Staff were able to provide some specialist services to service users therefore reducing the waiting time to receive treatment.
- The building is in need of refurbishment and repair
- Improvements needed for arrangements to transport service users to hospital
- Administration of the Mental Health Act documentation
- Elements of care documentation can be improved
- Integrated working between the health board and local authority could be improved
- Sharing of information regarding complaints, concerns and incidents between the health board, local authority and staff.

GP

We inspected the Presteigne Medical Practice and the Welshpool Medical Practice

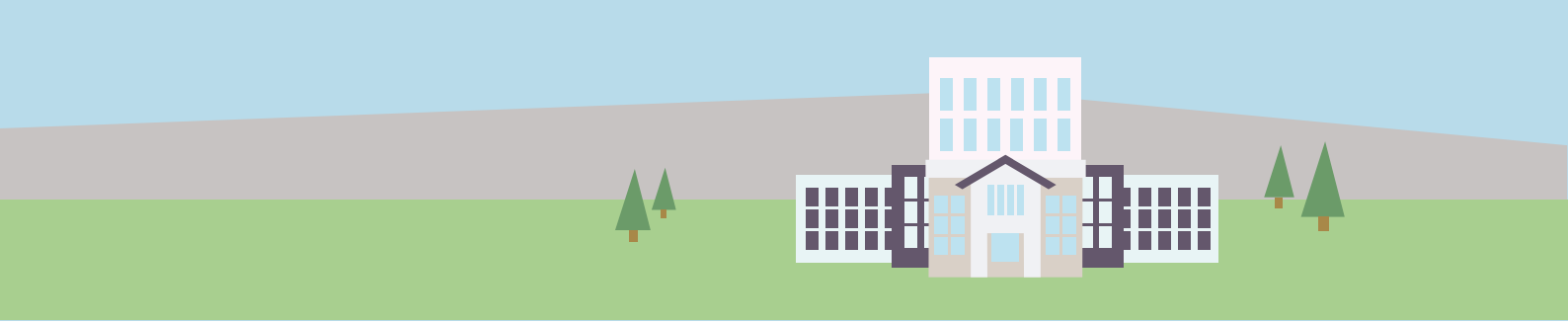
- No immediate assurance letters issued
- Positive and friendly interactions between staff and patients
- Supportive structure for staff
- Good standard of record keeping overall

- Better information provision needed regarding the complaints process
- Improvements to appointments process for patients with long term health conditions and regular clinics must be managed in a timely way
- Ensure that learning from significant events and safety incidents is appropriately shared and discussed by all staff within the practice

Dental

We inspected one independent dental practice

- Safe and effective care to their patients in a pleasant environment with friendly, professional and committed staff
- Patients very happy with the service they received according to our feedback
- Well run practice and that meets the relevant regulations to ensure the health, safety and welfare of staff and patients
- Evidence of various maintenance contracts to ensure the environment and facilities were safe and well maintained
- Infection control procedures were aligned to the relevant guidance and audit tools
- We found the practice to have good leadership and clear lines of accountability



Trusts – Public Health Wales, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust

Public Health Wales (PHW)

HIW continues to review PHW activity and performance through attendance at their quarterly Quality and Safety committee.

There has been some change within the organisation with Independent Members joining, changes within the Executive Team and a focus on delivery on the first year of a long term plan. Whilst there are some clear challenges around screening services it is clear that there is a strong commitment to quality and improvement and a willingness to engage with HIW on its National Reviews programme.

In July 2018 HIW published its review of substance misuse services. There are a number of recommendations for PHW to consider, particularly around co-occurring mental health needs, complexity of needs and harm prevention.

We have also consulted with PHW and the 1000 lives programme as part of our stakeholder engagement to discuss our research and intelligence functions, and identify mutual areas of interest.

Velindre University NHS Trust

During the year HIW regularly engaged with the organisation through their Quality & Safety Committee, Board meetings and meetings with executive officers.

In 2018/19 HIW conducted one unannounced inspection of Velindre Cancer Centre, within Velindre University NHS Trust. Our inspection team inspected two wards (first floor and chemotherapy inpatient) and explored how the service met Health and Care Standards.

The inspection findings were largely positive, with evidence showing that service provided safe and effective care. We also identified some areas of improvement and have made recommendations to the trust regarding actions required to ensure full compliance with Health and Care Standards.

The Trust are also tackling ICT systems issues that can affect patient safety if not addressed.

Welsh Ambulance Services NHS Trust (WAST)

HIW has continued to develop the relationship with WAST, with regular meetings and communication with executives and staff.

WAST has been a key stakeholder in helping HIW develop the content of new tools for inspecting Emergency Departments. This means that the interface between the Emergency Departments and ambulance service is better considered and tested while undertaking inspections. This work will also allow us to better consider the perspective of paramedics, as well as the hospital staff that work with them.

During 2018/19, HIW staff undertook a visit to the WAST Command and Control Centre in Carmarthen. This helped us to improve our knowledge and understanding of this function and to more fully appreciate the challenges and processes used by call handlers.

HIW continues to review all WAST activity and performance to determine any risk to patient safety and there are clearly some ongoing challenges around response times to patients, and the handover of these patients to health settings.

Annex A - Commitment Matrix

The following table is a list of the objectives HIW set for itself for 2018-19 together with details of how HIW met the objective

What we said	Measured by	Outcome
Deliverable 1 Process applications to register, or changes to registration, in a timely manner. Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	In addition to the project to register dental practices we processed 19 registered manager applications, 17 new provider registrations and 16 variations to existing registrations.
Deliverable 2 Conduct a programme of visits to suspected unregistered providers - as required. Deliver a programme of inspections in independent settings • Approximately 22 laser • Approximately 19 non-laser excluding mental health	Number of visits undertaken Number of inspections undertaken Number of reports published three months following inspection	We were made aware of 18 providers that potentially required registration. Following further investigation, including a visit to two providers, six applied to register, seven did not require registration and five confirmed that they would stop providing the service. We undertook and completed a criminal prosecution against an unregistered provider.
Deliverable 2b Deliver a programme of inspections in independent settings • Approximately 22 laser • Approximately 19 non-laser excluding mental health	Number of inspections undertaken Number of reports published three months following inspection	We carried out inspections of 29 independent settings, excluding mental health settings and private only dental practices. This was less than originally planned due to services de-registering upon notification of inspection and the need to undertake inspections in higher risk areas.

What we said	Measured by	Outcome
Deliverable 3 Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner	Number of concerns received Number of Reg 30/31 notifications received Analysis of source and action taken	During 2018-19, we received 340 concerns relating to either the NHS or the independent sector. We received 196 concerns regarding NHS settings or services. There was 126 concerns regarding independent healthcare provides registered with HIW We also received 18 concerns relation to unregistered providers or settings that do not require registration with HIW. All concerns are reviewed weekly and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. The Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 580 Regulation 30/31 notifications received. They are as follows: Death in Hospice – 389 Death excluding Hospice –5 Unauthorised absence – 57 Serious injuries – 95 Allegation of staff misconduct - 29 Outbreak of Infectious Disease – 3 Deprivation of Liberty Safeguards (DoLS)
Deliverable 4 Support legislative developments including: Continue Implementation of the Private Dentistry (Wales) Regulations 2017 Contribute to further policy development on regulation and inspection arising from the 'Services Fit for the Future' White Paper	Delivery of implementation plan following new dental regulations Future decisions on potential changes to the legislation	During the year we completed the project to register all dental practices offering private dental treatment. This resulted in the registration of 485 dental practices

Annex A - Commitment Matrix

What we said	Measured by	Outcome
Deliverable 5 Undertake a broad inspection programme in the NHS informed by intelligence and an assessment of risk including approximately: - 15 focussed inspections across the acute sector - 5 specific follow-up inspections - 28 GP inspections - 100 dental inspections - 5 IR(ME)R inspections - 5 surgical services inspections	Number of inspections undertaken	We carried out 132 inspections Hospitals - 13 NHS mental health units - 11 CMHT- 7 GP - 20 Dental - 73 IR(ME)R - 5 Surgical - 3 Follow-up – 6 (included in above figures)
Deliverable 6 Conclude our programme of ongoing thematic work including: - Patient Discharge - Community Mental Health - Youth Transition And commence a new thematic review towards the end of 2018	Publication of terms of reference of each project Publication of thematic review	During the year we published five thematic reviews relating to: - Patient Discharge - Substance Misuse Services - Community Mental Health Teams - Healthcare services for young people - Healthcare support for older people living in North Wales care homes We began work on our national review of care pathways surrounding older people and falls in 2018 – 2019. During 2019-20 we will commence national reviews into maternity services, and crisis care in mental health.
Deliverable 7 Continue our joint inspection work with UK agencies Approximately 16 death in c ustody reviews with the Prison and Probation Ombudsman Up to three joint reviews with HMI Prisons and HMI Probation	Number of inspections undertaken	We carried out 18 death in custody investigations. We undertook one joint inspection with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Deliverable 8 Conduct a high level review of each NHS body through - Further development of the Relationship Management function - Producing an Annual Statement for each Health Board and NHS Trust	Publication of health board and NHS trust annual statements	2018-19 annual findings were presented at board meetings and board development days for Health Boards and NHS Trusts by Relationship Managers.
Deliverable 9 Publish annual reports summarising the themes and issues arising from our work. In particular: - Hospital Inspections - GP Practices Annual Report - Dental Practices Annual Report - Mental Health Act Annual - Monitoring Report - Deprivation of Liberty - Safeguards (DOLS) Annual Report - IR(ME)R - Laser Annual Report - HIW Annual Report	Publication of reports	NHS Hospital Inspections – an overall summary of our hospital inspection programme was not published due to the disparate functions and purposes of different hospital wards and settings inspected. General Medical Practice (GP) inspections - Annual Report 2017-18 – published 29 March 2019 General Dental Practice Inspections Annual Report 2017-18 – published 29 March 2019 Mental Health Act Annual Monitoring Report – published 16 July 2019 Deprivation of Liberty Safeguards (DOLS) Annual Report 2017-18 – published 2 May 2019. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Annual Report 2017-18 – published 5 April 2019 HIW overarching Annual Report 2017-18 – published 19 July 2018

Annex A - Commitment Matrix

What we said	Measured by	Outcome
Deliverable 10 Undertake a programme of inspections in NHS and independent mental health settings including approximately: - 15 NHS mental health units - 19 independent mental health units Mental Health Unit inspections include: reviewing the application of the Mental Health Act 7 inspections of Community Mental Health Teams	Number of inspections undertaken	We carried out 29 inspections of mental health and learning disability units: - 11 NHS mental health units - 17 independent mental health units - 1 independent learning disability units Follow up – 6 (included in above figures) We carried out 7 Community Mental Health Team inspections.
Deliverable 11 Provide a Second Opinion Appointed Doctor service for about 750 SOAD requests	Publication of Key Performance Indicators	Key performance indicators have been formulated and shared with the health boards and independent healthcare providers. We are currently working on our systems to measure our performance more effectively.
Deliverable 12 Investigate homicides as commissioned by Welsh Government	Publication of Terms of Reference Publication of final report	We were not commissioned to undertake any new homicide investigations during 2018-19. We undertook a Special Review of ABMU Health Board's handling of its employment of Kris Wade during 2018-19. This review was published in January 2019
Deliverable 13 Hold two Healthcare Summits during 2018 -19	Clear audit trail of healthcare summits	We held two Healthcare Summits during 2018-19, chaired by HIW and attended by ten external bodies.

Annex A - Commitment Matrix – Continued

What we said	Measured by	Outcome
Deliverable 14 **Publish reports from all our inspection and review activity in accordance with our performance standards.**	Publication of reports Publication Schedule Publication of HIW performance against targets	Publication dates of all our reports are published on our website. The publication schedule can be found here: hiw.org.uk/publication-schedule
Deliverable 15 **Continue our joint work with other UK and international agencies on joint inspections and influencing best practice**	Participation in joint work Progression of joint thematic review of youth healthcare with Inspection Wales	HIW attended the European Partnership for Supervisory Organisations in Health Services and Social Care Conference. The purpose of the partnership is to help improve the quality of health and social care in Europe through connecting supervisory organisations in order to improve exchange of ideas, outcome of research, information and good practice. Two visits were undertaken by the Intelligence and Methodology teams to explore approaches and tools used by colleagues in Healthcare Improvement Scotland and the Regulation and Quality Improvement Authority in Northern Ireland. Senior staff attended the International Conference on Quality in Healthcare in Glasgow in order to learn from emerging and best practice elsewhere.
Deliverable 16 Evaluate the use of voluntary lay reviewers	Evaluation with recommendations for future action	Initial evaluation has begun with recommendations for future action being considered in 19/20

Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

www.hiw.org.uk

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Public Services Ombudsman Annual Letter 2018/19
Report Author:	Office of the Public Services Ombudsman Wales (PSOW)
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Public or In Committee	7
Purpose of Report:	Each year the PSOW provides each organisation with an Annual Letter that summarises activity and issues specific to Betsi Cadwaladr University Health Board. This year, PSOW has published the Annual letters as part of the Annual Report and Accounts instead of following publication of the Annual Report. It should be noted this report relates to **2018/19.** The purpose of this report is to share the Annual Letter with the Board and to inform the Board of the actions taken and improvements made since this reporting time-period.
Approval / Scrutiny Route Prior to Presentation:	To be presented to Quality Safety Group (QSG)
Governance issues / risks:	The Annual Letter describes a slight increase in the number of complaints received by the PSOW overall, with fewer cases requiring investigation. Specific to Betsi Cadwaladr University Health Board, the Health Board is one of four Health Boards within Wales which has continued to receive the highest number of complaints, however, none of the ten public interest health- related reports have concerned care and treatment delivered by Betsi Cadwaladr University Health Board.
Financial Implications:	No cost
Recommendation:	The Committee is asked to note the Annual Letter and the actions taken by the Health Board for information.

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 Engagement			
Equality Impact Assessment			

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

Public Services Ombudsman Annual letter 2018/19

1. Purpose of the report

The purpose of this report is to share the Annual Letter with the Health Board and to inform the Board of the actions taken and improvements made since this reporting time-period.

2. Introduction/Context

Each year the PSOW provides each organisation with an Annual Letter that summarises activity and issues specific to Betsi Cadwaladr University Health Board. This year, PSOW has published the Annual Letters as part of the Annual Report and Accounts instead of following publication of the Annual Report. It should be noted this report relates to **2018/19.**

The Annual Letter notes that Betsi Cadwaladr University Health Board is one of the four health boards in Wales which has continued to receive the highest number of complaints although fewer cases have required investigation by PSOW. In addition, Betsi Cadwaladr University Health Board has not received a public interest health-care related report in this time period although ten such reports have been published by PSOW in 2018/19.

The PSOW asks the Health Board to take the following actions:

1. Present the Annual Letter to the Board
2. Work to reduce the number of cases which require intervention by PSOW
3. Continue to work with the PSOW Improvement Officer to improve complaint handling

Each of these actions are addressed below.

3. Response to the required actions

1. Present the Annual Letter to the Board

The Annual letter is to be presented to the Board via the Quality and Safety Group and the Quality, Safety and Experience Committee.

2. Work to reduce the number of cases which require intervention by PSOW

There is a programme of improvement in place to manage complaints in real-time which includes:

- The development of performance trajectories for each division
- The monitoring of trajectories via the monthly Quality and Safety Group
- Weekly meetings with Governance leads and Heads of Nursing/Service, chaired by the Interim Assistant Director Service User Experience, to monitor

performance and support with achievement of real time management of complaints

In addition, there is a programme aimed at improving the quality of response letters which includes:

- Annual training programme for the management of investigations, *Putting Things Right* Regulations, and complaint handling
- Bespoke training sessions
- Dedicated corporate training lead (short term)
- Development of standard operating procedure on how to write a good response.

3. Continue to work with the PSOW Improvement Officer to improve complaint handling

The Health Board works with the Office of PSOW as required and a meeting with the newly appointed PSOW Improvement Officer is planned for September. Links with the Office of PSOW will also be improved as the Ombudsman is opening a small office in Bangor in 2019/20.

4.	Assessment of risk and key impacts

The PSOW Annual letter also highlights that the Public Services Ombudsman (Wales) Act 2019 has now been introduced. This has given the Ombudsman new powers aimed at:

- Improving access to his office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing the Ombudsman to undertake his own initiative investigations when required in public interest.
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

5.	Equality Impact Assessment

This is a document produced by the PSOW.

6.	Conclusions/next steps	

The Health Board will continue to work closely with the PSOW to improve complaints handling and the services provided to our population.

7.	Recommendations

The Committee is asked to note the Annual letter and the actions taken by the Health Board for information.

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 August 2019

communications
@ombudsman-wales.org.uk

Mr Mark Polin OBE QPM
Chair of the Board
Betsi Cadwaladr University Health Board

By Email Only
mandy.williams7@wales.nhs.uk

Dear Mr Polin

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Betsi Cadwaladr University Health Board. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Board finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

As you will note from my Annual Report, Betsi Cadwaladr UHB is one of the four health boards in Wales which has continued to receive the highest number of complaints. Whilst the number of complaints received by my office is slightly higher than last year, I am pleased that fewer cases required investigation. Also none of the ten public interest healthcare-related reports I issued concerned care and treatment delivered by your Health Board.

As you are aware, I visited the Health Board in April 2018 to learn about actions taken in response to the recommendations I made in public interest reports issued during 2017/18. I was pleased with the Health Board's positive response to the recommendations I had made and I hope that the actions taken will improve services for patients in the future.

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance
- Work to reduce the number of cases which require intervention by my office
- Work with my Improvement Officer to improve complaint handling
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Public Services Ombudsman for Wales

CC: Gary Doherty, Chief Executive
Denise Williams, Contact Officer

Factsheet

A. Complaints Received and Investigated with Health Board average adjusted for population distribution

Local Health Board	Complaints Received	Average	Complaints Investigated	Average
Betsi Cadwaladr University Health Board 2018/19	186	167	70	58
Betsi Cadwaladr University Health Board 2017/18	194	173	44	42
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Aneurin Bevan University Health Board	134	146	38	36
Cardiff and Vale University Health Board	102	123	28	30
Cwm Taf University Health Board	75	74	22	18
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Betsi Cadwaladr University Health Board	Complaints Received	Average
Health - Complaint Handling	25	12
Health - Appointments/admissions/discharge and transfer procedures	7	4
Health - Clinical treatment in hospital	113	70
Health - Clinical treatment outside hospital	23	8
Health - Confidentiality	1	1
Health - Continuing care	4	4
Health - Medical records/standards or record-keeping	2	1
Health - Non-medical services - food. cleanliness etc	2	0
Health - Other	11	5
Health - Patient list issues	3	3
NHS Independent Provider - Care Homes	2	0
Various Other - Poor/No communication or failure to provide information	1	0

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / voluntary settlement	Discontinued	Other Reports - Not Upheld	Other Reports - Upheld in whole or in part	Public Interest Reports	Grand Total
2018/19									
Betsi Cadwaladr University Health Board	32	26	46	38	4	16	48	-	210
Health Board average (adjusted)	28	21	45	34	2	14	34	2	180
2017/18									
Betsi Cadwaladr University Health Board	27	18	44	34	-	16	34	2	175
Health Board average (adjusted)	26	17	40	26	1	11	24	1	145

D. Number of cases with PSOW intervention

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% intervention
Betsi Cadwaladr University Health Board 2018/19	86	210	41%
Betsi Cadwaladr University Health Board 2017/18	70	175	40%
Abertawe Bro Morgannwg University Health Board	54	139	39%
Aneurin Bevan University Health Board	49	128	38%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2018/19, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2018/19 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Health Board during 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section D provides the numbers and percentages of cases received by my office in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	2019 Annual Nurse Staffing Levels(Wales) Act 2016 Reporting Framework
Report Author:	Ms Debra Hickman, Secondary Care Nurse Director
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The Executive Director of Nursing & Midwifery has the responsibility of presenting a biannual report on behalf of the Health Board outlining Nurse Staffing calculations that have been undertaken, how these have been maintained and any potential harms that may have resulted. In particular these may include : patient falls, Hospital Acquired Pressure Ulcers, medication errors or complaints whereby through a process of investigation are deemed to have identified a failure to maintaining appropriate nurse staffing levels as a causal factor and any mitigating actions taken in response to not maintaining nurse staffing levels. The reporting cycle (appendix 1) as indicated in the Annual Nurse Staffing Levels (Wales) Act 2016 guidance was revised in late Spring 2019. An Internal revised reporting schedule has been developed to ensure quarterly reports are received via Quality Safety Group and bi-annually to the Quality Safety & Experience Committee (appendix 2). Due to this revision it is requested that reports are now received in April and November.
Approval / Scrutiny Route Prior to Presentation:	Via Executive Director of Nursing and Midwifery
Governance issues / risks:	1. The Annual review of each of the sections within the Act 25a – 25e as legislated 2. The incidences of harm whereby investigation findings identify staffing deficits as a causal or contributory factor and the comparison between the same reporting period 2017/18 & 2018/19
Financial Implications:	None identified
Recommendation:	The Committee is asked to amend its cycle of business in respect of the compliance report for Nurse Staffing Act 2016.

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		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 Leadership & Governance Strategic and Service planning			
Equality Impact Assessment None required.			

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

Appendix 1

Further information on how to input and ensure the quality of the acuity data as part of the bi-annual audit can be found in the HCMS How to Guide (appendix 4).

How is the calculation of the nurse staffing level recorded?

Each health board/trust should develop systems for recording the evidence used and the rationale applied when calculating the nurse staffing level for each adult acute medical and surgical in-patient ward.

Appendix 5 provides a checklist of the factors which *must* be considered and appendix 6 provides a template for recording the calculating and the decision making process undertaken during the calculation process.

When is the calculation of the nurse staffing level undertaken?

The routine bi-annual calculation of the nurse staffing level should take place around March/April and August/September of each year. This timetable takes into account the bi-annual capture of acuity data across all adult acute medical and surgical in-patient wards which takes place January and June as directed by NHS Executive Directors of Nursing and the time it takes to process and publish the data. The following timetable provides a guide to assist each health board/trust in determining the annual cycle of actions in relation to the bi annual calculations and reporting requirements required under the Nurse Staffing Act.

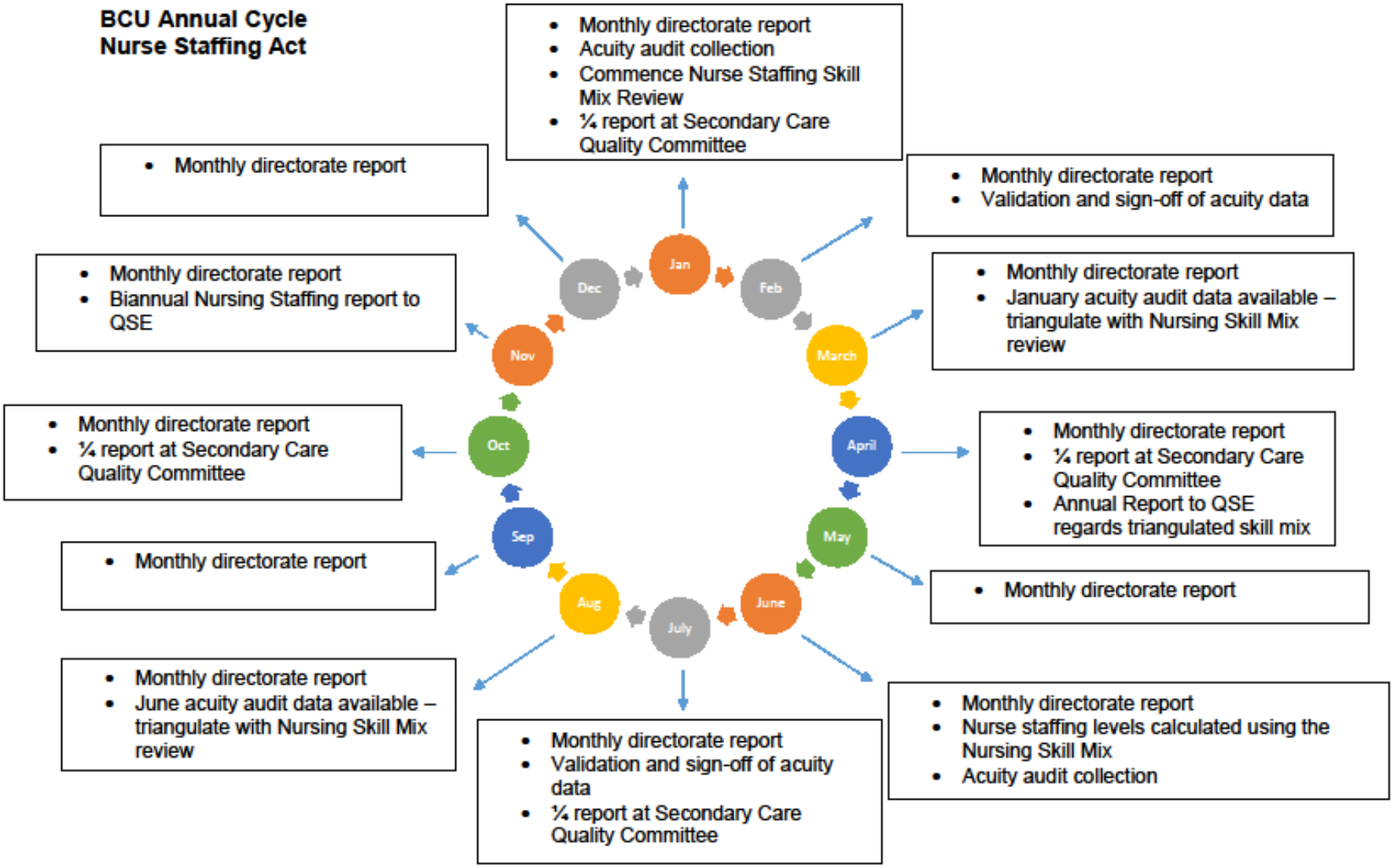
The following timetable provides a guide to assist each health board/trust in determining the annual cycle of actions in relation to the bi-annual calculations and reporting requirements required under the Nurse Staffing Act:

January	- Acuity audit undertaken.	Ongoing capture and monitoring of pertinent data relating to the agreed quality indicators and professional judgement criteria. Also, ongoing review and recording of any variation from planned rosters In addition the Board of the LHB (or Trust) should receive a written update of the nurse staffing level of each individual
February	- Validation and sign-off of the January acuity audit data.	
March	- January acuity audit data available to health boards - Health Boards to commence the process of re-calculating the Nurse staffing level using the triangulated approach.	
April	-Health Boards to finalise the Nurse staffing level. -Health Boards to present the annual report and bi-annual recalculation of the nurse staffing level to developmental Board and/or agreed committee	
May	- Annual report to board (25E)	

	- Update of the bi-annual recalculation of the nurse staffing level to the Board. This update can be provided to the Board via a formally delegated subcommittee.	adult acute medical and surgical ward when there is a change of use/service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary. (The updates can be provided to the Board via a formally delegated subcommittee)
June	- Acuity audit undertaken.	
July	- Validation and sign-off of the June acuity audit data	
August	- June acuity audit data available to health boards. - Health Boards to commence the process of re-calculating the Nurse staffing level using the triangulated approach.	
September	-Health Boards to finalise the Nurse staffing level.	
October	Health Boards to present the bi annual recalculation of the nurse staffing level to developmental Board	
November	A annual formal presentation by the designated person of the nurse staffing level of each individual adult acute medical and surgical ward to the Board of the LHB (or Trust)	
December		

NOTE: *The timetable sets out the actions to be undertaken by each health board and will be subject to review.*

Appendix 2


BCU Annual Cycle
Nurse Staffing Act
Monthly directorate report
Acuity audit collection
Commence Nurse Staffing Skill Mix Review
¼ report at Secondary Care Quality Committee
Monthly directorate report
Validation and sign-off of acuity data
Monthly directorate report
January acuity audit data available – triangulate with Nursing Skill Mix review
Monthly directorate report
¼ report at Secondary Care Quality Committee
Annual Report to QSE regards triangulated skill mix
Monthly directorate report
Monthly directorate report
Nurse staffing levels calculated using the Nursing Skill Mix
Acuity audit collection
Monthly directorate report
Validation and sign-off of acuity data
¼ report at Secondary Care Quality Committee
Monthly directorate report
June acuity audit data available – triangulate with Nursing Skill Mix review
Monthly directorate report
Monthly directorate report
Monthly directorate report
¼ report at Secondary Care Quality Committee
Monthly directorate report
Biannual Nursing Staffing report to QSE
Monthly directorate report
Jan
Feb
March
April
May
June
July
Aug
Sep
Oct
Nov
Dec

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Accessible Communication & Information - Welsh Government (WG) Narrative Performance Report
Report Author:	Carolyn Owen (Head of Patient and Service User Experience) Peter Morris (Patient and Service User Experience Manager – West)
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	To provide a summary of performance against the organisation's action plan for improved compliance with Accessible Communication and Information Standard (WG, 2013)
Approval / Scrutiny Route Prior to Presentation:	Associate Director Quality and Assurance
Governance issues / risks:	BCUHB has developed the infrastructure and underlying processes to respond positively with the requirements of the Accessible Healthcare Standards (AHCS) (WG, 2013), however the following risks remain:- *Staff Awareness;* this is not a mandatory enrolment and therefore the Sensory Loss Toolkit and in particular Factsheets 1-4 remain the principle control. The appointment of additional Patient Advice Liaison & Support Officers (PALS) in each operating region will result in additional resources dedicated to improving staff awareness and general compliance. However, managers need to be vigilant in relation to mainstreaming the advice contained within the Sensory Loss Toolkit and utilising this as the basis for developing increased awareness, matrons need to ensure operational accountability for this. *Recording Communication Needs;* this remains a considerable challenge and whilst the IM&T systems are currently in theory enabled this is not happening in practice and Welsh Patient Administration System (WPAS) and Patient Information Management System (PiMS) (West) are not routinely utilised for this purpose. *Accessible Health Care Scheme;* the accessible health care scheme is provided under an Service Level Agreement (SLA) with the Centre for Sign Sight and Sound (COSS) and enables the provision of a health advocacy service which aims to support service users with sensory loss to gain access to and progression within health services on the same basis as all other service users. This is an invaluable control, and continued funding is a prerequisite of continued compliance with the AHCS (WG, 2013)

	Ensuring that BCUHB's listens, learns and acts on Feedback from Service Users with Sensory Loss; BCUHB has a number of frameworks for engaging with service users such as the use of CRT/Viewpoint real time feedback questionnaire, patient stories, care2share, focus groups etc., The appointment of PALS officers in each region will enhance this ability moving forward.
Financial Implications:	The continued funding of the Accessible Health Care scheme, sometimes referred to as 'Transitional Funding'
Recommendation:	To endorse the controls/corrective actions highlighted in this report, and to ensure that staff, managers and other stakeholders recognise and act on their responsibility to ensure that service users with sensory loss are able to access our services on the same basis as all other service users.

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			

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

Accessible Communication and Information

NHS Organisation	Betsi Cadwaladr University Health Board
Date of Report	September 2019
Report Prepared By	Carolyn Owen Peter Morris

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the 'Standards' as an enabler to implementing them.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 31 April.

Complete form to be returned to: hss.performance@gov.wales

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?	**Yes**

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved during 2019-2020	Risks to Delivery	Corrective Actions
All public & patient areas should be assessed to identify the needs of people with sensory loss	Continued development of the self-evaluation tool, including primary care variant, which enables managers to evaluate compliance with the standards in relation to their service points, which include a section related to Environmental Signage and wayfinding and is supported by addition guidance. **See Appendix 1 & 2** The self-evaluation tool is utilised as an integral component of organisational governance and performance management in relation to compliance the AHCS.	Utilisation of the instrument still remains to be mainstreamed in all areas, and the majority of GP practices are not directly managed by BCUHB.	Organisational Compliance with AHCS achieved via the Organisational Quality & Safety Group and Listening & Learning Group thus providing executive/board level oversight. Compliance with the AHCS is in an integral component of the new Patient & Service Experience Strategy (BCUHB, Jun 2019) and will become an integral component of work streams in all three BCUHB operating areas. The appointment of 3x1 wte Patient Advice & Liaison Officers in each operating region will enable increased resources to be directly assigned to the project from Q2-2019/2020.

	The ward accreditation audit instrument contains items specifically relating to improved compliance with AHCS.		Continued Utilisation of existing performance, quality assurance and governance arrangements to support (i) improved utilisation of the evaluation tool and resultant action planning and (ii) exception reporting to relevant organisational scrutiny groups where this is not occurring. Area governance Teams are aware of the issue and supporting via Cluster Development programmes.
All public information produced by organisation should be assessed for accessibility prior to publication.	The Sensory Loss Toolkit and associated self-evaluation audit instruments (see above) ensures that the managers and staff are aware of their responsibility to produce information in accessible formats. Policy ISU02 – Written Information Patients reinforces this responsibility and provides best practice guidance. Additionally the responsibility for managers and staff to consider the needs of patients and service users with sensory loss in the production of information was reinforced during patient safety week by the Patient and Service User Experience Team. BCUHB is currently reviewing information on its intra and internet sites as an integral component of a wider on-project to migrate to WIS content management standard. Internet pages provide spoken access and improved visual access compared with 2018/2019., and the resources comply with Web Content	Requests for change to templates for appointment letters are under the auspices of WIS project management and whilst the Accessible Information Standards reinforce the need to ensure that public facing information is available in accessible format, this is very difficult to action at a local level.	BCUHB Head of Information is aware of the issue and is working to ensure that IM&T systems are able to provide information in accessible formats. Head of Patient & Service User Experience in conjunction with the Corporate Communications Team to review policy ISU02 – Written Information Patients in line with stated review period in order to facilitate compliance with the Accessible Health Care Standards (WG, 2013).

	Accessibility Guidelines (QCAG) 2.1 and include an ability to change font side and support for a variety accessibility add-ins such as Adobe™ – Read Out Loud. The requirement for patient information to be available accessible formats is now included within the audit tool for ward accreditation. The current SLA with WITS for 2019/2020 enables BRAILE translation where requested by service users. The new Patient and Service User Experience Strategy was endorsed by the Quality and Safety Group (QSG) sub-committee of the board and emphasises the need to adopt a trilingual (English, Welsh & BSL) approach to communicating with patients and service users. The use of EIDO patient information leaflets which are available in easy read and variable font format provide a useful resource in relation to the provision of information in accessible format, for standard procedures and diagnosis.		

Standards of Service Delivery	Key Actions Achieved during 2019-20	Risks to Delivery	Corrective Actions
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
Raising staff awareness	The latest version of the Sensory Loss Toolkit contains (i) factsheets (1-4) relating to best practice for dealing with service users with sensory loss and (ii) endorses the use of the NHS Wales e-sensory loss module. This is reinforced by the baseline evaluation tool (see above). These have been reviewed and updated within 2019/2020 to include a community/primary care variant. **See Appendix 3 & 4** BCUHB mandatory training policy has been amended to ensure that the NHS e-sensory loss module is offered as an alternative to the 3-year mandatory equality training refresher. The new ward accreditation audit instrument ward accreditation audit instrument contains specific items (PE12-PE14) related to compliance with accessible health care systems as a prerequisite for ward accreditation.	As in 2019/2020 - sensory loss training is not mandatory within the NHS in Wales and this does pose a significant risk in relation to increasing staff awareness, especially given the pressure to complete other mandatory training. Additionally Access to (enrolment on) e-learning modules which are not an integral component of the ESR learning suite, is for some staff groups problematic due to lack of access to computers during work hours and the need to search for specific courses and add these enrolments to ESR at an individual learner level. The policy framework underpinning national compliance with the standards does not include specific reference to performance targets associated with training/staff awareness. Whilst BCUHB had planned and argued strongly for changes to the NHS Wales e-learning infrastructure to enable the local (BCUHB level) mandatory enrolment of the NHS Sensory Loss Module on a 3 year cycle as	Guidance on searching for, and adding NHS e-learning modules to ESR enrolments has been placed on BCUHB's relevant intranet pages, and reinforced during BCUHB patient safety week. Additionally section 3.2 of the sensory loss Toolkit contains similar guidance and as an additional control where access to the e-learning module is not possible request that; *"3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines." (Baseline Evaluation Tool, p.4*) In the absence of an ALL Wales approach to the utilisation of the e-sensory loss module as a mandatory enrolment. BCUHB classroom based delivery of the 'Treat Me Fairly' module will include reference to (i) responsibility of BCUHB staff to book BSL interpretation services and (ii) Fact Sheets 1-4 from the Toolkit. The latter to be given to participants in the form of a hand out.

	BCUHB are hosting this year's 'It Make Sense Event' supported by Public Health Wales and Welsh Government in the Conwy Business Centre on 28th November 2019 – please see draft agenda below. It Makes Sense SENSORY LOSS AWARENESS MONTH Gwneud Synnwyr MIS YMWYBYDDIAETH COLLED SYNHWRAIDD 09:30 Registration 10:00 Video welcome Vaughan Gething Health Minister for Wales & Executive Director of Nursing and Midwifery 10:15 Paul Redfern BSMHD 10:45 Sandra's Story / COSS Live Well 11:05 Deaf Blind Cymru 11:.25 RNIB 11:45 Billy Baxter, story, Blind Veterans 12:15 Lunch 13:30 Workshops / Breakout Groups 15:30 Close – The BDA's BSL Charter Pledge – Jackie Hughes Independent Member for Equalities BCUHB	an alternative to 'Treat me Fairly' refresher. The lack of an all Wales Consensus has now caused BCUHB to abandon this approach. However, staff and managers are encouraged to undertake the NHS Wales e-sensory loss awareness module as an additional enrolment.	The 9x1wtes newly appointed PALS officers will undergo accredited BSL sign language level 1 training within Q3-2019/2020. Awyr Las agreed to resource this invaluable training. Awyr Las Blue Sky
Ensuring all public information is accessible for people with sensory loss	See 'Needs Assessment' above. The new Patient & Service User Experience Strategy (BCUHB, June 2019) contains specific work streams aimed at making it easier for service users with sensory loss to provide feedback on their experiences, eg revised patient story policy & guidelines, and associated equality impact assessment, will improve the	See 'Needs Assessment' above.	See 'Needs Assessment' above.

	reporting of real time feedback by protected characteristics. The Patient Experience Strategy and revised guidelines for taking patient stories were endorsed by BCUHB Quality and Safety Group – a sub-committee of the board, in June 2019. Both the Patient and Service User Experience and Patient Stories Guidelines have undergone a rigorous equality impact assessment.		

Standards of Service Delivery	Key Actions Achieved during 2019-2020	Risks to Delivery	Corrective Actions
Accessible appointment systems	Whilst within 2018/2019 All Wales Information Service (WIS), has ensure that systems are enabled in line with phase II of the Accessible Information Standard (AIS) to record communication needs and include these in e-referrals received by the Health Board. (Such an approach relies on fields relating to language, disability and communication needs being populated in a systematic and rigorous manner derived from universal reference values). Posters developed by the NHS Wales Centre for Equality and Human Rights in conjunction with the Snr Officers group, to be forwarded to all managed practices and to Cluster Development Managers/Officers within BCUHB to encourage service users with sensory to request that their communication needs are recorded within primary care information systems. **See Appendix 5 & 6** The use of type talk to facilitate access to centralised booking system. Working in conjunction with AHCW (see above) booking staff are able to facilitate improved access to the appointment system for service users with sensory loss. Additionally text reminders are utilised for appointments. Continued funding for 2019/2020 by BCUHB of the Accessible Health Care Worker (AHCW) scheme to facilitate access to and participation in health care for service users with sensory loss. Accessible	As in 2018/2019 the risks to delivery are similar moving forward; namely the utilisation of an IM&T infrastructure which relies on communication needs related to sensory loss being recorded within primary care and then transferred via electronic referral to secondary care. At a time when BCUHB is migrating to the merged WPAS platform and primary care is in the midst of a tendering process for the next generation of primary care MIS. Following on from the above; • Reliance on service users to request that communication needs relating to sensory loss are communicated to health care providers (primary, community & secondary). • Lack of standardised generic reference values for recording communication needs within WPAS within BCUHB. The above risks will largely remain throughout 2019/2020 until current National WIS projects are completed, and implemented operationally. Currently the appointment system does not automatically create an alert reminding HCPs	BCUHB Head of Information has requested that NWIS regularly audit whether fields relating to sensory loss are being populated within primary care. Reference values to be agreed and standardised within all BCUHB patient information systems. BCUHB Head of Information in conjunction with service managers, and service users to develop the capability to utilise information relating to communication needs to provide exception reports which enable HCPs and other staff to proactively respond to the communication needs arising from sensory loss, eg flagging TCI lists, clinic lists etc. Funding for the Accessible Health Care Scheme to continue for 2019/2020. (See also actions above in relation to increasing staff awareness).

	Health Care Scheme which in conjunction with the Centre for Sign Sight & Sound (COSS) and other voluntary organisations provides support for service users with sensory loss so that they are able to access information and services on the same basis as other service users. This has been an effective and innovative and effective interventions and was nominated for an Action on Hearing Loss award. Data for the period (April 2019 – August 2019) provided by the COSS indicates that the scheme supported the following activity; Make/Cancel Appointments 529 Book Hospital Transport 9 Communication Support 78 Access Health Service 83 Emergency Dental X-Ray & Results 21 Pharmacy Queries 9 Support to professionals 48 Raise Concerns 18 *Total* 795 **See Appendix 7**	to book BSL interpreter, and this relies on local knowledge of the service user's needs being passed on to the service point. Although this risk is partially ameliorated via the AHCW scheme and the local knowledge Given the above risks it is important that staff are aware of the needs of service users with sensory loss and that actions relating to increasing awareness cited above are implemented within and across BCUHB.	

<table>
<tr>
<td>Communication models</td>
<td>As in previous reporting periods within Q1-Q2 2019/2020 the WITS interpreter service continues to provide front line face to face BSL interpretation and feedback on whole is positive. The ability of the Service Level Agreement with WITS to support Braille translation has been effective on a small number of occasions. In the period April-August 2019 there have been n=510 BSL bookings, see table below;

BCUHB WITS Bookings April-August 2019
<table>
<tr><th>Language</th><th>No of Bookings</th></tr>
<tr><td>Polish</td><td>706</td></tr>
<tr><td>BSL</td><td>510</td></tr>
<tr><td>Arabic</td><td>344</td></tr>
<tr><td>Bulgarian</td><td>124</td></tr>
<tr><td>Portuguese</td><td>121</td></tr>
<tr><td>Romanian</td><td>99</td></tr>
<tr><td>Turkish</td><td>83</td></tr>
<tr><td>Cantonese</td><td>64</td></tr>
<tr><td>Kurdish Sorani</td><td>53</td></tr>
<tr><td>Bengali</td><td>52</td></tr>
</table>
Digitally accessed interpretation services can now be supported via BCUHB internet based on Skype™ Technology, although these are not yet mainstreamed.

BCUHB staff and managers have been sent specific reminders in relation to their responsibility to book</td>
<td>Staff Awareness in relation to the responsibility of HCPs to book a WITS interpreter as required; this risk is sometimes compounded where communication needs are unknown to the HCP/Service Point (see note above).

IM&T infrastructure and resources required to support DAISY implementation.

Feedback from Service Users indicates that the preference for a face to face interpretation service; and such an approach is supported via the Accessible Health Care Scheme.</td>
<td>As above AHCW scheme partially controls for this risk and continued, recurrent funding for this scheme moving forward is imperative.

Following on from the above the Accessible Health Care Communication card, is credit card available to all service users who wish to identify their communication needs.

Continue to improve staff awareness via training and though quality assurance initiatives such as ward accreditation, utilisation of self-evaluation tool as previously stated. Additionally the presence of extra PALS officers will enable the principles to be repeatedly reinforced as an integral component of their work stream eg ward observations, supporting compliance audit, undertaking patient stories, facilitating service user feedback etc.

Continue to implement technological solutions where these are practically possible and commensurate with the identified needs of service users; including the purchase of additional skype™ licences where necessary and hardware.</td>
</tr>
</table>

	interpretation services; this has been reinforced via e-mail, intranet, through patient safety week, via Factsheets 1-4 from the Sensory Loss Toolkit and incorporating these within face to face training eg new 'Treat Me Fairly' module.		

Primary and Community Care. Priority areas include:			
Standards of Service Delivery	**Key Actions Achieved during 2019-2020**	**Risks to Delivery**	**Corrective Actions**
Raising staff awareness	(See also Above). Continued review and update of the Community and Primary Care version of the Sensory Loss Toolkit – available on BCUHB intranet pages. Patient Advice Liaison and Support (PALS) officers have been appointed in all operational areas in order to support improved compliance with AHCS and increase staff awareness, in partnership with Acute & Area governance teams. PALS deployment rota includes all Community Hospitals and Managed GP practices. Within 2019/2020 phase II of the ward accreditation process includes all community hospitals and the associated ward metric (audit tool) include specific reference to compliance with accessible AHCS, (see PE12-14) below.	(See also Above). Geographic distribution of service points, and difficulty of engaging staff and service users in 'remote' locations. The majority of GP Practices are autonomous and not directly managed and therefore integrating these practices within BCUHB's governance frameworks relies on good will and the skill of the Cluster Development teams.	(See also Above). As in 2019/2020 Engagement of managed practices, cluster development teams and community matrons. Ensure compliance with AHCS is a regularly reported within Areas Governance and Matron's meeting. Following on from the above, utilisation of the self-evaluation Toolkit to ensure that compliance is regularly monitored and action plans for improvement are developed as appropriate. Include data in relation to compliance within local Quality Safety and Effectiveness and Quality and Safety Group (QSG), and Listening and Learning Groups which are executive sub-committees.
Accessible appointment systems	(See Above).	(See Above).	(See Above).

Communication models	(See Above).	(See Above).	(See Above).
Implementation of the Accessible Information Standard	As with 2019/2020 the key focus of work has continued to be focussed on the following; • Continue with awareness raising sessions and promotion of e-learning package. • In partnership with third sector colleagues, seek funding for pilot study for remote access to BSL interpretation. • Repeat audit of compliance with standards in secondary care. • Explore accountability systems and processes within BCUHB with a view to including audit of standards within these systems to ensure ownership within Divisions. • Continue engagement with people with sensory loss; utilising feedback to inform service development. • Work with All Wales Sensory Loss Group to advise and support development of national approach to identification and recording of communications needs (Phase 2 of pilot study). The new Patient & Service User Experience Strategy was approved in June 2019 and makes specific reference to improved compliance with AHCS and AHIS and objectives will be monitored via BCUHB's Quality & Safety and Listening and Learning Groups which are executive sub-committees.	Level of staff and managerial engagement given other priorities. See above note in relation to the non-mandatory nature of sensory loss training. Large geographical distribution of services across three operating areas (East, Central, West), and localised governance arrangements result in a large strategic and operational span of control. Culturally governance and organisational assurance have not always been viewed as an integral component of operational management. The above risks remain relevant moving forward into 2019/2020. Key controls (see above) include; • Continued funding of the Accessible Health Care Scheme (AHCS) • Efforts to Improve Staff Awareness • Changes in the reporting of local and Organisational Quality Safety and Effectiveness and Organisational Assurance data to specifically include progress made against agreed organisational plan for improved compliance with AHCS	(See Above) AHCS compliance reportable on a quarterly basis to Trust Board, reinforced operationally via Ward Accreditation, Establishment of the PALS service in all operational areas and reporting and review via BCUHB's Quality & Safety and Listening and Learning Groups which are executive sub-committees.

	Development of the systems and data models to facilitate the above were included within a recent review and re-contracting for BCUHB's patient feedback system, which enables real/near term monitoring of service users experience by protected characteristic as the basis for identifying effective practice and opportunities for service improvement. Which provides a robust and valid measure of how compliance with AHCS/AIS are experienced by BCUHB's patients and service users.		

Secondary Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention) Phase II roll out of Ward Accreditation to include all acute departments and community setting during 2019/2020. Items PE12-PE14 refer directly to level of compliance with AHCS
Accessible appointment systems	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Implementation of the Accessible Information Standard	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Standards of Service Delivery	Key Actions Achieved during 2019-2020	Risks to Delivery	Corrective Actions
Emergency & Unscheduled Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Concerns & Feedback (CF). Areas include:			
Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	PTR internet pages can be read via voice recognition software provide spoken access and improved visual access compared with 2018/2019., and the resources comply with Web Content Accessibility Guidelines (QCAG) 2.1 and include an ability to change font side and support for a variety accessibility add-ins such as Adobe™ – Read Out Loud. The PTR page is supported by BSL guidance in the form of a pre-recorded video link. In practice the support of an Accessible Health Care Worker may be required to ensure that service users with sensory loss are able to access the PTR framework on the same basis as other service users. (Funding for the AHCS to continue for 2019/2020) As in previous reporting periods service user feedback is regularly collected and fed back to service managers via (i) CRT/Viewpoint Real-Time Patient Feedback System	Accessing the PTR process for service users with sensory loss on the same basis as all other users. This risk is partially mitigated by BCUHB's accessible health care scheme (AHCS) and the appointment of additional PALS officers.	(See previously cited controls)

	(ii) Complaints and Incident Monitoring, (iii) Patient Stories and (iv) NHS Wales Inpatient Satisfaction Survey. The data from these sources is segmented by protected characteristic and included in the Organisational Listening and Learning from Experience report and included on the agenda of the Equalities Strategic Group. When issues in relation to accessing services and/or the PTR process are identified these are communicated to the relevant managers for action.		
Highlight any CFs received in sensory loss and actions taken	Within Q1-2019/2020 BCUHB has received one formal concern in relation to the non-availability of a WITS interpreter. This was identified in more or less real time via the mechanisms identified above and improvement actions initiated. Other issues in relation to (i) unavailability/booking of the WITS interpreter and/or interpreter of choice, (ii) accessing the appointment system to confirm or change an appointment, (iii) the provision of information in Braille, have been resolved at the informal level via PALS and/or Accessible Health Care Service. Thus, underling the importance of the collaboration between BCUHB and the Centre for Sign Sight and Sound.	Making, changing and emending hospital and other health care appointments remains challenging for many service users with sensory loss, and this finding is reinforced through engagement events. Capturing and acting on this experience in real-time also remains a challenge and whilst the current approach 'to design out' such situations is to be commended, it has to be recognised that these will arise and BCUHB needs to ensure that we are able to respond to these in a proactive manner. Service users with sensory loss are very willing to tell us about their experiences, the challenge for the Health Board remains to incorporate these into the learning and planning processes.	Continued monitoring of service user experience by protected characteristic including complaints and incidents to ensure that any issues are acted on in as close to real time as possible, and scrutinised by the BCUHB's organisational quality & safety, and listening & learning groups, as well as within local PTR scrutiny groups. Continued engagement with service user with sensory loss in order to identify and ameliorate issues impacting on access to and progression within health care services.

Patient Experience*	**Key Actions Achieved during 2019-2020**	**Risks to Delivery**	**Corrective Actions**

Mechanisms are in place to seek and understand the patient's experience of accessible communication and information	Within this reporting period BCUHB continues to utilise a variety of mechanisms to survey and learn from service user experience – see above. The DATIX complaints monitoring enables the segmentation of feedback via equality/discrimination which provides an indirect ability to monitor concerns via protected characteristics. The CRT/Viewpoint Real Time Patient Feedback Survey and the NHS Inpatient Survey enables the self-reporting of service user feedback by protected characteristics and a report is forwarded to BCUHB's strategic Equality Group on a quarterly basis and included in the Listening and Learning and Quality Safety & Effectiveness reports. Such feedback has been reinforced by the operational deployment of PALS officers in all operating areas from Q2-2019/2020 Continued development and deployment in Q2-2019/2020 of the new CRT/Viewpoint™ dashboard and underpinning data model, has significantly enhanced BCUB's ability to harvest service user experience and report this in real/near time be protected characteristic including sensory loss. This has enabled longitudinal reporting from reporting beginning in Q4-2018/2019, Q1-2019/2020 (Pilot & Development) into Q2-2019/2020 onwards (Roll Out)	As in previous reporting periods the utilisation of the CRT/Viewpoint tends to be greater in acute than community and primary care settings, and it is constant challenge to ensure sufficient returns to provide meaningful feedback and universal coverage. However, the utilisation of the survey measured by return rates, has in Q1-2019/2020 improved within Community Settings and within the West and Central operating areas generally, whilst feedback rates remain highest in the East operating area.	Continue to promote the role of feedback as 'free consultancy' in line with the principles of 'Using the Gift of Complaints' (Evans K, 2014). Utilise structured training and development events to develop the capacity of front line staff to take patient stories, in line with BCUHB guidelines. Utilise Care2Share in line with the PALS operational policy. Continue to promote the benefits of utilising CRT/Viewpoint as a key mechanism for capturing and acting on service user experience in real/near time, and ensure that non/poor utilisation is escalated to senior managers as appropriate in order to improve return rates.

	Key Themes	Corrective Actions
The key themes to emerge from patient experience feedback (both positive and negative)	(See above comments in relation to the booking of WITs interpreters and the controls cited). Protected Characteristic Pt Experience Report for Q1-2019/2020 **See Appendix 8** In summary, in line with previous reporting periods, patient and service user feedback derived from the CRT/Viewpoint patient survey indicates that in Q1-2019/2020 the self-reported satisfaction scores indicate that: • Service users who report a sensory loss either (Deaf or Hearing Impaired, or Blind or Sight Impaired), report a higher or equitable level of overall patient satisfaction compared with other service users and those who report that they have a *mental health* condition. • Excluding service users who report having a mental health condition; service users who report having a sensory loss report higher or equitable levels of satisfaction across all aspects of service user satisfaction with the exception of involvement in care, see Fig 2 below. Which triangulates with other feedback derived from engagement events and patients stories. This may be due to the complexity of their condition, and in relation to deaf or blind service users, that staff are more aware of their needs and therefore are more able to respond to these, and that these service users derive benefit from BCUHB's Accessible Health Care Scheme. Additionally this may be an indicator that staff awareness efforts in relation to the provision of services for people with sensory loss in line with BCUHB's statutory requirements is paying dividends.	(See Also previous cited corrected actions/controls). As in previous reporting periods there is a need to improve capability in relation to the reporting of service user feedback by protected characteristic and to ensure that this data is available to managers, staff and reported within the organisational Quality Assurance Frameworks. Work is already underway to ensure that such feedback is incorporated within standard IRIS reporting arrangements within BCUHB, such that managers and staff are able to pull data as opposed to this being pushed from the Patient Experience Team and this is triangulated with standard DATIX (incident and complaint reporting).

* **Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs**. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate pro-forma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.

Glossary of Terms

AHCS	Accessible Health Care Scheme
AHCW	Accessible Health Care Worker
AIS	Accessible Information Standard
BCUHB	Betsi Cadwaladr University Health Board
BSL	British Sign Language
CEHR	NHS Centre for Equality and Human Rights
CHC	Community Health Council
COSS	Centre of Sign Sight & Sound
CRT/Viewpoint™	Consumer Research Technology™ (Real/Near Time Service User Experience Feedback System)
DAISY	Digitally Accessed Interpretation System
IM&T	Information Management & Technology
IMTP	Integrated Medium Term Plan
LLExp	Listening and Learning From Experience (group)
MIS	Management Information System
PALS	Patient Advice and Liaison Service
PTR	Putting Things Right
QSE	Quality Safety & Effectiveness (committee)
QSG	Quality and Safety (committee)
SBAR	Situation Background Analysis/Assessment Recommendation (Communication/Planning Tool)
SLA	Service Level Agreement
SUExp	Service User Experience
WIS	Wales Information Services
WITS	Wales Interpretation Service
WOD	Work Force and Organisational Development
WPAS	Welsh Patient Administration System

Appendix 1

Base Line Assessment to Assess Compliance with the

All Wales Standards for Accessible Communication and Information for People with Sensory Loss.

Reference: All Wales Standards for Accessible Communication and Information for People with Sensory Loss, 2013

***** Please return completed pro-forma to**

Peter Morris, Service Experience Manager (West) YG, peter.morris2@wales.nhs Tel 03000 - 851120

Area	
Locality/Ward/Dept(s)	
Name of Person Completing this Pro-Forma	
Post/Designation	
E-Mail	
Tel	
	Date of Last Assessment _____/_____/_____ Previous Score _____/28

Identifying Sensory Loss : Standard states: A "Flagging" system should be in place on a patients computer or paper record to enable staff to clearly understand patients communication needs			
Area and Standard	**Current position**		**Comments in relation to current position**
1.1 Do you have a system(s) in place to identify and record patients communication needs on registration/first contact/admission	**0**= no		
	1= The system is in place but is not available for all staff (eg in nursing notes only)		
	2 =The system is in place and available to all staff		
	3 = The system is in place, available to all staff and compliance with identifying patient communication needs is audited on a regular basis		
1.2 Are there additional systems in place to remind health professionals of patient communication needs (such as alert card, at a glance board symbols) etc?	**0** = no		
	1= The systems are in place but not always used		
	2 =The systems are in place and compliance is good		

1.3 Do referral processes (forms etc) specifically identify patients communication needs	**0** = no		
	1 = The processes allows for identification of any special considerations/need but is not specific to communication		
	2 =The process is in place and has a specific section in relation to communication needs		
	3 The process is in place and compliance with identifying patient communication needs is audited on a regular basis		

Standard states: People with Sensory loss should be able to make an appointment using a variety of methods, as a telephone based system may be inaccessible to them; This would include, text, email, websites, and digital phone?			
2. Are there a variety of contact methods available for individuals with sensory loss to make an appointment/contact with your ward/dept?	**0=** no		
	1 =There are some alternative contact methods in place, but not in all areas		
	2 =There is a variety of alternative contact methods in place, but not in all areas		
	3 = There is a variety of alternative contact methods in place in all areas		
Training: Standard states: All frontline staff should be trained in how to communicate effectively with someone with sensory loss			

3.1 Is awareness raising of how to communicate with individuals with sensory loss part of BCUHB or dept Orientation Programme	**0** = No **1** = Yes		
3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines'.	**1** = <25% **2** = <50% **3** =<75% **4** = 100%		
3.3 Have staff received training in the available communication tools in your area such as induction loop OR text phone?	**1** = <25% **2** = <50% **3** =<75% **4** = 100%		

Environment: • **All Reception and consultation areas should be fitted with a hearing loop system.** • **Appropriate communication support should be provided to people with sensory loss**			
4.1 Is there access to a fixed hearing loop in the reception/clinical area and is appropriate signage visible?	**0** = No **1** = Yes, hearing loop available **2** = Yes, hearing loop available and visible signage in place		

4.2 Is there information available for all staff in order to access any appropriate services required, for example? 1. Sign language interpreter 2. Lipspeaker 3. Hearing loop induction system 4. Personal listening system	**0** = No **1** = Yes		
4.3 Is signage clear and easy to understand and in compliance with BCUHB Way Finding guidance.	**0** = No **1** = some signs comply with guidance **2** = All signage complies with guidance		
4.4 Is all written information (Patient leaflets/correspondence) provided in accessible formats as outlined in BCUHB Written Patient Information Guidelines	**0** = No **1** = No, but if patients ask this can be arranged **2** = Some written information is in accessible format **3** = All written information is in accessible format		

Total Score – Out of A Maximum of 28

Action Plan Following Assessment/Re-Assessment

Improvements made since previous assessment **AND Examples of Good Practice you feel would be worth sharing with others;**

Assessment Section	Key Actions to Improve Compliance	Who is responsible	By When

(Copy as appropriate – or please feel free to utilise your own action planning tool)!

Appendix 2

GP - Base Line Assessment to Assess Compliance with the All Wales Standards for Accessible Communication and Information for People with Sensory Loss.

Reference: All Wales Standards for Accessible Communication and Information for People with Sensory Loss, 2013

***** Please return completed pro-forma to**

Peter Morris, Service Experience Manager (West) YG, peter.morris2@wales.nhs Tel 03000 851120

Area	
Name of Practice	
Name of Person Completing this Pro-Forma	
Post/Designation	
E-Mail	
Tel	
	Date of Last Assessment _____/_____/_____ Previous Score _____/28

Identifying Sensory Loss : Standard states: A "Flagging" system should be in place on a patients computer or paper record to enable staff to clearly understand patients communication needs			
Area and Standard	**Current position**		**Comments in relation to current position**
1.1 Do you have a system(s) in place to identify and record patients communication needs on registration/first contact/admission	**0**= no		
	1= The system is in place but is not available for all staff (eg in nursing notes only)		
	2 =The system is in place and available to all staff		
	3 = The system is in place, available to all staff and compliance with identifying patient communication needs is audited on a regular basis		
1.2 Are there additional systems in place to remind health professionals and other practice staff of patient communication needs (such as alert card, at a glance board symbols) etc?	**0** = no		
	1= The systems are in place but not always used		
	2 =The systems are in place and compliance is good		

1.3 Do appointment call systems enable service users with sensory loss to access services on the same basis as other users.	**0** = no		
	1 = The processes allows for identification of any special considerations/need but is not specific to communication		
	2 =The process is in place and has a specific section in relation to communication needs		
	3 The process is in place and compliance with identifying patient communication needs is audited on a regular basis		

Standard states: People with Sensory loss should be able to make an appointment using a variety of methods, as a telephone based system may be inaccessible to them; This would include, text, email, websites, and digital phone?			
3. Are there a variety of contact methods available for individuals with sensory loss to make, amend and confirm an appointment/contact with your practice?, (eg text phone, internet, email, MyHealthOnline).	**0=** no		
	1 =There are some alternative contact methods in place, but not in all areas		
	2 =There is a variety of alternative contact methods in place, but not in all areas		
	3 = There is a variety of alternative contact methods in place in all areas		

Training: Standard states: All frontline staff should be trained in how to communicate effectively with someone with sensory loss			
3.1 Is awareness raising of how to communicate with individuals with sensory loss part of your Induction/Orientation Programme?	**0** = No **1** = Yes		
3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines'.	**1** = <25% **2** = <50% **3** =<75% **4** = 100%		
3.3 Have staff received training in the available communication tools in your area such as induction loop OR text phone?	**1** = <25% **2** = <50% **3** =<75% **4** = 100%		

Environment:

- **All Reception and consultation areas should be fitted with a hearing loop system.**
- **Appropriate communication support should be provided to people with sensory loss**

4.1 Is there access to a fixed hearing loop in the reception/clinical area and is appropriate signage visible?	**0** = No **1** = Yes, hearing loop available **2** = Yes, hearing loop available and visible signage in place		
4.2 Is there information available for all staff in order to access any appropriate services required, for example? 5. Sign language interpreter 6. Lipspeaker 7. Hearing loop induction system 8. Personal listening system	**0** = No **1** = Yes		
4.3 Is signage clear and easy to understand and in compliance with NHS Way Finding guidance (DOH, 2005), see also BCUHB Summary (BCUHB, 2016)	**0** = No **1** = some signs comply with guidance **2** = All signage complies with guidance		
4.4 Is all written information (Patient leaflets/correspondence) available in accessible formats.	**0** = No **1** = No, but if patients ask this can be arranged **2** = Some written information is in accessible format **3** = All written information is in accessible format		

Total Score – Out of A Maximum of 28

Action Plan Following Assessment/Re-Assessment

Improvements made since previous assessment **AND Examples of Good Practice you feel would be worth sharing with others;**			
Assessment Section	**Key Actions to Improve Compliance**	**Who is responsible**	**By When**

(Copy as appropriate – or please feel free to utilise your own action planning tool)!

Appendix 3

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

Sensory Loss Toolkit Contents

Introduction

Section One: Emergency Care

Section Two: Planned Care

Section Three: Factsheets

About this Sensory Loss Toolkit

This toolkit has been developed to assist staff to access the appropriate services, resources in order to support patients who have sensory loss.

How does the toolkit work?

The purpose of the toolkit is to:

- Provide quick access guides in the form of flowcharts and factsheets that guide staff when supporting a patient with sensory loss.
- It is structured into two sections of flowcharts:
  a) Emergency Care
  b) Planned Care, with supporting factsheets.
- To use the toolkit follow the flowchart (s) that match the person's individual needs; whilst referring to the supporting factsheets.

For further information about this toolkit

A more detailed version of this toolkit containing links to national support groups etc, is available on the BCUHB Intranet http://howis.wales.nhs.uk/sitesplus/861/page/48396

If you have any questions about this toolkit please contact the Service User Experience Team on 01978 727125 or email add BCU.PatientExperience@wales.nhs.uk

What is Sensory Loss?

Sensory Loss is an umbrella term which includes the experience of people who are:

- Deaf, deafened or hard of hearing;
- Blind or partially sighted;
- Deafblind: i.e. have a combined sight and hearing loss

Sensory loss mainly refers to a person's sight or hearing being impaired - 95% of communication takes place via these senses. Loss of these senses can, amongst other things, cause difficulties with access to information, mobility and communication.

Ineffective communication is a patient safety issue and can result in poorer health outcomes. In BCUHB, we know that patients:

- have not heard their names being called out in clinics or waiting areas
- have missed appointments as they have not been able to read appointment letters
- following consultations, have not fully understood what was said, or what they should do leading to problems with informed consent

Section One

Emergency Care

- Flowchart 1: Deaf Person
- Flowchart 2: Hard of Hearing Person
- Flowchart 3: Visual Loss

Flow Chart 1:

Emergency Care Deaf

People who communicate though

British Sign Language (BSL) / Sign Supported English

Please refer to supporting factsheets

If required, use the '*Hospital Communication Handbook*' provided with this toolkit to establish communication

Does the patient carry an Accessible Health Communication Card? (AHC card designed for deaf people) ***Factsheet 1***

Yes

Book the approved service as identified on the person's AHC card via the Wales Interpretation and Translation Service (WITS) ***Factsheet 2***

No

Using the '*Hospital Communication Handbook*', if required establish the patient's communication needs. If appropriate, book approved interpretation via WITS ***Factsheet 2b***

Levels of Communication Need

- General and routine communication - choosing a drink, meals, hygiene and similar needs can be addressed by all staff using the '*Hospital Communication Handbook*', or by the patient's other preferred method, such as written notes. BSL is not the same as Welsh/English – use plain language.
- If the communication relates to consent, complex needs, surgery, medication, drug therapy, consultations and discharge arrangements then **a registered and qualified interpreter must be booked** via WITS. Be aware of good practice when working with a BSL interpreter. ***Factsheet 2b***
- Be aware of good communication practice with patients with sensory loss. ***Factsheet 3*** or '*Hospital Communication Handbook*'.

Record the patient's communication needs on the **ALERT** page of the case notes and ensure this information is relayed at all safety briefings and at handover. ***Factsheet 5***

Write down any **key information**, such as further instructions and medication details. If required arrange for patient information to be available in accessible formats. ***Factsheet 4***

Flow Chart 2:
Emergency Care Hard of Hearing

Please refer to supporting factsheets

If required, use the *'Hospital Communication Handbook'* provided with this toolkit to establish communication

- If the patient is wearing a hearing aid with a 'telecoil loop' setting, inform them that a loop system is available (in reception areas). ***Factsheet 6***
- Be aware of communication skills when communicating with a person with sensory loss. ***Factsheet 3***

If the patient is **unable to communicate** well:

Check Hearing Aids:

- Do they use hearing aid? Do they have the aid with them? If so, and the patient still cannot hear you well; ask if you can check if it is working. ***Factsheet 7***
- If they do not have one or have not brought it: offer use of a personal listener. Available from Audiology. Emergency Departments have been issued with their own supply of personal listeners. ***Factsheet 8***

Check Ears for occluding wax and if clear, **make** an inpatient request to Audiology for assessment or recommend that the patient seeks outpatient referral via their GP

.

Ensure that **all** staff are aware of the patient's needs and be mindful of how the patient is alerted when the doctor/clinician is ready to see them. ***Factsheet 3***

Record the patient's communication needs on the ALERT page of the case notes and ensure this information is relayed at all safety briefings and at handover. Factsheet 5. Ensure that any electronic records e.g. Myrddin are also updated.

Write down all key information, such as further instructions and medication details, and provide to patients before they leave the department. ***Factsheet 4***

Flow Chart 3:

Emergency Admission Visual Loss

Please refer to supporting factsheets

On Admission

- Check the patient's communication and information needs and where appropriate instigate the ALERT procedure and the 'At a Glance System' ***Factsheet 5***
- Ensure that all staff are made aware of the patient's needs in relation to their sensory loss.

General Support

- Be aware of good communication skills with patients who have sensory loss. ***Factsheet 3***
- Orientate patients to their surroundings. ***Factsheet 12 (page 1)***
- Be aware of good practice when guiding person with sensory loss. ***Factsheet 10***
- Offer general support in relation to the completion of paperwork and procedures. ***Factsheet 11***

Information

Offer all **patient information/key information** in accessible formats. ***Factsheet 4***

Section Two

Planned Care

- Flowchart 4: Sensory Loss

Flow Chart 4:
Planned Care
Inpatient / Outpatient
Please refer to supporting

If required, use the 'Hospital Communication Handbook' provided with this toolkit to establish communication

Preparing for an appointment or admission

- **Check** the patient's support, communication and information needs, record on the medical records, including an ALERT. ***Factsheet 5***
- Arrange **BSL interpreters** or other support as needed. ***Factsheet 2***
- Ensure the patient is aware of *on-site assistance* such as porters & volunteers
- Arrange hospital transport for eligible patients. ***Factsheet 9***

Arriving at the hospital

- For visual loss, be aware of good practice when guiding. ***Factsheet 10***

In the Waiting Room

- Offer **general support** in the waiting room. ***Factsheet 11***
- If the patient is wearing a hearing aid, indicate that there is a **loop system** for use at the reception desk. ***Factsheet 6***
- Use good practice with **BSL interpreters** ***Factsheet 2b***

Offering and Providing Medical Care

- Use **good communication** practice. ***Factsheet 2b and 3.***
- For hard of hearing, consider offering a **personal listener. *Factsheet 8***
- Provide all **key information** after each consultation, write this down if necessary**.** ***Factsheet 4***

Patient Care on the Ward

- Consider **general support** for sensory loss on the ward. ***Factsheet 12***
- Agree and use **symbols** on the "at a glance board". ***Factsheet 5***
- Complete **hearing aid maintenance** on the ward. ***Factsheet 7***.
- For those hard of hearing, offer a **personal listener** temporarily. ***Factsheet 8.*** Follow-up all difficulties by checking ears for occluding wax and if clear, considering Audiology referral.

Section Three

Sensory Loss Factsheets

Factsheet 1 Accessible Communication Card

Factsheet 2 Interpretation for Deaf/Hard of Hearing

Factsheet 2b Good Communication Practice working with a BSL Interpreter

Factsheet 3 Communication Tips with Patients

Factsheet 4 Patient Information in Accessible Formats

Factsheet 5 BCUHB ALERT System

Factsheet 6 Audio Loop Systems – Guidance for Staff

Factsheet 7 Helping to maintain Hearing Aids

Factsheet 8 Personal Listener loan for wards

Factsheet 9 Hospital Transport

Factsheet 10 Guiding a person with Sight Loss

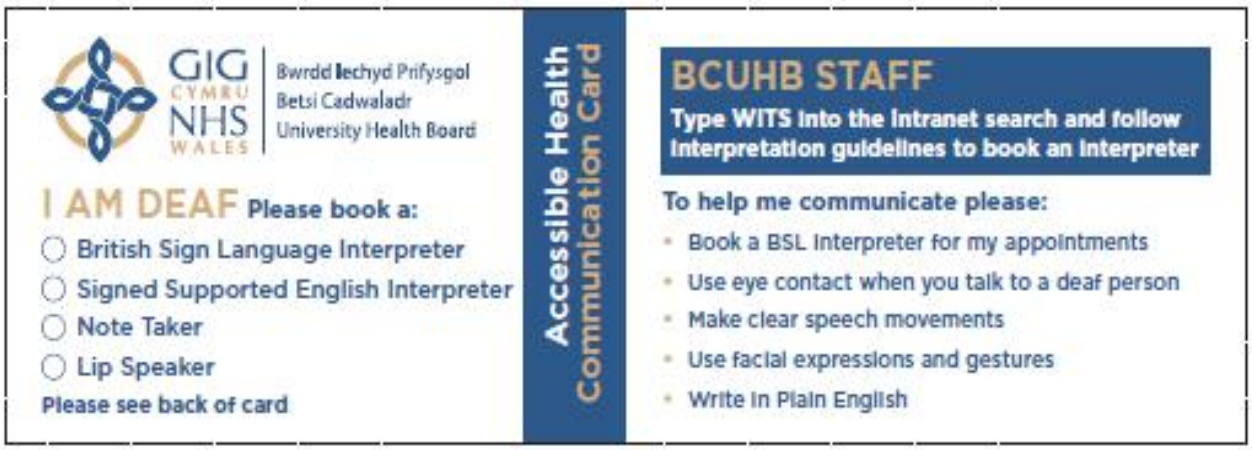
Factsheet 11 Support in the Waiting Room

Factsheet 12 Patient Care on the Ward

Factsheet 1

Accessible Health Communication Card

BCUHB has, in partnership with d/Deaf service users, developed an **"Accessible Health Communication Card"**.



This card helps:

- Patients who are d/Deaf, deafened and hard of hearing to communicate their individual disability and personal communication needs to staff
- Prompts staff on the appropriate action to be taken.
- Recommends a few communication tips (for further information see ***Factsheet 3***)

If a patient requires a copy of this card they are available via:

Centre for Sign Sight and Sound (COSS)
Tel: 01492 530013 email: info@signsightsound.org.uk
or by collection from Audiology Department reception areas.

Factsheet 2

Interpretation services for Deaf Patients

If a patient needs a British Sign Language (BSL) interpreter or other communication support, this must be arranged through the Wales Interpretation and Translation Service (WITS). The booking must be made by the healthcare professional, or an identified representative (such as the booking clerk) in accordance with the written protocol.

For translation support please contact:

Wales Interpretation and Translation Service (WITS) preferably by telephone or by email:

- **Telephone** 02920 537555
- **Email** WITS@cardiff.gov.uk

Further details about these arrangements, including the written information protocols are on the BCUHB intranet. Use search word '**GC06**' which relates to the Protocol to Deliver Interpretation Services.
http://howis.wales.nhs.uk/sitesplus/861/document/304681

Interpreter Preference Form

Patients using the service are able to state which BSL interpreters they prefer to use. WITS and BCUHB will try to book these Interpreters for appointments but cannot guarantee availability.

The request from for expressing a preference is available to download from BCUHB intranet site – use search words **'Prefered Choice Form'**

http://howis.wales.nhs.uk/sitesplus/861/document/397108

The form should be returned via e-mail using the following address
WITS@cardiff.gov.uk

Guide to Booking an Interpreter

If you need to book a BSL interpreter or communication support, remember to:

- Give as much warning as possible
- Give details of venue, directions and contact telephone number
- Give the patient's name/address
- Briefly explain the purpose of the appointment
- If the patient's appointment is cancelled, please inform the Interpreter as soon as possible

Factsheet 2b

Good Practice
when working with a BSL Interpreter

It is important to allow for an additional time for any appointments involving BSL Interpretation.

Before the appointment

- Ensure that the interpreter is aware well in advance of the general nature of what is likely to be discussed at the appointment i.e. the type of examination/test, test results or treatment/therapy options. This will help the interpreter to prepare appropriately for the appointment.

- If patient information is to be used in video or DVD format, please ensure that the Interpreter has the opportunity to view it before the appointment; either send the video/DVD to the Interpreter in advance or arrange for the interpreter to view it on the day before the appointment begins.

- Adjust the booking time with the BSL Interpreter according to individual need. The patient will be familiar with a preferred interpreter whereas a little time may need to be spent with an unknown interpreter before the appointment begins.

Layout within the Consultation/Treatment Room

- Arrange seating within the consultation area to allow the patient and interpreter to see each other clearly.

- Interpreters will advise on the best place for them to sit or stand and will take into account lighting and visibility.

- If you are using any form of models or diagrams for demonstration purposes during the appointment, consider carefully how they are positioned in relation to the interpreter. It is important that the patient does not have to make changes to the line of sight.

During the appointment

- Say ‘Hello my name is…..’ If possible learn how to sign this introduction. It will go a long way to making the patient feel at ease.
- Give your title and explain what your responsibility is in relation to the patient.
- Do not speak too quickly or for too long. Talk at a reasonable speed and pause every few sentences to allow the interpreter time to translate.
- The interpreter needs time to comprehend and reproduce verbally what has been signed in BSL by the patient and vice versa, so expect short time delays as this happens. This is especially important during questions or discussion of options.
- Avoid jargon and abbreviations and give simple, careful explanation of any procedures or terms.
- If more than one health professional is involved with the patient it is good practice for only one person to speak at a time, looking directly at the patient not at the Interpreter.
- Remember that a BSL user cannot focus on two visual sources at the same time. When using any form of visual support for demonstration (models/diagrams) allow extra time and work with the interpreter to create pauses in verbal delivery whilst your explanation is relayed. Give the patient the opportunity to study whatever is being shown to them.

Factsheet 3

Communication tips when communicating with patients with sensory loss

- **Ask, approach, assist:** Ask if a patient needs help before you begin providing it; to avoid startling people announce your approach; do not assume you know what assistance a patient needs.
- **Check**: Even if someone is wearing a hearing aid, it does not mean that they can hear perfectly. Check if they need to lip read.
- **Do not talk from another room:** Patients with hearing/sight loss waiting for their appointment need to be clearly notified when the doctor is ready to see them. Do not just call out their name.
- **Face the person:** on the same level and in good light. Position yourself so that the light is shining on your face, not in the eyes of the listener. Ask if the hearing impaired listener hears better in one ear or the other, so that you will know where to position yourself.
- **Say the person's name before beginning a conversation:** This gives the listener a chance to focus attention and reduces the chance of missing words at the beginning of the conversation.
- **Speak clearly and naturally, without shouting or exaggerating mouth movements:** Shouting distorts the sound of speech and may make lip reading more difficult. It can also be uncomfortable for hearing aid users and it looks aggressive. Slow down a little, pause between sentences or phrases, and wait to make sure that you have been understood before going on. In a group, take turns in speaking, and do not interrupt other speakers or talk across them.
- **Keep your hands away from your face while talking:** as your speech will be more difficult to understand. Beards and moustaches can also interfere with the ability of those with hearing loss to lip read.
- **Be aware of possible distortion of sounds for those with hearing loss:**. Most people with hearing loss have greater difficulty understanding speech when there is background noise, or when you are further than a metre away.
- If the person has difficulty understanding a particular phrase or word after you have repeated it once, **try to find a different way of saying it,** rather than repeating words again.
- **Familiarise the listener with the general topic of the conversation:** Avoid sudden changes of topic. If the subject is changed, clarify what you are talking about now. In a group setting, repeat questions or key facts before continuing with the discussion.
- **Giving specific information** e.g. place or phone numbers to someone with hearing loss, have them repeat the specifics back to you**.** Many numbers and words sound alike.
- **Provide key information in writing,** such as directions, schedules, appointment times etc and, during a conversation; offer to write details down if a patient doesn't understand well.

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Factsheet 4

Patient Information in Accessible Formats

Accessible information is information that is produced in a different format other than the standard printed page. People with a sensory loss (hearing or sight), or a learning disability may request accessible information. Accessible information includes: large print, audio cassette, computer disk, easy read versions etc. Assumptions should not be made as to which format a person requires and the patient should be asked what their preferred format is.

Providing information in accessible formats:

BCUHB works with a number of organisations who provide information in accessible formats, which are detailed below and can be contacted for advice and support.

Is the request related to someone with sight loss?	Contact the RNIB transcription service on: Telephone **0303 1239999**
Is the request for information for a person who communicates through BSL?	Contact: WITS Translation Services email: WITS@cardiff.gov.uk Telephone **02920 537555**
For General guidance on the provision of information for patients	Further details about these arrangements including BCUBH's policy and procedure are available via our intranet site: Use the search word: **ISU02** - which relates to BCUHB's Policy: *'Written Information for Patients'*

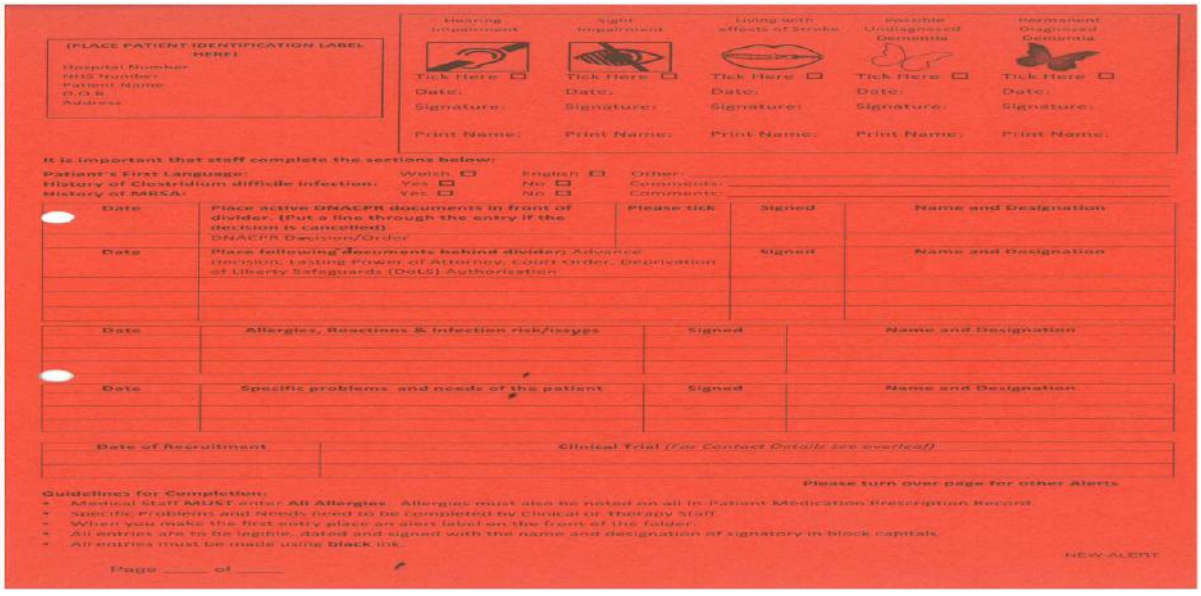
Factsheet 5

BCUHB Alert System and

At a Glance Boards

An ‘ALERT’ is a way of recording in a patient’s case notes and on the inpatient ‘Patient Status at a Glance Boards’ that they have additional need, including communication support and brings this to the attention of staff. For the case notes an ‘ALERT’ label should be placed on the front cover of the patient’s notes and individual needs recorded on the RED ALERT sheet contained inside. There are tick boxes for hearing loss, sight loss and space for specific needs e.g. hearing aids, glasses worn, BSL interpreter required etc.

For the Patient Status at a Glance Boards please note, verbal consent is required from the patient/family/carer for the symbol to be displayed. Symbols are available within the toolkit further details contact BCU.TCTeam@wales.nhs.uk


(PLACE PATIENT IDENTIFICATION LABEL HERE)

Hospital Number
NHS Number
Patient Name
D.O.B.
Address

Hearing Impairment — Tick Here ☐ Date: Signature: Print Name:
Sight Impairment — Tick Here ☐ Date: Signature: Print Name:
Living with effects of Stroke — Tick Here ☐ Date: Signature: Print Name:
Possible Undiagnosed Dementia — Tick Here ☐ Date: Signature: Print Name:
Permanent Diagnosed Dementia — Tick Here ☐ Date: Signature: Print Name:

It is important that staff complete the sections below:

Patient's First Language: Welsh ☐ English ☐ Other:
History of Clostridium difficile Infection: Yes ☐ No ☐ Comments:
History of MRSA: Yes ☐ No ☐

Date	Place active DNACPR documents in front of divider. (Put a line through the entry if the decision is cancelled) DNACPR Decision/Order	Please tick	Signed	Name and Designation
Date	Place following documents behind divider: Advance Decision, Lasting Power of Attorney, Court Order, Deprivation of Liberty Safeguards (DoLS) Authorisation		Signed	Name and Designation
Date	Allergies, Reactions & Infection risk/issues		Signed	Name and Designation
Date	Specific problems and needs of the patient		Signed	Name and Designation

Date of Recruitment — Clinical Trial (For Contact Details see overleaf)

Please turn over page for other Alerts

Guidelines for Completion:
- Medical Staff MUST enter All Allergies. Allergies must also be noted on all In Patient Medication Prescription Record.
- Specific Problems and Needs need to be completed by Clinical or Therapy Staff.
- When you make the first entry place an alert label on the front of the folder.
- All entries are to be legible, dated and signed with the name and designation of signatory in block capitals.
- All entries must be made using black ink.

NEW ALERT

Page _____ of _____

These sheets form part of any new case notes created from 2015 onwards, older case notes that may not routinely contain ALERT documentation. For further information please contact your local Medical Records Department, or refer to:

BCUHB Standardisation of Acute Health Records Folder:

http://howis.wales.nhs.uk/sitesplus/861/page/60242

Factsheet 6

Audio Loop Systems

What is an audio (induction) loop system?

Loop systems make communication easier for hearing aid users, particularly in noisy reception areas. A loop system works when the hearing aid is switched to the loop programme, then the main hearing aid microphone is switched off and the user only hears the sound from the loop system. The user needs to be within the range of the unit, which is approximately 1.2 metres.

Types of loop system available within BCUHB

Portable loops

Portable Loops (an example is shown above) are self contained devices with a loop and a microphone built in. They can be placed on a counter, desk or a table in a consulting room. The loop stand is placed between the staff member and the patient. The staff member will need to switch on the unit. Their voice is picked up by the microphone and then converted into a signal with a transmitting range or around 1.2 metres. The service user will need to ensure that their hearing aid is switched to the loop programme. Portable loops are mains powered but they also have internal rechargeable batteries so that they can be used in areas where no plug socket is available. These may be useful where consulting rooms are in a noisy location.

Counter loop systems

A counter loop system is a permanently fixed unit which is designed to cover a reception desk. As with portable loops it has a range of around 1.2 metres. A small unit and loop pad are mounted beneath the counter and a small microphone is positioned above. The unit can be permanently switched on or it can be switched on when it is needed. Counter loop systems will need to be professionally installed and maintained.

Making patients aware that a loop is available

Suppliers and installers will usually provide signs, posters, labels, etc that depict the appropriate symbols, such as the one shown above. These should be **clearly** displayed to indicate that a loop system is available.

What problems might affect successful use?

- **Switching the system on**: Many hearing aid users report trying to use loop systems in public places, only to find that they are not switched on.
- **Routine checks**: It is a good idea to designate one member of staff within the department who will take responsibility for switching the system on everyday and for periodically performing a check on the loop to ensure that internal batteries are fully charged.
- **Buzzing**: If a buzzing sound is reported try moving the microphone a little further from the screen may help. Make sure the speaker is close enough to the microphone. If you feel the loop system is faulty, report to the Estates Department. Maintenance of audio loops is the responsibility of the Estates Department.

Further information or guidance

For general guidance on loop systems you can also visit the *Action on Hearing Loss* website: www.actiononhearingloss.org.uk/loops

Factsheet 7

Helping to maintain Hearing Aids

Advice and support regarding Hearing Aids can be provided in the Audiology Department within clinic hours. This factsheet is intended as a reference point for the ward staff and for out of hours guidance.

Hearing aids are valuable National Health Service (NHS) property and are on loan for as long as needed. If an aid is lost or damaged through misuse then a charge may be made to replace it. If for any reason the aid is no longer required, please return it to Audiology.

Batteries:

Appointments are not needed for new batteries. You can collect new batteries from the Audiology Department with a record book or battery slip or by using the patient's details.

Retubing:

- The tubing on the hearing aid will need to be changed every 4-6 months, as it will begin to harden and discolour and the performance will be reduced.
- Just take the hearing aid to the Open Access clinic or phone Audiology to book an appointment in a local community hospital.
- It is beneficial if the hearing aid user can attend, as their ears can be checked and progressed; otherwise you may bring the hearing aid in on their behalf.

Cleaning:

- For a thorough clean, separate the hearing aid and earmould as follows.
- Pull the soft tubing off from the hearing aid elbow, taking care not to pull it out of the earmould.
- Wash the tubing and earmould in warm soapy water and rinse thoroughly in clean water.
- Shake to remove any water from the tube and either leave to dry overnight in a warm, dry place or wipe with a tissue.
- Then push the tubing back onto the hearing aid elbow, with the curves together

Supporting Hearing Aids

Switching hearing aids on:

- Make sure that there is a battery in the aid.
- Check which ear the hearing aid is for if there are two – a red dot on the aid indicates the right ear, and a blue for the left.
- Switch the aid on by closing the battery drawer fully.
- If there is a whistling sound, this should stop when in the ear correctly. If it does not stop, check the ear for wax.

Taking hearing aids out:

- Hearing aids must be taken out when lying down to sleep for example, each night.
- Push the hearing aid off the top of the ear.
- Pull the earmould out of the ear canal using the plastic part – pulling the tubing may cause the tube to loosen and come out.
- Switch the aid off by opening the battery drawer. Put the hearing aid in a safe place.

Regular checks:

- Wipe the earmould and hearing aid daily with a tissue.
- Check that the tube is not blocked at the end – if you can see wax, remove it with the hook issued inside the hearing aid wallet. Alternatively, clean the mould thoroughly.
- Check that the battery is working by switching on, cupping your hands around and listening for a whistle, this indicates it is not working.
- Some hearing aids may beep for a number of seconds before coming on.

Changing the battery:

- The battery will need to be changed every 2 to 3 weeks.
- You can wait until the hearing aid user hears the aid "beep" or if they are unable to tell you, you ma y change the battery regularly – every 2 weeks if switched off each night.

- To change the battery: Open the battery drawer completely.
- Remove the sticker from the new battery. Insert it with the positive (flat) side facing up.

Factsheet 8

Personal Listener loan for wards

Personal listeners are available **on loan** for individual patient's use whilst on the ward or during an outpatient visit. These have been funded by Awyr Las as part of this toolkit.

A device can be collected **from the nearest Audiology department by ward or out-patient staff.** It must used with one patient only. It must then be returned to Audiology. Emergency Departments have their own supply.

They are intended as a **temporary** means of communication. This may be:

- until a temporary issue (such as ear wax) has been resolved,
- until lost hearing aids are found,
- or until Audiology referral is made and assessment completed.

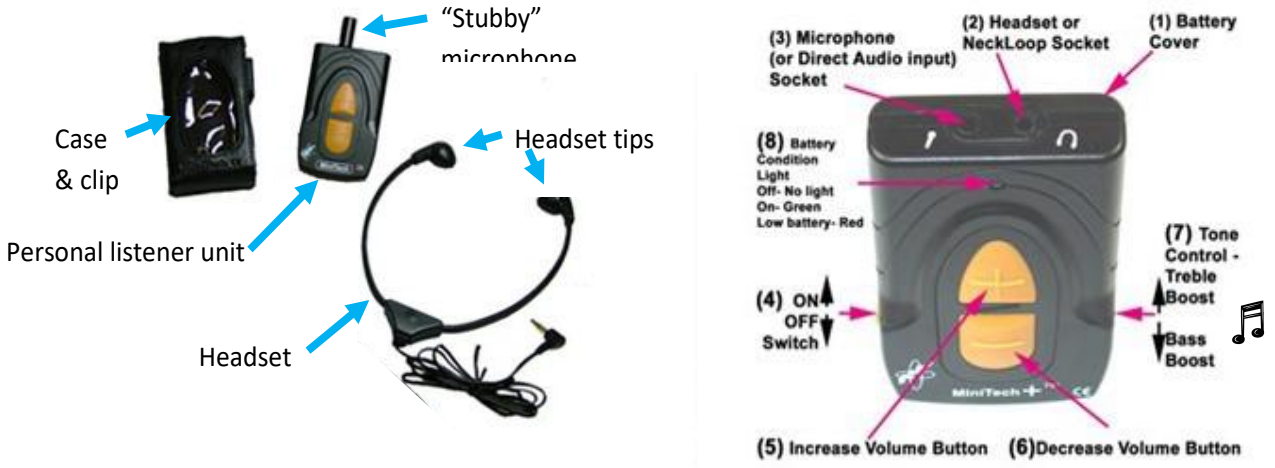


Figure 1. Minitech personal listener: parts & controls

1. Set up:

- The unit, case, microphone, and headset (see Figure 1) will be supplied in clean working order with new headset tips and two AA batteries.
- Make sure the unit's ON/OFF switch is in the OFF position initially (4).
- Place batteries in the back of the unit, replacing the cover securely (1).
- Check that the "stubby" microphone is fully inserted into the socket (3).
- Fully insert the headset (or headphones/earphones) into the socket (2).

2. Check if it is working:

- Check that the microphone and headset are fully inserted.
- Set on/off switch to ON position (4), the LED light should show green (8).
  - No light indicates batteries should be replaced.
  - RED indicates that the batteries will need changing within 4 hours.
- Replacement batteries (AA size) are available from the Audiology Department. Batteries should last around 4-5 days.

3. Using the device:

- **Set on/off switch** to ON position (4), the LED light will show **green** (8).
- Assist the patient in putting on the **headset**. They may prefer their own headphones or earphones for comfort if they have a mild hearing loss.
- **Increase the volume** by pressing the " **+** " pad (5) as many times as required. Your voice should be heard at arm's length away. To reduce volume, press the " **–** " pad (6).
- **To increase clarity**, turn the tone wheel (7) towards the note: " ♬ " . You would expect older people or those that have worked in noisy places to need this.
- **If you have whistling** (feedback) either reduce the volume, or increase the distance between the microphone and headset (e.g. place on a lap or table).
- **Secure the unit** in a comfortable place with the microphone visible:
  - Either clip to the patient's clothing
  - or place on a pillow or nearby table
  - or suggest that the patient or a relative hold it



4. Whilst needed by the individual but not in use:

- Switch the unit off with the ON/OFF switch. This will prolong battery life.
- Wipe the headset eartips with a detergent wipe.
- Store in a safe place, such as on the bedside table or in the drawer.

5. When finished with:

- Remove the tips from the headset & dispose of them (do not dispose of the headset itself). Return any personal headphones or earphones to the patient.
- Wipe the headset, case and cord with a detergent wipe. Do not wipe the microphone.
- Return the 4 parts (unit, stubby microphone, case and headset) to Audiology.

Where can we borrow one from?

Personal listeners may be borrowed from the Audiology departments at the following sites at present (December 2015). If you are based in a community hospital or other outpatients location, contact the Audiology department or Patient Experience Team for information.

East:
Audiology Department
Wrexham Maelor Hospital
Tel: 01978 725304

Centre:
Audiology Department
Ysbyty Glan Clywd
Tel: 01745 534524

West:
Audiology Department
Ysbyty Gwynedd
Tel: 01248 384020

Factsheet 9

Hospital Transport

Hospital (Patient) Transport

Patients with sight or hearing difficulty that prevents them from using public transport may qualify for Hospital Patient Transport.

To book transport and establish eligibility criteria for patients please contact:

The Transport Booking Centre on: **0300 123 2317**

The office is open:

- **Monday to Thursday: 9.00am - 5.00pm** (excluding public holidays)
- **Friday: 9.00am - 4.00pm**

A relative/carer will be able to accompany a patient who requires constant care throughout the journey, or if they have communication difficulties, or if they are under 18 years of age.

Factsheet 10

Guiding a person with Sight Loss

If a person who is vision impaired requires assistance from a sighted person to move from one place to another, a popular method is the '**sighted guide'** technique. Using this approach, the person with impaired vision holds on to the sighted person's arm as they walk along. It is important for the sighted person to lead by walking slightly ahead. Different people will have their own preferences about how they like to be guided, so ask individuals which method they are most comfortable with.

Making contact

- Introduce yourself. If guiding assistance is required check with the person their preferred method
- If the person requests the sighted guide technique then ask which side they wish to be guided on, stand alongside the person and let them take your arm.
- If the person is seated, allow them to stand up unassisted unless they request your help.

Correct guiding position

- The person will hold your arm just above the elbow. Keep your arm relaxed and close to the side of your body
- Remain half a step ahead of the person you are guiding.
- Give brief but clear verbal instructions, mention appropriate hazards and say if there are steps or kerbs up or down.
- If you have to leave the person you're guiding at any time, let them know and leave them in contact with a solid object, such as a wall.

Narrow spaces

- You may need to walk single file when moving through crowds or narrow spaces. Put your guiding arm behind your back; the person with a visual impairment straightens out their arm and walks directly behind you.

Going through doors

- Approach the door with the person you are guiding on the hinge side. Use your guiding arm to open the door. The person with a visual impairment can use their free hand to take the door handle from you, then find the handle on the other side of the door, and close it behind you both.
- If the person you are guiding is not on the hinge side as you approach a door, ask them to change sides. He or she will side-step behind you, taking your other elbow with their other hand.
- To facilitate this, bend your free elbow and point it out behind your back, making it easier for the person with vision impairment to locate.

Steps and Stairs

- Always approach steps and stairs straight on, not diagonally.
- Stop or pause when you reach a step or kerb and say ‘step down’ or ‘step up’.
- If the step is higher or lower than usual, warn the person you are guiding.
- Tell the person you are guiding that you are approaching stairs and whether they are going up or down.
- Approach the stairs so that the free hand of the person you are guiding is at the handrail, and explain whether the rail is above or below their hand.
- Always say when you have reached the top or bottom of the stairs, and pause for a moment.
- If the handrail is on the left and the person with the vision impairment is on the right, change sides as before.

Sitting on a chair

- Grip the back of the chair so that the person you are guiding can feel where it is. The person can then use your arm to guide them into the seat.
- If the back of the chair is against a wall, it may be easier to walk towards it in such a way that the person’s leg brushes gently against the seat of the chair.
- Let the person sit down unaided; never push anyone backwards into a chair.

Factsheet 11

Support in the Waiting Room

Offer to assist the patient
if any forms/paper work need to be completed:

- Be mindful of confidentiality, find a quiet, private place to read the questions aloud and record the answers on behalf of the person if needed.
- Completed forms should be read back to the patient who can then be shown where to sign.

Be aware of hazards:

- Such as low coffee tables etc which could become tripping hazard.

Inform the patient of the waiting room procedures:

- Advise the patient how they will be called e.g. by name, by number, of if there is a digital display screen in operation.
- Hard of hearing patients have been left sitting in waiting rooms due to not hearing their name being called. Please do not shout names from a distance.
- Do not assume that any notices or signage will be read or understood.

Inform the team:

- That the patient has a sensory loss and may require assistance.

Factsheet 12

Sensory Loss
Patient Care on the Ward

Visual Loss

On the Ward

Orientate the patient to the new surroundings by describing the ward layout and mapping the key features, including potential hazards:

- Describe the room left to right and the position of the patient's bed in relation to the other beds (e.g. '*third bed on the left from the entrance'*).
- Warn them of the procedure in relation to fire alarms.
- With the patient, count the number of paces from the patient's bed to ward entrance, toilet, day room – it may be useful to practise the route.
- If necessary, explain the position of objects around the bed (light switches, call system, bed, bedside locker) and what is on top of the locker.
- Ensure that the patient is familiar with the location of their different personal items and will be able to find them when they are alone.
- If you need to move something, put it back in the same place so that the patient can find it when you are gone.

Personal Care

- If the patient can use the toilet independently, it would help if you tell them the exact position of the toilet, the flushing handle and toilet roll holder.
- If it is necessary to assist a patient with bathing, place the patient's hand on the side of the bath and so the patient may lower himself/herself into it.
- Most adults with sight loss can dress/undress independently. If assisting a patient, always tell them what you are about to do for them.

Medication, Tests and Procedures

- Place any tablets in their hand rather than just leaving them on the locker.

Mealtimes

- At mealtimes, offer to read the menu or ask if they would like a large print.

- Place the patient's hand on their drink. Describe to the patient the location of food on the plate in front of them in relation to numbers on a clock face, for example, vegetables are at 3 o'clock or chips are at 9 o'clock.

- For a patient with low vision, use plates/cups that contrast in colour to the table or tray, for example, a dark plate will stand out against a white tray.

BSL users

On arrival - whilst the interpreter or family members are present

- Agree communication preferences. For day to day needs, this may be use of the hospital communication book, lipreading or written notes.
- Give all introductory information, including warning of the procedure in relation to fire alarms.
- Answer any detailed questions or concerns that they may have.

Alerting

- Make sure that you have been seen when approaching.
- Alert by moving the patient's shoulder or arm when arousing from sleep.

Hard of hearing

Communication

- Ensure that there is a safe place for hearing aids or personal listener when not in use.
- Make sure your face is visible and be aware of confidentiality if raising your voice.

All those with sensory loss

Day Room

- Many people with sight loss and hearing loss enjoy television, so ask if they would like it switched on. Ask for preferences on seat and volume.

Going home

- Ensure that the patient knows the date and time of any future appointments and any instructions or medication that they have been given.

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

Sensory Loss Toolkit Contents

Community/GP Staff (Ver 0.4)

About this Sensory Loss Toolkit

This toolkit has been developed to assist staff to access the appropriate services, resources in order to support patients who have sensory loss.

How does the toolkit work?

The purpose of the toolkit is to:

- Provide quick access guides in the form of flowcharts and factsheets that guide staff when supporting a patient with sensory loss.
- It is structured into two sections of flowcharts:
  a) Emergency Care
  b) Planned Care, with supporting factsheets.
- To use the toolkit follow the flowchart (s) that match the person's individual needs; whilst referring to the supporting factsheets.

For further information about this toolkit

A more detailed version of this toolkit containing links to national support groups etc, is available on the BCUHB Intranet http://howis.wales.nhs.uk/sitesplus/861/page/48396

If you have any questions about this toolkit please contact the Service User Experience Team on 01978 727125 or email add BCU.PatientExperience@wales.nhs.uk

What is Sensory Loss?

Sensory Loss is an umbrella term which includes the experience of people who are:

- Deaf, deafened or hard of hearing;
- Blind or partially sighted;
- Deafblind: i.e. have a combined sight and hearing loss

Sensory loss mainly refers to a person's sight or hearing being impaired - 95% of communication takes place via these senses. Loss of these senses can, amongst other things, cause difficulties with access to information, mobility and communication.

Ineffective communication is a patient safety issue and can result in poorer health outcomes. In BCUHB, we know that patients:

- have not heard their names being called out in clinics or waiting areas
- have missed appointments as they have not been able to read appointment letters
- following consultations, have not fully understood what was said, or what they should do leading to problems with informed consent

Section One

Referral to Crisis Team

- Flowchart 1: Deaf Person
- Flowchart 2: Hard of Hearing Person
- Flowchart 3: Visual Loss

Flow Chart 1:

Emergency Referral to Crisis Team

People who communicate though
British Sign Language (BSL) / Sign Supported English

Please refer to supporting factsheets

If required, use the '*Hospital Communication Handbook*' provided with this toolkit to establish communication

Does the patient carry an Accessible Health Communication Card? (AHC card designed for deaf people) ***Factsheet 1***

Yes

Book the approved service as identified on the person's AHC card via the Wales Interpretation and Translation Service (WITS) ***Factsheet 2***

No

Using the '*Hospital Communication Handbook*', if required establish the patient's communication needs. If appropriate, book approved interpretation via WITS ***Factsheet 2b***

Levels of Communication Need

- General and routine communication - choosing a drink, meals, hygiene and similar needs can be addressed by all staff using the '*Hospital Communication Handbook*', or by the patient's other preferred method, such as written notes. BSL is not the same as Welsh/English – use plain language.
- If the communication relates to consent, complex needs, surgery, medication, drug therapy, consultations and discharge arrangements then **a registered and qualified interpreter must be booked** via WITS. Be aware of good practice when working with a BSL interpreter. ***Factsheet 2b***
- Be aware of good communication practice with patients with sensory loss. ***Factsheet 3*** or '*Hospital Communication Handbook*'.

Record the patient's communication needs on the **ALERT** page of the case notes and ensure this information is relayed at all safety briefings and at handover. ***Factsheet 5***

Write down any **key information**, such as further instructions and medication details. If required arrange for patient information to be available in accessible formats. ***Factsheet 4***

If required, use the *'Hospital Communication Handbook'* provide ith this toolkit to establish communication

- If the patient is wearing a hearing aid with a 'telecoil loop' setting, inform them that a loop system is available (in reception areas). ***Factsheet 6***
- Be aware of communication skills when communicating with a person with sensory loss. ***Factsheet 3***

If the patient is **unable to communicate** well:

Check Hearing Aids & Batteries:

- Do they use hearing aid? Do they have the aid with them? If so, and the patient still cannot hear you well; ask if you can check if it is working. ***Factsheet 7***
- Check hearing aid batteries – always carry spare batteries with you (available from audiology)
- If they do not have one or have not brought it: offer use of a personal listener. Available from Audiology. Emergency Departments have been issued with their own supply of personal listeners. ***Factsheet 8***

Check Ears if occluding wax is present, telephone the GP receptionist on the patients behalf to make a appointment with the specialist nurse on the patient's behalf.

Ensure that **all** staff are aware of the patient's needs and be mindful of how the patient is alerted when the doctor/clinician is ready to see them. ***Factsheet 3***

Record the patient's communication needs on the ALERT page of the case notes and ensure this information is relayed at all safety briefings and at handover. Factsheet 5. Ensure that any electronic records e.g. Myrddin are also updated.

Write down all key information, such as further instructions and medication details, and provide to patients before they leave the department. ***Factsheet 4***

Flow Chart 3:

Emergency Admission onto Community Case Load

Please refer to supporting factsheets

First Visit

- Check the patient's communication and information needs and where appropriate instigate the ALERT procedure and the 'At a Glance System' ***Factsheet 5***
- Ensure that all staff are made aware of the patient's needs in relation to their sensory loss.

General Support

- Be aware of good communication skills with patients who have sensory loss. ***Factsheet 3***
- Be aware that patient will be aware of their surroundings and familiar with handholds, doorways and floor surfaces. Ensure that you do not leave bags, folders or sharp bins on the floor and/or where patients are not expecting these – this could lead to slips, trips and falls.
- Be aware of good practice when guiding person with sensory loss. ***Factsheet 10***

Information

Offer all **patient information/key information** in accessible formats. ***Factsheet 4***

Section Two

Planned Care

- Flowchart 4: Sensory Loss

Flow Chart 4:

Planned Care

Inpatient / Outpatient and Community Patients

Please refer to supporting factsheets

If required, use the 'Hospital Communication Handbook' provided with this toolkit to establish communication

Preparing for an appointment or admission

- **Check** the patient's support, communication and information needs, record on the medical records, including an ALERT. ***Factsheet 5***
- Arrange **BSL interpreters** or other support as needed. ***Factsheet 2***
- Ensure the patient is aware of *on-site assistance* such as porters & volunteers
- Arrange hospital transport for eligible patients. ***Factsheet 9***

Arriving at the hospital

- For visual loss, be aware of good practice when guiding. ***Factsheet 10***

In the Waiting Room

- Offer **general support** in the waiting room. ***Factsheet 11***
- If the patient is wearing a hearing aid, indicate that there is a **loop system** for use at the reception desk. ***Factsheet 6***
- Use good practice with **BSL interpreters** ***Factsheet 2b***

Offering and Providing Medical Care

- Use **good communication** practice. ***Factsheet 2b and 3.***
- For hard of hearing, consider offering a **personal listener. *Factsheet 8***
- Provide all **key information** after each consultation, write this down if necessary**. *Factsheet 4***

Patient Care on the Ward

- Consider **general support** for sensory loss on the ward. ***Factsheet 12***
- Agree and use **symbols** on the "at a glance board". ***Factsheet 5***
- Complete **hearing aid maintenance** on the ward. ***Factsheet 7***.
- For those hard of hearing, offer a **personal listener** temporarily. ***Factsheet 8.*** Follow-up all difficulties by checking ears for occluding wax and if clear, considering Audiology referral.

Section Three

Sensory Loss Factsheets

Factsheet 1 Accessible Communication Card

Factsheet 2 Interpretation for Deaf/Hard of Hearing

Factsheet 2b Good Communication Practice working with a BSL Interpreter

Factsheet 3 Communication Tips with Patients

Factsheet 4 Patient Information in Accessible Formats

Factsheet 5 BCUHB ALERT System

Factsheet 6 Audio Loop Systems – Guidance for Staff

Factsheet 7 Helping to maintain Hearing Aids

Factsheet 8 Personal Listener loan for wards

Factsheet 9 Hospital Transport

Factsheet 10 Guiding a person with Sight Loss

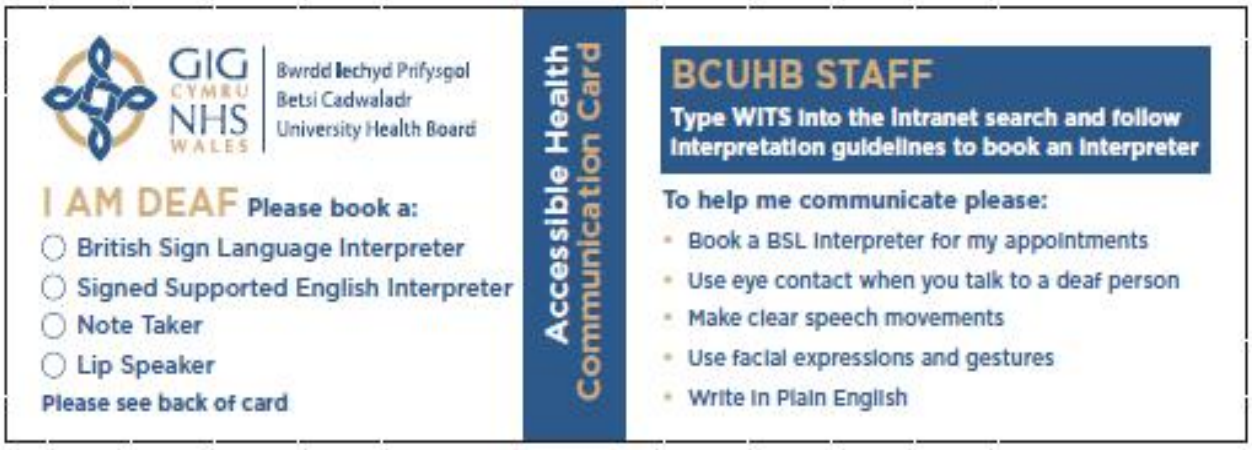
Factsheet 11 Support in the Waiting Room

Factsheet 12 Patient Care on the Ward

Factsheet 1

Accessible Health Communication Card

BCUHB has, in partnership with d/Deaf service users, developed an **"Accessible Health Communication Card"**.



This card helps:

- Patients who are d/Deaf, deafened and hard of hearing to communicate their individual disability and personal communication needs to staff
- Prompts staff on the appropriate action to be taken.
- Recommends a few communication tips (for further information see ***Factsheet 3***)

If a patient requires a copy of this card they are available via:

Centre for Sign Sight and Sound (COSS)
Tel: 01492 530013 email: info@signsightsound.org.uk
or by collection from Audiology Department reception areas.

Factsheet 2

Interpretation services for Deaf Patients

If a patient needs a British Sign Language (BSL) interpreter or other communication support, this must be arranged through the Wales Interpretation and Translation Service (WITS). The booking must be made by the healthcare professional, or an identified representative (such as the booking clerk) in accordance with the written protocol.

For translation support please contact:

Wales Interpretation and Translation Service (WITS) preferably by telephone or by email:

- **Telephone** 02920 537555
- **Email** WITS@cardiff.gov.uk

Further details about these arrangements, including the written information protocols are on the BCUHB intranet. Use search word '**GC06**' which relates to the Protocol to Deliver Interpretation Services.
http://howis.wales.nhs.uk/sitesplus/861/document/304681

Interpreter Preference Form

Patients using the service are able to state which BSL interpreters they prefer to use. WITS and BCUHB will try to book these Interpreters for appointments but cannot guarantee availability.

The request from for expressing a preference is available to download from BCUHB intranet site – use search words **'Prefered Choice Form'**

http://howis.wales.nhs.uk/sitesplus/861/document/397108

The form should be returned via e-mail using the following address
WITS@cardiff.gov.uk

Guide to Booking an Interpreter

If you need to book a BSL interpreter or communication support, remember to:

- Give as much warning as possible
- Give details of venue, directions and contact telephone number
- Give the patient's name/address
- Briefly explain the purpose of the appointment
- If the patient's appointment is cancelled, please inform the Interpreter as soon as possible

Factsheet 2b

Good Practice
when working with a BSL Interpreter

It is important to allow for an additional time for any appointments involving BSL Interpretation.

Before the appointment

- Ensure that the interpreter is aware well in advance of the general nature of what is likely to be discussed at the appointment i.e. the type of examination/test, test results or treatment/therapy options. This will help the interpreter to prepare appropriately for the appointment.

- If patient information is to be used in video or DVD format, please ensure that the Interpreter has the opportunity to view it before the appointment; either send the video/DVD to the Interpreter in advance or arrange for the interpreter to view it on the day before the appointment begins.

- Adjust the booking time with the BSL Interpreter according to individual need. The patient will be familiar with a preferred interpreter whereas a little time may need to be spent with an unknown interpreter before the appointment begins.

Layout within the Consultation/Treatment Room

- Arrange seating within the consultation area to allow the patient and interpreter to see each other clearly.

- Interpreters will advise on the best place for them to sit or stand and will take into account lighting and visibility.

- If you are using any form of models or diagrams for demonstration purposes during the appointment, consider carefully how they are positioned in relation to the interpreter. It is important that the patient does not have to make changes to the line of sight.

During the appointment

- Say ‘Hello my name is…..’ If possible learn how to sign this introduction. It will go a long way to making the patient feel at ease.
- Give your title and explain what your responsibility is in relation to the patient.
- Do not speak too quickly or for too long. Talk at a reasonable speed and pause every few sentences to allow the interpreter time to translate.
- The interpreter needs time to comprehend and reproduce verbally what has been signed in BSL by the patient and vice versa, so expect short time delays as this happens. This is especially important during questions or discussion of options.
- Avoid jargon and abbreviations and give simple, careful explanation of any procedures or terms.
- If more than one health professional is involved with the patient it is good practice for only one person to speak at a time, looking directly at the patient not at the Interpreter.
- Remember that a BSL user cannot focus on two visual sources at the same time. When using any form of visual support for demonstration (models/diagrams) allow extra time and work with the interpreter to create pauses in verbal delivery whilst your explanation is relayed. Give the patient the opportunity to study whatever is being shown to them.

Factsheet 3

Communication tips

When communicating with patients with sensory loss

- **Ask, approach, assist:** Ask if a patient needs help before you begin providing it; to avoid startling people announce your approach; do not assume you know what assistance a patient needs.
- **Check**: Even if someone is wearing a hearing aid, it does not mean that they can hear perfectly. Check if they need to lip read.
- **Do not talk from another room:** Patients with hearing/sight loss waiting for their appointment need to be clearly notified when the doctor is ready to see them. Do not just call out their name.
- **Face the person:** on the same level and in good light. Position yourself so that the light is shining on your face, not in the eyes of the listener. Ask if the hearing impaired listener hears better in one ear or the other, so that you will know where to position yourself.
- **Say the person's name before beginning a conversation:** This gives the listener a chance to focus attention and reduces the chance of missing words at the beginning of the conversation.
- **Speak clearly and naturally, without shouting or exaggerating mouth movements:** Shouting distorts the sound of speech and may make lip reading more difficult. It can also be uncomfortable for hearing aid users and it looks aggressive. Slow down a little, pause between sentences or phrases, and wait to make sure that you have been understood before going on. In a group, take turns in speaking, and do not interrupt other speakers or talk across them.
- **Keep your hands away from your face while talking:** as your speech will be more difficult to understand. Beards and moustaches can also interfere with the ability of those with hearing loss to lip read.
- **Be aware of possible distortion of sounds for those with hearing loss:**. Most people with hearing loss have greater difficulty understanding speech when there is background noise, or when you are further than a metre away.
- If the person has difficulty understanding a particular phrase or word after you have repeated it once, **try to find a different way of saying it,** rather than repeating words again.
- **Familiarise the listener with the general topic of the conversation:** Avoid sudden changes of topic. If the subject is changed, clarify what you are talking about now. In a group setting, repeat questions or key facts before continuing with the discussion.
- **Giving specific information** e.g. place or phone numbers to someone with hearing loss, have them repeat the specifics back to you**.** Many numbers and words sound alike.
- **Provide key information in writing,** such as directions, schedules, appointment times etc and, during a conversation; offer to write details down if a patient doesn't understand well.

Factsheet 4

Patient Information in Accessible Formats

Accessible information is information that is produced in a different format other than the standard printed page. People with a sensory loss (hearing or sight), or a learning disability may request accessible information. Accessible information includes: large print, audio cassette, computer disk, easy read versions etc. Assumptions should not be made as to which format a person requires and the patient should be asked what their preferred format is.

Providing information in accessible formats:

BCUHB works with a number of organisations who provide information in accessible formats, which are detailed below and can be contacted for advice and support.

Is the request related to someone with sight loss?	Contact the RNIB transcription service on: Telephone **0303 1239999**
Is the request for information for a person who communicates through BSL?	Contact: WITS Translation Services email: WITS@cardiff.gov.uk Telephone **02920 537555**
For General guidance on the provision of information for patients	Further details about these arrangements including BCUBH's policy and procedure are available via our intranet site: Use the search word: **ISU02** - which relates to BCUHB's Policy: *'Written Information for Patients'*

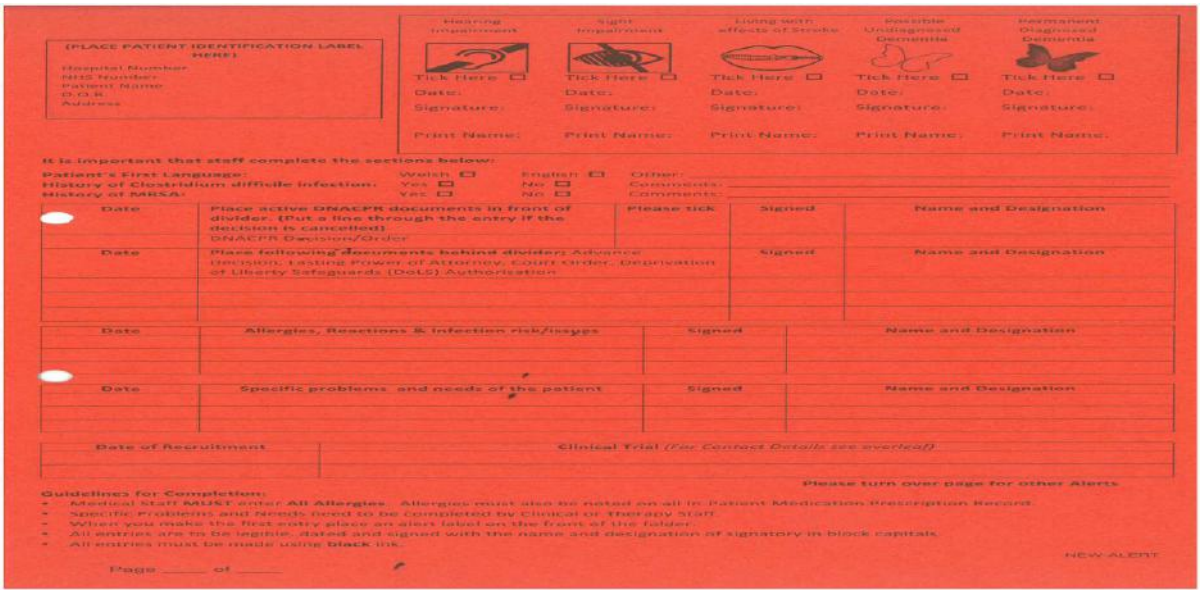
Factsheet 5

BCUHB Alert System and

At a Glance Boards

An ‘ALERT’ is a way of recording in a patient’s case notes and on the inpatient ‘Patient Status at a Glance Boards’ that they have additional need, including communication support and brings this to the attention of staff. For the case notes an ‘ALERT’ label should be placed on the front cover of the patient’s notes and individual needs recorded on the RED ALERT sheet contained inside. There are tick boxes for hearing loss, sight loss and space for specific needs e.g. hearing aids, glasses worn, BSL interpreter required etc.

For the Patient Status at a Glance Boards please note, verbal consent is required from the patient/family/carer for the symbol to be displayed. Symbols are available within the toolkit further details contact BCU.TCTeam@wales.nhs.uk



These sheets form part of any new case notes created from 2015 onwards, older case notes that may not routinely contain ALERT documentation. For further information please contact your local Medical Records Department, or refer to:

BCUHB Standardisation of Acute Health Records Folder:

http://howis.wales.nhs.uk/sitesplus/861/page/60242

Factsheet 6

Audio Loop Systems

(N/A for Community Staff)

What is an audio (induction) loop system?

Loop systems make communication easier for hearing aid users, particularly in noisy reception areas. A loop system works when the hearing aid is switched to the loop programme, then the main hearing aid microphone is switched off and the user only hears the sound from the loop system. The user needs to be within the range of the unit, which is approximately 1.2 metres.

Types of loop system available within BCUHB

Portable loops

Portable Loops (an example is shown above) are self contained devices with a loop and a microphone built in. They can be placed on a counter, desk or a table in a consulting room. The loop stand is placed between the staff member and the patient. The staff member will need to switch on the unit. Their voice is picked up by the microphone and then converted into a signal with a transmitting range or around 1.2 metres. The service user will need to ensure that their hearing aid is switched to the loop programme. Portable loops are mains powered but they also have internal rechargeable batteries so that they can be used in areas where no plug socket is available. These may be useful where consulting rooms are in a noisy location.

Counter loop systems

A counter loop system is a permanently fixed unit which is designed to cover a reception desk. As with portable loops it has a range of around 1.2 metres. A small unit and loop pad are mounted beneath the counter and a small microphone is positioned above. The unit can be permanently switched on or it can be switched on when it is needed. Counter loop systems will need to be professionally installed and

Making patients aware that a loop is available

Suppliers and installers will usually provide signs, posters, labels, etc that depict the appropriate symbols, such as the one shown above. These should be **clearly** displayed to indicate that a loop system is available.

What problems might affect successful use?

- **Switching the system on**: Many hearing aid users report trying to use loop systems in public places, only to find that they are not switched on.
- **Routine checks**: It is a good idea to designate one member of staff within the department who will take responsibility for switching the system on everyday and for periodically performing a check on the loop to ensure that internal batteries are fully charged.
- **Buzzing**: If a buzzing sound is reported try moving the microphone a little further from the screen may help. Make sure the speaker is close enough to the microphone. If you feel the loop system is faulty, report to the Estates Department. Maintenance of audio loops is the responsibility of the Estates Department.

Further information or guidance

For general guidance on loop systems you can also visit the *Action on Hearing Loss* website: www.actiononhearingloss.org.uk/loops

Factsheet 7

Helping to maintain Hearing Aids

Advice and support regarding Hearing Aids can be provided in the Audiology Department within clinic hours. This factsheet is intended as a reference point for the ward staff, community staff and for out of hours guidance.

Hearing aids are valuable National Health Service (NHS) property and are on loan for as long as needed. If an aid is lost or damaged through misuse then a charge may be made to replace it. If for any reason the aid is no longer required, please return it to Audiology.

Batteries:

Appointments are not needed for new batteries. You can collect new batteries from the Audiology Department with a record book or battery slip or by using the patient's details.

Retubing:

- The tubing on the hearing aid will need to be changed every 4-6 months, as it will begin to harden and discolour and the performance will be reduced.
- Just take the hearing aid to the Open Access clinic or phone Audiology to book an appointment in a local community hospital.
- It is beneficial if the hearing aid user can attend, as their ears can be checked and progressed; otherwise you may bring the hearing aid in on their behalf.

Cleaning:

- For a thorough clean, separate the hearing aid and earmould as follows.
- Pull the soft tubing off from the hearing aid elbow, taking care not to pull it out of the earmould.
- Wash the tubing and earmould in warm soapy water and rinse thoroughly in clean water.
- Shake to remove any water from the tube and either leave to dry overnight in a warm, dry place or wipe with a tissue.
- Then push the tubing back onto the hearing aid elbow, with the curves together

Supporting Hearing Aids

Switching hearing aids on:

- Make sure that there is a battery in the aid.
- Check which ear the hearing aid is for if there are two – a red dot on the aid indicates the right ear, and a blue for the left.
- Switch the aid on by closing the battery drawer fully.
- If there is a whistling sound, this should stop when in the ear correctly. If it does not stop, check the ear for wax.

Taking hearing aids out:

- Hearing aids must be taken out when lying down to sleep for example, each night.
- Push the hearing aid off the top of the ear.
- Pull the earmould out of the ear canal using the plastic part – pulling the tubing may cause the tube to loosen and come out.
- Switch the aid off by opening the battery drawer. Put the hearing aid in a safe place.

Regular checks:

- Wipe the earmould and hearing aid daily with a tissue.
- Check that the tube is not blocked at the end – if you can see wax, remove it with the hook issued inside the hearing aid wallet. Alternatively, clean the mould thoroughly.
- Check that the battery is working by switching on, cupping your hands around and listening for a whistle, this indicates it is not working.
- Some hearing aids may beep for a number of seconds before coming on.

Changing the battery:

- The battery will need to be changed every 2 to 3 weeks.
- You can wait until the hearing aid user hears the aid "beep" or if they are unable to tell you, you ma y change the battery regularly – every 2 weeks if switched off each night.

- To change the battery: Open the battery drawer completely.
- Remove the sticker from the new battery. Insert it with the positive (flat) side facing up.

Factsheet 8

Personal Listener loan for wards

(N/A for Community Staff)

Personal listeners are available **on loan** for individual patient's use whilst on the ward or during an outpatient visit. These have been funded by Awyr Las as part of this toolkit.

A device can be collected **from the nearest Audiology department by ward or out-patient staff.** It must used with one patient only. It must then be returned to Audiology. Emergency Departments have their own supply.

They are intended as a **temporary** means of communication. This may be:

- until a temporary issue (such as ear wax) has been resolved,
- until lost hearing aids are found,
- or until Audiology referral is made and assessment completed.

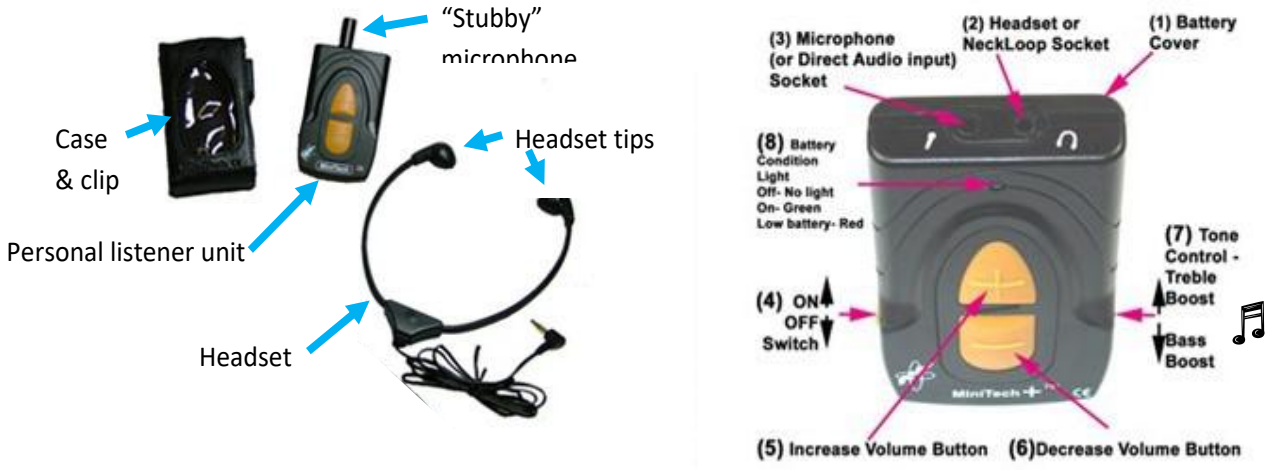


Figure 1. Minitech personal listener: parts & controls

2. Set up:

- The unit, case, microphone, and headset (see Figure 1) will be supplied in clean working order with new headset tips and two AA batteries.
- Make sure the unit's ON/OFF switch is in the OFF position initially (4).
- Place batteries in the back of the unit, replacing the cover securely (1).
- Check that the "stubby" microphone is fully inserted into the socket (3).
- Fully insert the headset (or headphones/earphones) into the socket (2).

2. Check if it is working:

- Check that the microphone and headset are fully inserted.
- Set on/off switch to ON position (4), the LED light should show green (8).
  - No light indicates batteries should be replaced.
  - RED indicates that the batteries will need changing within 4 hours.
- Replacement batteries (AA size) are available from the Audiology Department. Batteries should last around 4-5 days.

3. Using the device:

- **Set on/off switch** to ON position (4), the LED light will show **green** (8).
- Assist the patient in putting on the **headset**. They may prefer their own headphones or earphones for comfort if they have a mild hearing loss.
- **Increase the volume** by pressing the " **+** " pad (5) as many times as required. Your voice should be heard at arm's length away. To reduce volume, press the " **–** " pad (6).
- **To increase clarity**, turn the tone wheel (7) towards the note: " ♬ " . You would expect older people or those that have worked in noisy places to need this.
- **If you have whistling** (feedback) either reduce the volume, or increase the distance between the microphone and headset (e.g. place on a lap or table).
- **Secure the unit** in a comfortable place with the microphone visible:
  - Either clip to the patient's clothing
  - or place on a pillow or nearby table
  - or suggest that the patient or a relative hold it



4. Whilst needed by the individual but not in use:

- Switch the unit off with the ON/OFF switch. This will prolong battery life.
- Wipe the headset eartips with a detergent wipe.
- Store in a safe place, such as on the bedside table or in the drawer.

5. When finished with:

- Remove the tips from the headset & dispose of them (do not dispose of the headset itself). Return any personal headphones or earphones to the patient.
- Wipe the headset, case and cord with a detergent wipe. Do not wipe the microphone.
- Return the 4 parts (unit, stubby microphone, case and headset) to Audiology.

Where can we borrow one from?

Personal listeners may be borrowed from the Audiology departments at the following sites at present (December 2015). If you are based in a community hospital or other outpatients location, contact the Audiology department or Patient Experience Team for information.

East:
Audiology Department
Wrexham Maelor Hospital
Tel: 01978 725304

Centre:
Audiology Department
Ysbyty Glan Clywd
Tel: 01745 534524

West:
Audiology Department
Ysbyty Gwynedd
Tel: 01248 384020

Factsheet 9

Hospital Transport

Hospital (Patient) Transport

Patients with sight or hearing difficulty that prevents them from using public transport may qualify for Hospital Patient Transport.

To book transport and establish eligibility criteria for patients please contact:

The Transport Booking Centre on: **0300 123 2317**

The office is open:

- **Monday to Thursday: 9.00am - 5.00pm** (excluding public holidays)
- **Friday: 9.00am - 4.00pm**

A relative/carer will be able to accompany a patient who requires constant care throughout the journey, or if they have communication difficulties, or if they are under 18 years of age.

Factsheet 10

Guiding a person with Sight Loss

If a person who is vision impaired requires assistance from a sighted person to move from one place to another, a popular method is the '**sighted guide'** technique. Using this approach, the person with impaired vision holds on to the sighted person's arm as they walk along. It is important for the sighted person to lead by walking slightly ahead. Different people will have their own preferences about how they like to be guided, so ask individuals which method they are most comfortable with.

Making contact

- Introduce yourself. If guiding assistance is required check with the person their preferred method
- If the person requests the sighted guide technique then ask which side they wish to be guided on, stand alongside the person and let them take your arm.
- If the person is seated, allow them to stand up unassisted unless they request your help.

Correct guiding position

- The person will hold your arm just above the elbow. Keep your arm relaxed and close to the side of your body
- Remain half a step ahead of the person you are guiding.
- Give brief but clear verbal instructions, mention appropriate hazards and say if there are steps or kerbs up or down.
- If you have to leave the person you're guiding at any time, let them know and leave them in contact with a solid object, such as a wall.

Narrow spaces

- You may need to walk single file when moving through crowds or narrow spaces. Put your guiding arm behind your back; the person with a visual impairment straightens out their arm and walks directly behind you.

Going through doors

- Approach the door with the person you are guiding on the hinge side. Use your guiding arm to open the door. The person with a visual impairment can use their free hand to take the door handle from you, then find the handle on the other side of the door, and close it behind you both.
- If the person you are guiding is not on the hinge side as you approach a door, ask them to change sides. He or she will side-step behind you, taking your other elbow with their other hand.
- To facilitate this, bend your free elbow and point it out behind your back, making it easier for the person with vision impairment to locate.

Steps and Stairs

- Always approach steps and stairs straight on, not diagonally.
- Stop or pause when you reach a step or kerb and say ‘step down’ or ‘step up’.
- If the step is higher or lower than usual, warn the person you are guiding.
- Tell the person you are guiding that you are approaching stairs and whether they are going up or down.
- Approach the stairs so that the free hand of the person you are guiding is at the handrail, and explain whether the rail is above or below their hand.
- Always say when you have reached the top or bottom of the stairs, and pause for a moment.
- If the handrail is on the left and the person with the vision impairment is on the right, change sides as before.

Sitting on a chair

- Grip the back of the chair so that the person you are guiding can feel where it is. The person can then use your arm to guide them into the seat.
- If the back of the chair is against a wall, it may be easier to walk towards it in such a way that the person’s leg brushes gently against the seat of the chair.
- Let the person sit down unaided; never push anyone backwards into a chair.

Factsheet 11

Support in the Waiting Room

Offer to assist the patient
if any forms/paper work need to be completed:

- Be mindful of confidentiality, find a quiet, private place to read the questions aloud and record the answers on behalf of the person if needed.
- Completed forms should be read back to the patient who can then be shown where to sign.

Be aware of hazards:

- Such as low coffee tables etc which could become tripping hazard.

Inform the patient of the waiting room procedures:

- Advise the patient how they will be called e.g. by name, by number, of if there is a digital display screen in operation.
- Hard of hearing patients have been left sitting in waiting rooms due to not hearing their name being called. Please do not shout names from a distance.
- Do not assume that any notices or signage will be read or understood.

Inform the team:

- That the patient has a sensory loss and may require assistance.

Factsheet 12

Sensory Loss
Patient Care on the Ward (N/A for Community Staff)

Visual Loss

On the Ward

Orientate the patient to the new surroundings by describing the ward layout and mapping the key features, including potential hazards:

- Describe the room left to right and the position of the patient's bed in relation to the other beds (e.g. '*third bed on the left from the entrance'*).
- Warn them of the procedure in relation to fire alarms.
- With the patient, count the number of paces from the patient's bed to ward entrance, toilet, day room – it may be useful to practise the route.
- If necessary, explain the position of objects around the bed (light switches, call system, bed, bedside locker) and what is on top of the locker.
- Ensure that the patient is familiar with the location of their different personal items and will be able to find them when they are alone.
- If you need to move something, put it back in the same place so that the patient can find it when you are gone.

Personal Care

- If the patient can use the toilet independently, it would help if you tell them the exact position of the toilet, the flushing handle and toilet roll holder.
- If it is necessary to assist a patient with bathing, place the patient's hand on the side of the bath and so the patient may lower himself/herself into it.
- Most adults with sight loss can dress/undress independently. If assisting a patient, always tell them what you are about to do for them.

Medication, Tests and Procedures

Mealtimes

- At mealtimes, offer to read the menu or ask if they would like a large print.

- Place the patient's hand on their drink. Describe to the patient the location of food on the plate in front of them in relation to numbers on a clock face, for example, vegetables are at 3 o'clock or chips are at 9 o'clock.
- For a patient with low vision, use plates/cups that contrast in colour to the table or tray, for example, a dark plate will stand out against a white tray.

BSL users

On arrival - whilst the interpreter or family members are present

- Agree communication preferences. For day to day needs, this may be use of the hospital communication book, lipreading or written notes.
- Give all introductory information, including warning of the procedure in relation to fire alarms.
- Answer any detailed questions or concerns that they may have.

Alerting

- Make sure that you have been seen when approaching.
- Alert by moving the patient's shoulder or arm when arousing from sleep.

Hard of hearing

Communication

- Ensure that there is a safe place for hearing aids or personal listener when not in use.
- Make sure your face is visible and be aware of confidentiality if raising your voice.

All those with sensory loss

Day Room

- Many people with sight loss and hearing loss enjoy television, so ask if they would like it switched on. Ask for preferences on seat and volume.

Going home

- Ensure that the patient knows the date and time of any future appointments and any instructions or medication that they have been given.

Appendix 5


Do you have Sensory Loss?
■ Are you blind or partially sighted?
■ Are you Deaf or hard of hearing?
Tell your GP surgery how you want them to communicate with you.
Ask for information to be given to you in an accessible format.
Share your concerns with your GP surgery if the information you receive is not accessible to you.
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Audio/BSL Version

Appendix 6

Oes gennych Golled Synhwyraidd?

- **Ydych chi'n ddall neu'n rhannol ddall?**
- **Ydych chi'n Fyddar neu'n drwm eu clyw?**

Dywedwch wrth eich meddyg teulu sut rydych chi am iddynt gyfathrebu â chi.

Gofynnwch am wybodaeth mewn fformat hygyrch.

Rhannwch eich pryderon gyda'ch meddygfa os nad yw'r wybodaeth a gewch yn hygyrch i chi.

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Fersiwn Sain / BSL

Appendix 7

Statistics for Accessible Health Liaison Services

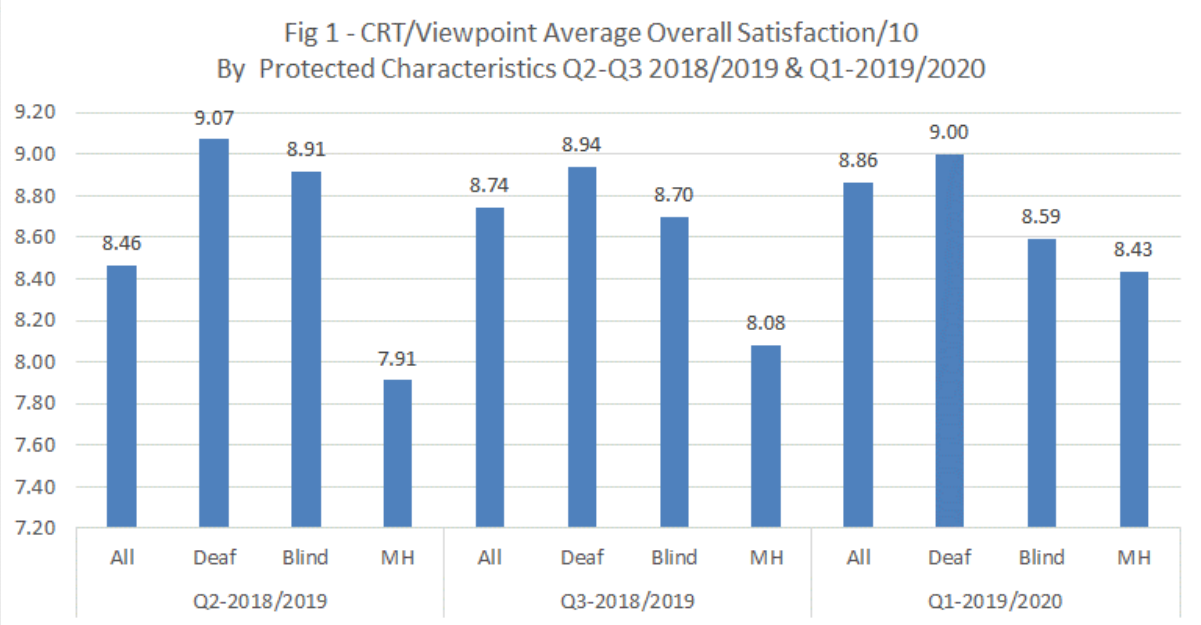
Month	Make/Cancel Appts	Book Hospital Transport	Communication Support	Access Health Service	Emergency Dental X-Ray & Results	Pharmacy Queries	Support to professionals	Raise Concerns	*Total*
April	49	3	12	11	2	2	12	4	95
May	96	2	14	20	2	0	13	2	149
June	80	2	14	22	0	3	9	2	132
July	139	1	15	14	12	1	15	6	203
August	165	1	23	16	5	3	15	9	237
September	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0
January	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0
	529	9	78	83	21	9	48	18	795

Make/Cancel Appts	529
Book Hospital Transport	9
Communication Support	78
Access Health Service	83
Emergency Dental X-Ray & Results	21
Pharmacy Queries	9
Support to professionals	48
Raise Concerns	18
Total	795

Appendix 8

Patient & Service User Experience Feedback by Protected Characteristic
Summary for Operational Equality Group – Q1-2019/2020

BCUHB has continued to develop the infrastructure necessary to report on service user feedback by protected characteristic, the prime mechanism being CRT/Viewpoint real time patient feedback system. As in previous reporting periods, Fig 1 below clearly indicates that service users who report a sensory loss either (Deaf or Hearing Impaired, or Blind or Sight Impaired), report a higher or equitable level of overall patient satisfaction compared with other service users and those who report that they have a *mental health* condition. Service users who report that they have a *mental health* condition report the lowest level of satisfaction.



Excluding service users who report having a *mental health condition*; service users who report having a sensory loss report higher levels of satisfaction across all aspects of service user satisfaction with the exception of *involvement in care*, see Fig 2 below. Which triangulates with other feedback derived from engagment events and patients stories. This may be due to the complexity of their condition, and in relation to deaf or blind service users, that staff are more aware of their needs and therefore are more able to respond to these, and that these service users derive benefit from BCUHB's Accessible Health Care Scheme. Additinally this may be an indicator that staff awareness efforts in relationto the provision of services for people with sensory loss in line with BCUHB's statutory requirements is paying dividens.

Fig 2 – Average (Mean) Scores /4

	Q3-2018/2019				Q4-2018/2019				Q1-2019/2020			
	All	Deaf	Blind	MH	All	Deaf	Blind	MH	All	Deaf	Blind	MH
Did Staff Introduce themselves to You?	3.56	3.74	3.61	3.45	3.60	3.61	3.67	3.57	3.65	3.69	3.65	3.48
Did you feel that you were listened to?	3.61	3.62	3.44	3.44	3.66	3.65	3.75	3.60	3.68	3.71	3.56	3.50
Were given all the information you needed?	3.54	3.53	3.43	3.31	3.60	3.52	3.65	3.47	3.59	3.54	3.53	3.41
Did you get assistance when needed?	3.47	3.61	3.67	3.36	3.49	3.59	3.70	3.53	3.48	3.63	3.61	3.46
Were you involved as much as you wanted to be?	3.56	3.57	3.54	3.30	3.59	3.48	3.52	3.45	3.60	3.58	3.48	3.36
Did staff take time to find out what matters to you?	3.60	3.64	3.49	3.42	3.64	3.58	3.64	3.57	3.67	3.62	3.52	3.46
How would you rate your overall experience?	8.74	8.94	8.70	8.08	8.90	8.98	9.15	8.60	8.86	9.00	8.59	8.43

Quality, Safety & Experience Committee **24.9.19**	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: • Organ and Tissue Donation Policy • Handcuffs Policy • Threats to the Person in Forensic Establishments Policy • Major Incident Protocol – Ty Llywelyn Medium Secure Unit
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 meeting held on 11th September 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.

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Organ and Tissue Donation Policy
Report Author:	Mrs Helen Bullock - Specialist Nurse Organ Donation
Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies and Health Sciences
Public or In Committee	Public
Purpose of Report:	This policy requires approval by the Committee and Board. Its aim is support and guide the donation process in Emergency Departments, Critical Care and theatres. To ensure best practice and high quality care for donors, donor families and recipients, while also maximising outcomes.
Approval / Scrutiny Route Prior to Presentation:	Organ and Tissue Committee Members 12th April 2019 Engagement with departmental leads BCUHB wide completed 7th May 2019 Secondary Care Quality Group approval 17th July 2019 QSG approval 11th September 2019.
Governance issues / risks:	No governance significant issues or risk identified on completion of equality impact assessment. The policy ensures collaboration with relevant organisations and a performance focus. It also ensures openness, transparency and integrity in our end of life practices and formalises our practice with national guidance/regulations. The Organ and Tissue Donation Group plan to work on ongoing issues which may hinder implementation due to compliance in some areas. In addition to engagement with religious and ethnic minority groups already part of NHSBT action plan to improve consent rates and end of life care.
Financial Implications:	No new or additional financial implications to BCUHB following the implementation of this policy as it is formalising existing practice. Resources used are already accounted for as part of the patient's usual emergency care. Any rare additional costings are either covered by NHS Blood and Transplant (NHSBT) or reimbursed to the relevant department by the Organ and Tissue Donation Group. The Specialist Nurse Organ Donation (SNOD), Clinical Lead Organ Donation (CLOD) and Organ

	and Tissue Donation Group take responsibility to ensure this is done in a timely manner in the weeks following the case. The Organ and Tissue Donation budget is set by NHSBT for the following year in early summer. It is dependent on the number of organ donors we have facilitated in the previous financial year. As per the policy any additional costings will be approved by NHSBT and Organ and Tissue Donation Group members prior to action. There is a rare and unlikely risk that in order that a donor is not lost and reported to Welsh Government that we agree actions which will result in additional unbudgeted costings, which the Organ and Tissue Donation Group and NHSBT are unable to cover such as overtime, additional investigations. This would be escalated and approved with appropriate management within BCUHB to look for potential alternatives and/or approval prior to action (see policy).
Recommendation:	The QSE are asked to endorse this BCU wide policy for implementation which formalises and standardises current and long standing practice.

Version: 1.0

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

Author & Title	Organ & Tissue Donation Policy Helen Bullock Specialist Nurse Organ Donation (East)
Responsible dept / director:	Adrian Thomas, Executive Director of Therapies and Health Sciences
Approved by:	Organ and Tissue Donation Group, Secondary Care Quality Group and QSG.
Date approved:	12/04/19, 17/07/19 and 11/09/19
Date activated (live):	
Documents to be read alongside this document:	Intensive Care Society – Guidelines for limitation of treatment for adults requiring Intensive Care (2003) Human Tissue Authority: Human Transplantation (Wales) Act – Code of Practice (2013) Human Tissue Authority: The Human Transplantation (Wales) Act (2013) Mental Capacity Act Code of Practice (MCA, 2005) Intensive Care Society (ICS): Guidelines for adult organ and tissue donation (2004) Academy of Medical Royal Colleges: Code of practice for the diagnosis of death (2008) British Medical Association (BMA): End of life decisions (2009) General Medical Council (GMC): Treatment and care towards the end of life (2010) Organ Donation for transplantation: Improving donor identification and consent rates for deceased organ donation. NICE: clinical guideline 135, (2011) Timely Identification and Referral of potential organ donors: As strategy for implementation of best practice- NHSBT (2012) Approaching the families of potential organ donors: Best practice guidance- NHSBT (2012) Organ Donation and the Emergency Department: A Strategy for Implementation of Best Practice – NHSBT (2016) Welsh Intensive Care Society – All Wales Guidelines for the Management of Devastating Brain Injury (2017) Management of Perceived Devastating Brain Injury after Hospital Admission: A Consensus Statement. The Faculty of Intensive Care Medicine (2018)

Date of next review:	09/2022

First operational:	New Policy				
Previously reviewed:					
Changes made yes/no:					

Appendices:

1. INTRODUCTION

Organ transplantation is a lifesaving/enhancing treatment for end stage organ failure. The increasing effectiveness of transplantation means that many more patients can be considered for treatment in this way. However, there is a shortage of donors. For some people this means waiting sometimes for years undergoing difficult, stressful and time consuming treatment. For some it means they will die before a suitable organ becomes available.
Therefore, all patients meeting criteria set out in the NICE guidelines must be referred to specialist nurses for organ donation in order to assess their potential to donate and their recorded decision on the NHS Organ Donor Register. Family members should be approached in line with the good practice set out in national guidelines

2. STATEMENT

BCUHB will ensure that:

2.1 An effective and robust donor identification and referral scheme is in place. Required referral is intended to ensure that all potential organ and tissue donors are identified and referred, at the earliest opportunity, to the Specialist Nurse Organ Donation (SNOD) or the Tissue Co-ordinator.

2.2 Brain Stem Testing (BST) is carried out in all patients where neurological death is a likely diagnosis, even if Donation after Neurological Death (DND) is an unlikely outcome.

2.3 An appropriate discussion regarding organ and tissue donation is a usual part of end of life care.

2.4 The Organ Donor Register (ODR) held by NHS Blood and Transplant (NHSBT) organ donation and transplantation is checked to establish whether the potential donor is registered.

2.5 All ventilated patients who are having active treatment withdrawn or who are to undergo brain stem testing are identified and automatically referred to the SNOD.

2.6 Families of potential tissue only donors are approached, and a referral made to Tissue Services at the National Referral Centre if appropriate (NRC Speke, NHS BT).

3. AIM / PURPOSE

This document describes the procedures to be used when facilitating Organ and Tissue Donation within Betsi Cadwaladr University Health Board (Health Board).

4. OBJECTIVE

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, to ensure that organ and tissue donation is considered a usual part of end of life care.

5. SCOPE / AREA OF APPLICATION

The Organ Donation section of this policy applies to all staff whose involvement may be required to facilitate the donation process, predominately but not limited to, staff in the following areas:

- Critical Care Department
- Emergency Department
- Theatres, recovery unit

The Tissue Donation section of this policy applies to all staff employed by the Health Board who are involved with the care of the dying, recently deceased and recently bereaved.

6. ROLES AND RESPONSIBILITIES

6.1 Executive Director of Therapies and Health Sciences

Will be accountable to the Health Board in ensuring compliance with this policy in all areas of the Health Board.

6.2 Clinical Directors, Clinical Leads, Lead Nurses, Matrons and Ward Managers

Must have a working knowledge of the policy and ensure dissemination of the information and compliance with this policy by all staff members in all critical care areas.

6.3 Specialist Nurse Organ Donation (SNOD)

- Will provide education, support and advice to all staff who will work with this policy.

- To provide a 24 hour on call service to facilitate all aspects of the organ donation process.

- To maintain close communication with the ICU, ED and theatre link nurses, offering ongoing education, feedback and support.

- Will perform an audit of all deaths in the ICU and ED, to feedback quarterly to the Clinical Management Team and the Health Board Organ and Tissue Donation Group, for onward feedback to the Health Board.

6.4 Clinical Lead for Organ Donation (CLOD).

- CLOD should provide clinical leadership within the Health Board on organ donation and champion improvements in the way in which potential organ donors are identified, families are consented and organs donated. Working alongside the BCUHB, SNOD and Organ and Tissue Donation Group they should identify and contribute to resolving barriers to organ donation.

- The clinical lead is a source of knowledge regarding the ethical and legal aspects of organ donation. They will contribute to the effective functioning of the Health Board Organ and Tissue Donation Group and will provide clinical oversight of performance reports including suitable metrics to facilitate the monitoring of donor identification, referral and management.

6.5 Organ and Tissue Donation Group

- To support the development of strategies and policies within the Health Board to ensure that potential organ donor patients are identified and to review

- To use the audit data available to drive improvements in practice and support the individuals who are key to organ and tissue donation taking place.

- To report on an annual basis to the Health Board and NHS Blood and Transplant the hospital donation activity and a plan for the future work of the group.

6.6 Intensive Care staff and Emergency Department staff

- Refer all patients who meet referral criteria via the **24-hour pager number: 03000 20 30 40**

- Work collaboratively with the SNOD to ensure a planned approach to Organ/ Tissue Donation and End of Life choices.

6.7 BCUHB staff in all other departments involved in this policy

To comply with this policy throughout organ donation referral and retrieval procedures as outlined in the flowcharts.

6.8 Organ and Tissue Donation Link Nurses

- To adopt a supportive and informative role and act as a knowledge resource for their colleagues.
- Work closely with SNOD to ensure teaching delivered to all ICU, Theatre and Emergency Department staff.
- Feedback any concerns or ideas to SNOD regarding recent donation activity, teaching or de-briefing needs.
- Attend regular meetings with SNOD

6.9 Mortuary Staff

- To identify the correct patient with the retrieving personnel for either multi tissue donation or eye donation.
- Carry out transfer of consented patients via NHSBT approved transport providers to Tissue and Eye Services in Speke, Liverpool for purposes of tissue donation (please note – this will only be facilitated on weekdays during normal working hours due to Mortuary staff's working hours)

6.10 Out of Hours Tissue and Eye Retrievals

- Out-of-hours tissue retrievals will be carried out on site, access to the mortuary will be sought via the Site Manager and hospital Porters. Porters to identify the correct patient with the retrieval personnel.
- A copy of the consent and Post Donation Feedback letter will be forwarded to the Mortuary staff the next working day

7. ORGAN DONATION

7.1 Early identification of potential donors (Appendix 5)

- Discussions should be initiated with the specialist nurse for organ donation as per NICE Clinical Guideline 135 when:

- There is intention to withdraw life sustaining treatment
- There is intention to use brain-stem death tests to confirm death
- A patient is admitted with very severe brain injury (defined as a Glasgow Coma Score of 3-4 with at least one absent brain-stem reflex) that cannot be attributed to the effects of sedation.

7.2 Consent

- Where a patient has the capacity to make their own decisions their views on organ donation should be sought by the SNOD.

- If a patient lacks capacity to make decisions about their end of life care the SNOD will establish whether taking steps before death to facilitate organ donation would be in the patient's best interests.

7.3 Collaborative approach to family (Appendix 5)

- Organ donation must not be discussed with family members until it is clear that they have accepted the likely death of their relatives in accordance with best practice (NHSBT, 2015).

- Approach to families of potential organ donors must be planned with the SNOD and consultant in charge of the patient's care.

- The discussion with family must only happen with the SNOD present. Unless agreed with SNOD otherwise.

- Decisions on suitability of a potential donor are made by the SNOD or the transplant teams.

7.4 Organ Donor Register (ODR)

- The Human Transplantation (Wales) Act (2013) recognises that a wish to donate may have been expressed verbally or recorded by joining the ODR or carrying a donor card. Before approaching a family, it must be confirmed via the SNOD whether the patient is on the ODR as restrictions may have been placed by the patient.

- If a patient is not registered they must still be given the option for organ and/or tissue donation as part of end of life care.

- If the patient is a Welsh resident and has no registered decision, or expressed decision – they may have their consent deemed. The SNOD will follow the code of practice and NHSBT best practice guidance, to assess whether deemed consent can apply.

- Where patients have an opt out registration, a conversation with the SNOD should still take place and a plan be made on how to proceed.

7.5 Testing for death using neurological Criteria

- Regardless of any consideration of organ donation and in line with the Academy of Medical Royal Colleges (2008) Code of Practice for the Diagnosis and Confirmation of Death and the Intensive Care Society (2004), clinicians are encouraged to consider the diagnosis of death by neurological criteria.

- This often requires stabilisation of the patient and guidance (Appendix 3) is available for medical and nursing staff from the SNOD and the CLOD. Achieving this diagnosis helps the clinical staff and families understand that the patient has died and helps reduce doubt that the patient might have made any recovery
  Testing for death using neurological criteria must be conducted as per process described in appendices and the form used for documentation (Appendix 1).

7.6 Maintain patient stability

- Every effort must be made to maintain the patient clinical stability before and during brainstem testing and while an appropriate assessment for donation is performed.

- Providing that this delay is in the patients overall best interests, life sustaining treatments should not be withdrawn or limited until the patient's wishes around organ donation have been explored and the clinical potential for the patient to donate has been assessed in accordance with legal and professional guidance

7.7 Donation after Death by neurological criteria (DND – Appendix 7)

- Two sets of bedside clinical tests of brainstem function are undertaken to confirm the diagnosis of death by neurological criteria. The time of death is recorded as the time the first set of testing is completed. The diagnosis of death using neurological criteria testing form must be used to document the process (Appendix 1).

- If the clinicians responsible for the care of the patient cannot be certain that the tests can be completed then the tests should be abandoned, and if appropriate, treatment withdrawn. The patient should then be considered for donation after circulatory death (DCD).

- After Brainstem test has been completed and donation agreed with family the patient must be clinically optimised using agreed guidelines (Appendix 3) with the support of the SNOD.

7.8 Donation after Circulatory Death (DCD - Appendix 6)

- The decision to withdraw active treatment must be made by the consultant in charge of the care of the patient and be in compliance with Intensive Care Society, British Medical Association, General Medical Council and local unit policy. The withdrawal of treatment decision will be independent from any subsequent discussion regarding organ donation. The medical plan will be clearly documented in the medical notes of the patient including how the treatment is to be withdrawn.

- Consideration for DCD must be given to all ventilated patients in ITU and the ED where a decision has been made to withdraw life sustaining treatment. Controlled DCD is the retrieval of organs from patients who have suffered an asystolic or circulatory death, following the planned withdrawal of treatment.

- Contact the SNOD once the decision to withdraw treatment has been made. It is not possible to offer a family the possibility for organ donation if treatment is withdrawn prior to retrieving arrangements being in place.

- Once a decision to withdraw treatment has been made the current level of support should continue until a time to withdrawal is agreed with relatives.

- In the case of DCD it is generally appropriate to add new therapies or undertake invasive interventions to optimise up to the point of withdrawal. The continued use of monitoring, haemodynamic and respiratory support will be necessary to allow for an accurate timing of asystole and to assess the warm ischaemic time of the organs being considered for transplantation.

- Following withdrawal, it will be necessary for the SNOD to monitor and record heart rate, blood pressure, respiratory rate and oxygen saturation. Remote monitoring should be used to allow the family privacy with their loved one when treatment is withdrawn. During this period the SNOD will keep close contact with the transplant surgeons who will assess viability for transplant. Following guidance from the surgeons the SNOD will stand down if the patient has not died within a specified timeframe. The SNOD will ensure all staff involved and family members are aware of this.

- If asystole occurs within the timeframe, death must be diagnosed after five minutes by the ICU team as recommended in guidance from the Academy of Medical Royal Colleges (2008). Any return of cardiac or respiratory activity during this period of observation should prompt a further five minutes of

observation after asystole develops again. The family may stay with their deceased relative during the five minutes. The donor will then be taken as quickly as possible to the operating theatre to avoid further warm ischaemic damage to organs. A medical doctor must be available to diagnose death after five minutes to ensure no delay in the transfer to theatre. The diagnosis of death must be clearly documented in the medical notes (Appendix 2) of the patient as this will need to be seen by the transplant surgeons before the retrieval operation can begin.

7.9 Care after donation (Appendix 8)

- SNOD will remain with the patient throughout the process of donation.
- After donation the SNOD will follow best practice as per NHSBT and BCUHB recommendations, guidelines and policy.

7.10 Donation from the Emergency Department

- Potential donors will be intubated and ventilated, with a medical plan for withdrawal of treatment or a decision to perform brain stem tests clearly documented in the medical notes.
- Identified potential donors must be referred to the SNOD.
- Where verbal consent for organ donation has been obtained the SNOD, the patient should be transferred from ED to an appropriate critical care area.
- All reasonable efforts to optimise resource allocation whilst avoiding any perceived risk to patient safety will be explored in the interests of facilitating the donation process. Clinical decisions about the most appropriate care for patients must take priority.
- Escalation in accordance with local bed policy must occur where organ donation is deemed not able to proceed due to bed availability, including discussions with SNOD.

7.11 Theatre and Staff Availability

- The SNOD will liaise with the theatre co-ordinator regarding the timing of retrieval and which members of the theatre team will be needed to assist during the operation.
- The organ retrieval operation should be treated as emergency. If there will be any impact on booked activity this should be escalated accordingly.

- A minimum of a runner is required to help with locating equipment and supplies. A SNOD will be present in the theatre throughout the retrieval process co-ordinating.

- The retrieval team will consist of surgeons, scrub nurse and a perfusionist. The SNOD will keep theatre staff up-dated with the expected time of arrival of the retrieval team.

- In the case of a DND donor, an anaesthetist and ODP is required from the donating hospital to facilitate transfer of the ventilated patient to theatre and provide care intra-operatively up to the cessation of ventilation as directed by the transplant surgeons.

- An anaesthetist is required in DCD donors where lungs have been accepted to secure the patients airway with a cuffed endotracheal tube in accordance with the lung optimisation pathway (Appendix 4).

- Following the organ retrieval operation, the SNOD and theatre staff perform last offices as the final act of caring (Appendix 8). The family may wish to be involved and can be offered this opportunity.

7.12 Coroner information

- Where appropriate, the coroner will give permission for organ donation to proceed. As a general rule almost all deaths occurring in the ED will require coroner referral, and many deaths occurring on ITU. The coroner may wish to speak with the medical doctor in charge of the care of the patient before giving consent. The coroner may place restrictions on what can be retrieved. Any discussion with the coroner needs to be clearly documented in the medical notes of the patient.

- Provisional approval from the coroner can be sought prior to discussion with the family to expedite the process, but it is essential that permission is gained prior to the commencement of the organ retrieval operation. The coroner is willing to be contacted out of hours in order to give approval of the process when he/she is able to do so.

8. TISSUE DONATIONS

8.1 Referral

Due to the nature of cause of death for many patients in the hospital setting, eyes will be the predominant tissue donated.
Other life-saving and life-enhancing tissues that can be donated:

- Skin

- Heart Valves and blood vessels
- Bone
- Tendons
- Windpipe

Eye donation must occur up to 24 hours after death and other tissues must be retrieved within 48 hours of death. A valid blood sample (minimum of 10mls whole blood or 5mls of serum) is required within 24 hours of death or 7 days' pre-mortem if one is available in the hospital labs (NHSBT will arrange this). Mandatory blood tests will be performed by NHSBT for all tissue donors, testing for HIV, Hepatitis B, C, E, HTLV and Syphilis.

Specialist Nurse in Tissue Donation (SNTD) from NHSBT are available between 08:00 and 20:00 seven days a week for advice. All referrals are triaged and Next of Kin (NOK) contacted if the patient is potentially suitable. The SNTD will require medical history and details of the potential donor along with NOK details, as directed by the form.

There is a phased implementation of the electronic Tissue Donor Referral Form (FRM5275- Appendix 9), whereby every death is referred to NHSBT.

Where this is not implemented, a traditional approach to the family can be made. Followed by referral of the potential tissue donation, by calling Tissue Services on **0800 432 0559**.

8.2 Consent

Where medically suitable, all patients should have the opportunity to discuss their wishes with regards to potential tissue donation when they die.
A SNTD (from NHSBT's National Referral Centre) will telephone the NOK at home if the patient is suitable for tissue donation.

Consent for donation is established by the SNTD during a recorded telephone interview with the NOK. For multi-tissue donation, there is the option for the deceased to be transferred to NHSBT's Dedicated Donation Facility in Speke, Liverpool for the purpose of tissue donation. Consent for this will be sought during the NOK's conversation with the NHSBT SNTD.

Tissue donation can be subject to Coroner's consent, NHSBT SNTD are responsible for having these discussions and seeking lack of objection, where applicable.

When consent for donation has been established, the Donation Team will be mobilised by NHSBT. They will contact the hospital to arrange a convenient time to carry out the tissue donation and the retrieval will take place in the hospital mortuary.

Tissue and Eye Services Donation Team will independently perform retrieval under NHSBTs Human Tissue Authority licence, number 11018.

If relevant consent is in place, the deceased will be transferred to the Dedicated Donation Facility for the purpose of tissue donation by NHSBT approved funeral directors and returned to the hospital mortuary, usually within 24 hours.

For any tissue donation, a copy of the consent will be provided to the mortuary and a Post Donation Feedback letter issued on completion of the retrieval.

9. RESOURCES

If provision of an ICU bed, anaesthetist, ICU/ED nursing or theatre staff is not available to facilitate donation, discussions with the attending SNOD must take place. In addition, escalation to Clinical Site Manager.

Reimbursement for over time, agency nursing or an additional anaesthetic session/s may be possible, which must be pre agreed with the SNOD or CLOD prior to action.

Loss of donation opportunity due to resources will be subject to escalation through clinical governance and will be reported to the Organ and Tissue Donation Group and Welsh Government.

10. TRAINING

- NHSBT is responsible for training and maintaining competency of SNOD.
- Training from NHSBT is available for CLODs. CLODs are responsible for maintaining their competency.
- SNODs will ensure that appropriate member of staff receive a level of training corresponding to their role.
- CLODS are responsible for raising awareness and supporting best practice amongst medical and clinical staff.

11. IMPLEMENTATION

The policy is expected to be implanted with immediate effect following approval.

12. FURTHER INFORMATION – CLINICAL DOCUMENTS

The Human Transplantation Act (Wales) 2013 has changed how consent for organ donation can be determined since its implementation on 1st December 2015.

The HTA Code of Practice informs the multidisciplinary team how to use the act to determine consent, however the SNOD is best placed to determine whether a patient has given consent for organ donation.

The act applies to people over the age of 18 who have capacity and who voluntarily live in Wales and then die in Wales. Consent to donation can be deemed if an individual does not have a registered decision.

13. ENVIRONMENT IMPACT

No negative environment impact is expected as a result of this policy.

14. EQUALITY

An equality impact assessment has been completed and no adverse impact has been identified upon any groups or individuals protected as defined by the Equality Act 2010.

BCHUB Organ and Tissue Donation Group will monitor continued compliance with this document and it's delivery by hospital and NHSBT staff, through the Potential Donor Audit.

15. WELSH LANGUAGE

The Welsh Language (Wales) Measure (2011) has given the Welsh language official status in Wales by placing Welsh Language Standards on organisations. 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, together with promoting and facilitating the use of the Welsh language.

In the conduct of public business, the aim of the Health Board is to provide an "Active Offer", meaning services should be provided in Welsh without the service user having to ask for it. Enabling our patients and the public to receive high-quality, language appropriate care is paramount to the way we provide and plan our

services, as well as encouraging other users and providers to use and promote the Welsh language in the health sector. We have a clear vision – everyone who comes into contact with our services should be treated with dignity and respect by receiving a safe and responsive service that is accessible in their language of choice. The Welsh Language Standards must be adhered to in any contact with the family during the donation process and in relation to gaining their consent for donation. Their preferred language of communicating with the Health Board must be documented and acted upon.

16. AUDIT

- BCUHB staff compliance to this policy including required referral will be monitored via ongoing local and national data collection; this will ensure that the opportunity to donate has not been missed. The data collection will occur monthly of all deaths that occur on the ICU/HDU and ED.

- All data obtained will be collated by the SNOD and submitted onto the National Potential Donor Audit database held by NHSBT. This data will be presented on a quarterly basis to BCUHB Organ & Tissue Donation Group, to the Health Board, the Department of Health and the Welsh Government on an annual basis.

- Variation from the guidelines and/or identification of lost donation opportunity at any stage will be subject to escalation through clinical governance.

17. REVIEW

This policy will be reviewed every 2 years or earlier if recommended by the BCUHB Organ Donation Group.

8. REFERENCES

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19. APPENDICES

APPENDIX 1

Form for the Diagnosis of Death
using Neurological Criteria {abbreviated guidance version}

This form is consistent with and should be used in conjunction with, the AoMRC (2008) ***A Code of Practice for the Diagnosis and Confirmation of Death*** and has been endorsed for use by the Faculty of Intensive Care Medicine and Intensive Care Society.

HOSPITAL ADDRESSOGRAPH or

Surname
First Name
Date of Birth
NHS Number

Evidence for Irreversible Brain Damage of known Aetiology

Primary Diagnosis:

Evidence for Irreversible Brain Damage of known Aetiology:

Diagnostic caution is advised in certain '**Red Flag**' patient groups. See Page 3 for details.

Exclusion of Reversible Causes of Coma and Apnoea

	1st Test Dr One	1st Test Dr Two	2nd Test Dr One	2nd Test Dr Two
Is the coma due to depressant drugs? Drug Levels (if taken):	Yes / No	Yes / No	Yes / No	Yes / No
Is the patient's body temperature ≤34°C?	Yes / No	Yes / No	Yes / No	Yes / No
Is the coma due to a circulatory, metabolic or endocrine disorder?	Yes / No	Yes / No	Yes / No	Yes / No
Is the apnoea due to neuromuscular blocking agents, other drugs or a non brain-stem cause (*eg*. cervical injury, any neuromuscular weakness)?	Yes / No	Yes / No	Yes / No	Yes / No

Tests for Absence of Brain-Stem Reflexes

	1st Test Dr One	1st Test Dr Two	2nd Test Dr One	2nd Test Dr Two
Do the pupils react to light?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any eyelid movement when each cornea is touched in turn?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any motor response when supraorbital pressure is applied?	Yes / No	Yes / No	Yes / No	Yes / No
Is the gag reflex present?	Yes / No	Yes / No	Yes / No	Yes / No
Is the cough reflex present?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any eye movement during or following caloric testing in each ear?	Yes / No	Yes / No	Yes / No	Yes / No

Brain-Stem Reflexes

Please circle as appropriate

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Form for the Diagnosis of Death
using Neurological Criteria {abbreviated guidance version}

Patient Name: **NHS Number:**

Apnoea Test

Apnoea Test				
	1st Test Dr One	**1st Test Dr Two**	**2nd Test Dr One**	**2nd Test Dr Two**
Arterial Blood Gas pre apnoea test check: (Starting $PaCO_2 \geq 6.0$ kPa and starting pH <7.4 or $[H^+]$ >40 nmol/L)	1st Test Starting $PaCO_2$: Starting pH/$[H^+]$:		2nd Test Starting $PaCO_2$: Starting pH/$[H^+]$:	
Is there any spontaneous respiration within 5 (five) minutes following disconnection from the ventilator?	Yes / No	Yes / No	Yes / No	Yes / No
Arterial Blood Gas Result post apnoea test: ($PaCO_2$ should rise > 0.5 kPa)	1st Test Final $PaCO_2$: *Perform lung recruitment*		2nd Test Final $PaCO_2$: *Perform lung recruitment*	
Document any Ancillary Investigations Used to Confirm the Diagnosis or any required Clinical Variance from AoMRC (2008) Guidance				
Completion of Diagnosis				
Are you satisfied that death has been confirmed following the irreversible cessation of brain-stem-function?	**YES / NO**		**YES / NO**	
Legal time of death is when the 1st Test indicates death due to the irreversible loss of brain stem function. Death is confirmed following the 2nd Test.	**Date:** **Time:** **Dr One** Name Grade GMC Number Signature **Dr Two** Name Grade GMC Number Signature		**Date:** **Time:** **Dr One** Name Grade GMC Number Signature **Dr Two** Name Grade GMC Number Signature	

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Form for the Diagnosis of Death
using Neurological Criteria {abbreviated guidance version}

It remains the duty of the two doctors carrying out the testing to be satisfied with the aetiology, the exclusion of all potentially reversible causes, the clinical tests of brain-stem function and of any ancillary investigations so that each doctor may independently confirm death following irreversible cessation of brain-stem function.

Guidance Summary of the AoMRC Code of Practice

The diagnosis of death by neurological criteria should be made by at least two medical practitioners who have been registered for more than five years and are competent in the conduct and interpretation of brain-stem testing. At least one of the doctors must be a consultant. Testing should be performed completely and successfully on two occasions with both doctors present. It is recommended that one doctor perform the test while the other doctor observe; roles may be reversed for the second test.

Diagnostic caution is advised in the following 'Red Flag' patient groups.
(Based on the literature and unpublished case reports.)

1. Testing **< 6 hours** of the loss of the last brain-stem reflex
2. Testing **< 24 hours** where aetiology primarily anoxic damage
3. **Hypothermia**
   (24 hour observation period following re-warming to normothermia recommended)
4. Patients with **any neuromuscular disorders**
5. **Steroids** given in space occupying lesions such as abscesses
6. Prolonged **fentanyl** infusions
7. Aetiology **primarily** located to the **brain-stem or posterior fossa**

Evidence for Irreversible Brain Damage of Known Aetiology

- There should be no doubt that the patient's condition is due to **irreversible brain damage of known aetiology**. Occasionally it may take a period of continued clinical observation and investigation to be confident of the irreversible nature of the prognosis. The timing of the first test and the timing between the two tests should be adequate for the reassurance of all those directly concerned. **If in doubt wait and seek advice.**

Children (one examining doctor should normally be a paediatrician or should have experience with children and one of the doctors should not be primarily involved in the child's care)

- **Older than 2 months post term**: This guideline can be used in these children.
- **Between thirty seven weeks corrected gestation (post menstrual) age to 2 months of age post term**: use the RCPCH Guidance available at www.rcpch.ac.uk
- **Infants less than 37 weeks corrected gestation (post menstrual) age:** the concept of brain-stem death is inappropriate for infants in this age group.

Drugs

- The patient should not have received any drugs that might be contributing to the unconsciousness, apnoea and loss of brainstem reflexes (narcotics, hypnotics, sedatives or tranquillisers). Where there is any doubt specific drug levels should be carried out (midazolam less than < 10mcg/L, thiopentone <5mg/L). Alternatively consider ancillary investigations.
- There should be no residual effect from any neuromuscular blocking agents (atracurium, vecuronium or suxamethonium), consider the use of peripheral nerve stimulation.
- Renal or hepatic failure may prolong metabolism / excretion of these drugs.

Temperature, Circulatory, Metabolic or Endocrine Disorders

- Prior to testing aim for: temperature > 34°C, mean arterial pressure consistently >60mmHg (or age appropriate parameters for children), maintenance of normocarbia and avoidance of hypoxia, acidaemia or alkalaemia ($PaCO_2$ <6.0 kPa, PaO_2 >10 kPa and pH 7.35 –7.45 / $[H^+]$ 45-35 nmol/L).
- Serum Na^+ should be between 115-160mmol/L; Serum K^+ should be > 2mmol/L; Serum PO_4^{3-} and Mg^{2+} should not be profoundly elevated (>3.0mmol/L) or lowered (<0.5mmol/L) from normal.
- Blood glucose should be between 3.0-20mmol/L before each brain-stem test.
- If there is any clinical reason to expect endocrine disturbances then it is obligatory to ensure appropriate hormonal assays are undertaken.

Form for the Diagnosis of Death
using Neurological Criteria {abbreviated guidance version}

Brain Stem Reflexes
- Pupils should be fixed in diameter and unresponsive to light.
- There should be no corneal (blink) reflex (care should be taken to avoid damage to cornea).
- Eye movement should not occur when each ear is instilled, over one minute, with 50mls of ice cold water, head 30°. Each ear drum should be clearly visualised before the test.
- There should be no motor response within the cranial nerve or somatic distribution in response to supraorbital pressure. Reflex limb and trunk movements (spinal reflexes) may still be present.
- There should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter placed down the trachea to the carina.

Apnoea Test
- End tidal carbon dioxide can be used to guide the starting of each apnoea test but should not replace the pre and post arterial $paCO_2$.
- Oxygenation and cardiovascular stability should be maintained through each apnoea test.
- **Confirm $PaCO_2$ ≥6.0 kPa and pH < 7.4 / $[H^+]$ >40 nmol/L.** In patients with chronic CO_2 retention, or those who have received intravenous bicarbonate, confirm $PaCO_2$ >6.5 kPa and the pH < 7.4 / $[H^+]$ >40 nmoles/L.
- Either use a CPAP circuit (eg Mapleson B) or disconnect the patient from the ventilator and administer oxygen via a catheter in the trachea at a rate of >6L/minute.
- There should be no spontaneous respiration within a minimum of 5 (five) minutes following disconnection from the ventilator.
- **Confirm that the PaCO2 has increased from the starting level by more than 0.5 kPa.**
- At the conclusion of the apnoea test, manual recruitment manoeuvres should be carried out before resuming mechanical ventilation and ventilation parameters normalised.

Ancillary Investigations
- Ancillary investigations are **NOT** required for the diagnosis and confirmation of death using neurological criteria. Any ancillary or confirmatory investigation should be considered **ADDITIONAL** to the fullest clinical testing and examination carried out to the best of the two doctors capabilities in the given circumstances.

Organ Donation
- National professional guidance advocates the confirmation of death by neurological criteria wherever this seems a likely diagnosis and regardless of the likelihood of organ donation.
- NICE guidance recommends that the specialist nurse for organ donation (SN-OD) should be notified at the point when the clinical team declare the intention to perform brain-stem death tests and this is supported by GMC guidance.

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Form authorship and feedback
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APPENDIX 2

Diagnosis of Death by Circulatory Criteria

Patient Name:	
Date of Birth:	
Hospital Number:	
NHS Number:	

PRECONDITIONS: (ONE of the following must be met)

A decision has been taken not to attempt cardiorespiratory resuscitation ☐

Attempts at resuscitation have failed ☐

Life sustaining treatment has been withdrawn ☐

DIAGNOSIS OF DEATH

The patient has been observed for 5 minutes to confirm irreversible cardiorespiratory arrest:

Absence of mechanical cardiac function: ☐

- absence of heart sounds on auscultation
- absence of central pulse on palpation

(In monitored patients an absence of pulsatile flow on invasive arterial pressure monitoring may be used)

Absence of respiratory function:

- Observation of the patient for signs of breathing ☐

After 5-minute observation irreversible loss of consciousness has been confirmed:

- No corneal reflexes ☐
- No pupillary reflexes to light ☐
- No motor response to supra-orbital pressure ☐

DATE TIME

The patient was confirmed to have died at: _____ on _____

Signature of professional diagnosing death:

Printed name of professional diagnosing death:

Position of professional diagnosing death:

APPENDIX 3

Donor optimisation following Diagnosis of Death by Neurological criteria (planned DND)

Guidance for critical care staff / donor care physiologist

TARGETS SUMMARY

MAP 60-80mmHg
PaO_2 8-14KPa
SpO_2 >95%
Urine output 0.5 – 2 ml/kg/hr
BM 4 – 9 mmol/L
Temperature 35.5 – 37.5 C
Administer Methylprednisolone

System	Primary goal	Secondary goals
Lung / ventilation	*To prevent aspiration and maintain respiratory function*	
	PaO_2 8 – 14KPa SpO_2 > 95% Minimise FiO_2	Low tidal volume ventilation (6-8mls/kg Ideal Body Weight) Recruitment manoeuvre (post BSDT and when clinically indicated) Chest physiotherapy (on call physio required out of hours) Regular suction Stop NG feed – place on free drainage
Cardiovascular	*To maintain organ perfusion, minimise cardiac stress and prevent pulmonary oedema*	
	MAP 60-80mmHg Adequate fluid filling *(may require cardiac output monitoring)*	Minimise crystalloid infusion Wean noradrenaline to MAP target If vasopressor or inotrope required use VASOPRESSIN in preference to noradrenaline If MAP > 90 without support consider GTN (+/- discuss with recipient centres via SNOD)
Renal	*To maintain good urine output, prevent fluid overload and treat diabetus insipidus*	
	Urine output 0.5 – 2 ml/kg/hr	Use crystalloid bolus if required High u/o with rising Na should be treated with DDAVP

		(give bolus then start infusion)
Endocrine	*To improve post-transplant organ function*	
	BM 4-9mmol/L METHYLPREDNISOLONE *(15mg/kg bolus up to 1g)* Consider Liothyronine (1-3 units per hour)	Use insulin infusion to achieve BM target
Metabolic	*To improve post-transplant organ function*	
	Temperature 35.5 – 37.5C	Na^+ 135-160mmol/L K^+ 4-5.5 mmol/L Mg^{2+} > 0.8mmol/L Ca^{2+} 2-2.6mmol/L (corr.) PO_4^- > 0.8mmo/L

APPENDIX 4

Lung Donation after Circulatory Death

Checklist for Lung Optimisation in Theatre

HOSPITAL ADDRESSOGRAPH or

Surname

First Name

Date of Birth

Hospital Number

For completion in the operating theatre by the anaesthetist / thoracic surgeon / donor care physiologist

Diagnosis of death has been confirmed and recorded in the patient's notes	

Secure the patient's airway with a cuffed endotracheal tube (if the patient has been extubated)	Intubation date_____ Intubation time_____

Ensure 10 minutes after circulatory arrest has occurred before optimising lungs:

Set the flow metre to 15L/min FiO_2 1.0 (100% O_2)
Under no circumstances should the patient be mechanically ventilated

↓

Using the anaesthetic circuit, manually carry out a **single recruitment manoeuvre** to reinflate the lungs – *suggested manoeuvre: maintain 30cm H_20 for 30 seconds using APL valve*

Reinflation date_____
Reinflation time_____

↓

Set the APL valve to **CPAP 5cm H_2O** and maintain flow at 15L/min

↓

Further single recruitment manoeuvres are often necessary, at a later time, during the lung retrieval process, and are guided by the thoracic team.

↓

Hand over care of the airway to the thoracic team.

Anaesthetist / Thoracic Surgeon / Donor Care Physiologist, Name and Designation

Name_____ Signature_____

Grade_____ Date and Time_____

Rationale for Lung Optimisation

1. Lung Donation after Circulatory Death (DCD) is vital to increasing the number of lungs available for transplantation and there is evidence to suggest that lungs from DCD donors are as successful for transplantation as those retrieved from a donor following brain stem death.

2. After circulatory arrest and following the diagnosis of death it is vital to secure the patient's airway with a cuffed endotracheal tube as aspiration during abdominal retrieval procedures will prevent lung donation. Some patients may already have a cuffed airway (either endotracheal tube or tracheostomy) in situ.

3. There is a potential risk that lung ventilation, following circulatory arrest, may restore cardiac activity and the cerebral circulation therefore no lung recruitment manoeuvres should be carried out within the first 10 minutes following circulatory arrest.

4. Also, under no circumstances should the patient be mechanically ventilated, as there is a theoretical risk that rhythmic movements of the lungs could restore cardiac activity.

5. However, without reinflation and oxygenation, lung donation cannot successfully occur and the Department of Health Consensus statement agreed to a single recruitment manoeuvre with oxygen, followed by the application of CPAP, in accordance to the method outlined on the flow chart.

This checklist was adapted for use in the North West Region from the Nottingham University Hospitals checklist, referencing the Consensus Statement on Donation after Circulatory Death from the British Transplantation Society and Intensive Care Society (endorsed by DoH and NHSBT) 2010

http://www.odt.nhs.uk/pdf/DCD_Consensus_2010.pdf

For further information, please also refer to:

National Standards for Organ Retrieval from Deceased Donors (please ask the SNOD)

http://www.aomrc.org.uk/doc_details/9322-an-ethical-framework-for-controlled-donation-after-circulatory-death

APPENDIX 5

WITHDRAWAL OF TREATMENT OR TESTING FOR NEUROLOGICAL DEATH

CONSULTANT and MDT makes decision to withdraw life-sustaining treatment or perform brainstem death tests

Continue routine nursing and medical care. Complete DNA-CPR if appropriate

MEDICAL or **NURSING** staff refer patient to **SNOD**

24 hour referral number:
03000 20 30 40

SNOD consults ODR and performs initial medical assessment.
If patient is a potential donor **SNOD** will attend.

If the patient is unsuitable for organ donation the family should be offered the choice of tissue donation.

The **PATIENT** should be managed in an appropriate clinical setting. This may include transfer to the ICU +/- physiological stabilisation.

MEDICAL, NURSING team and **SNOD** discuss potential withdrawal / brain stem testing with family.

Routine end of life care should continue including ensuring patient comfort and addressing religious and family needs.

CONSULTANT, NURSING STAFF & SNOD plan approach to family.

Approach and discussion of organ donation should only be undertaken once the family have accepted plan for withdrawal or neurological death confirmed through testing. This should usually be undertaken during a separate end-of-life planning conversation

FAMILY agree to organ donation on behalf of patient

SNOD takes consent from family. This must be documented in the patient's notes

If the family do not wish to proceed with organ donation bereavement care should be planned. This should include the bedside NURSE with support from the SNOD. The option of **tissue donation** should be given.

CONSULTANT clarifies any legal or coronal issues. Discussions with the coroner must be documented in the patient's notes.

Withdrawal of life sustaining treatment: DONATION AFTER CIRCULATORY DEATH flowsheet (**Appendix 6**)

Brain stem testing: DONATION AFTER NEUROLOGICAL DEATH flowsheet (**Appendix 7**)

APPENDIX 6

DONATION AFTER CIRCULATORY DEATH (DCD)

Continue routine end of life care

End of life care plan should be discussed with **FAMILY, NURSING STAFF, SNOD and CONSULTANT**
Include appropriate end of life care medication

SNOD - Blood for virology/tissue typing sent. Further investigations as necessary.

12-lead ECG, routine bloods, CXR, ECHO (reported in notes by **MEDICAL** staff)

Patient booked on emergency list by **SNOD**. Offering of organs undertaken according to NHSBT guidelines.

Prior to retrieval team's arrival **ICU TEAM** and **SNOD** to decide if withdrawal will occur in ICU or Anaesthetic room.
If Anaesthetic room, **PATIENT** should be transferred on arrival of retrieval teams.

If withdrawal in Anaesthetic room **NURSE & SNOD** to accompany patient. **FAMILY** should be offered the opportunity to remain with the **PATIENT** throughout withdrawal and end-of-life care. The **ICU** bed should remain available for the patient to return to in the event of non-proceeding. **NURSE** should remain with the patient throughout.

Throughout the end of life period the **FAMILY** should be allowed to spend time with the patient. Mementos (handprints and hair locks) should be offered and facilitated by **SNOD** and **NURSING** staff.
Support for **FAMILY** members should continue throughout. Religious and cultural wishes of the patient and **FAMILY** should be facilitated.

CLINICAL TEAM withdraw life-sustaining treatment.

ICU DOCTOR will diagnose and document death **(see appendix 2**) following 5 minutes of monitored asystole in accordance with the AoMRC code of practice.

Every effort must be made by the ITU Medical team to allow for a successful organ donation following DCD to take place. This will require the presence of the **ICU DOCTOR** from the time of treatment withdrawal to the time of death or stand down. It is recommended the **ITU CONSULTANT** be present in the unit during this process.

At the onset of monitored mechanical asystole (arterial line trace) the **ICU DOCTOR** will be required to diagnose death.

PATIENT is transferred to theatre following diagnosis of death.

If lung donation is possible **ANAESTHETIST** follows lung optimisation pathway (appendix 4)

If donation does not proceed **PATIENT** should be transferred back to the ICU. On-going bereavement care should continue to be offered by **ICU NURSE** and **SNOD.** Routine end-of-life care should include a documented plan.

Following organ retrieval:
Follow
Care after donation
Policy flow sheet (**Appendix 8**)

APPENDIX 7

DONATION AFTER DEATH USING NEUROLOGICAL CRITERIA (DND)
(Consent for donation obtained)

Prior to brain stem testing normal homeostasis should be maintained

Ventilation:	LTV (6-8mls/kg) PaCO2 5-6 kPa SpO2 >95%
CVS:	MAP>60-80 (Insert CVC unless strong contraindication exists)
Metabolic:	Na 135-160 mmol/L Start DDAVP if signs of DI Maintain normothermia

Brain stem testing (BST) undertaken by **CONSULTANT + CONSULTANT or SENIOR REGISTRAR**

FAMILY members should be offered the opportunity to witness BST with support from the **SNOD.**
BST should be performed according to AMoRC guidelines and recorded on the DND testing form (see **appendix 1)** and in patient's notes.

FAMILY should be informed of the results of BST

MEDICAL and **NURSING** staff continue physiological optimisation of the donor

Physiological optimisation is aimed at ensuring the best possible outcome from donation. Guidance on procedure and goals is provided in **Appendix 3.** Staff may be supported by a **DONOR CARE PHYSIOLOGIST** from the transplant retrieval team.

SNOD - Blood for virology/tissue typing sent. Further investigations as necessary

12-lead ECG, routine bloods, blood group, CXR (reported in notes by **MEDICAL** staff)
Echocardiogram
(Performed by sonographer. If out-of-hours consider discussion with on-call **CARDIOLOGIST)**

Patient booked on emergency list by **SNOD**. Offering of organs undertaken according to NHSBT guidelines.

Throughout the assessment and optimisation period the **FAMILY** should be allowed to spend time with the patient. Mementos (handprints and hair locks) should be offered and facilitated by **SNOD** and **NURSING** staff.
Support for **FAMILY** members should continue throughout. Religious and cultural wishes of the patient and **FAMILY** should be facilitated.

Once retrieval teams have assembled **FAMILY** should be offered the opportunity to see the patient prior to transfer to theatre.

Following organ retrieval:
Follow
Care after donation
Policy flow sheet (**Appendix 8**)

APPENDIX 8

CARE AFTER DONATION

SNOD will remain with the **PATIENT** throughout the process of donation

Nursing staff / SNOD performs last offices

PATIENT is transferred to the mortuary

Tissue donation should proceed if family have provided consent

SNOD contacts **FAMILY** post theatre to pass on information regarding organ retrieval. **FAMILY** follow up should continue in the form of telephone conversations, letters and home visits.

SNOD writes to staff including **CONSULTANT, ICU DOCTOR** and **ICU NURSE** with details of the outcome of organ donation.

FAMILY members should be offered the opportunity to participate in care after death. **FAMILY** requests such as clothing should be facilitated where possible. **FAMILY** should be offered the opportunity to view the **PATIENT** after death

Information should be shared with the family according to the NHSBT Donor Family Care policy

APPENDIX 9

FORM FRM5275/1.2	Effective: 05/01/17

NHS Blood and Transplant

Tissue Donor Referral Email

Please email this completed form to: NHSBT.TissueDonorReferral@nhs.net
This hospital supports tissue donation, this could potentially save and improve the lives of up to 50 people.
You are not required to approach families on behalf or NHS Blood and Transplant to discuss tissue donation.

Patient Name:				NHS Number:	
Date of Death:				Time of Death:	
Date of Birth:		Age		Gender:	Male / Female
Date of admission:				Body weight:	
Circumstances of admission & suspected cause of death.					
Coroners Case:	Yes / No / Unknown			Are the next of kin aware of the death?	Yes / No

Next of Kin Contact Details

Name of the next of kin:		Relationship to patient:	
Contact Number (1):		Contact number (2):	

Medical History

Please tick any of the following if they apply to this patient:

Lab diagnosed infections (e.g. MRSA) ☐ Evidence of Sepsis ☐ Malignancy ☐ Blood-borne Malignancy ☐
Neurological Diseases (e.g. Alzheimer's, Dementia, Parkinson's, MS or ALS) ☐ Prion Disease/s (e.g. vCJD) ☐
Other Infection/s (e.g. Active TB, HIV, HEP B, HEP C, HTLV I/II) ☐ History of IVDU ☐
Previous Organ or Tissue Transplant ☐

Past Medical History or Additional Information	
Recent interventions during this admission: Transfusions, Antibiotic treatment, etc.	

Patient GP Details

GP Name:			
GP Address:		GP Contact No.	

Additional Information

Tissue / Organ Donation mentioned in end of life care plan?	Yes / No
Tissue Donation information given to NOK?	Yes / No

Referring Details

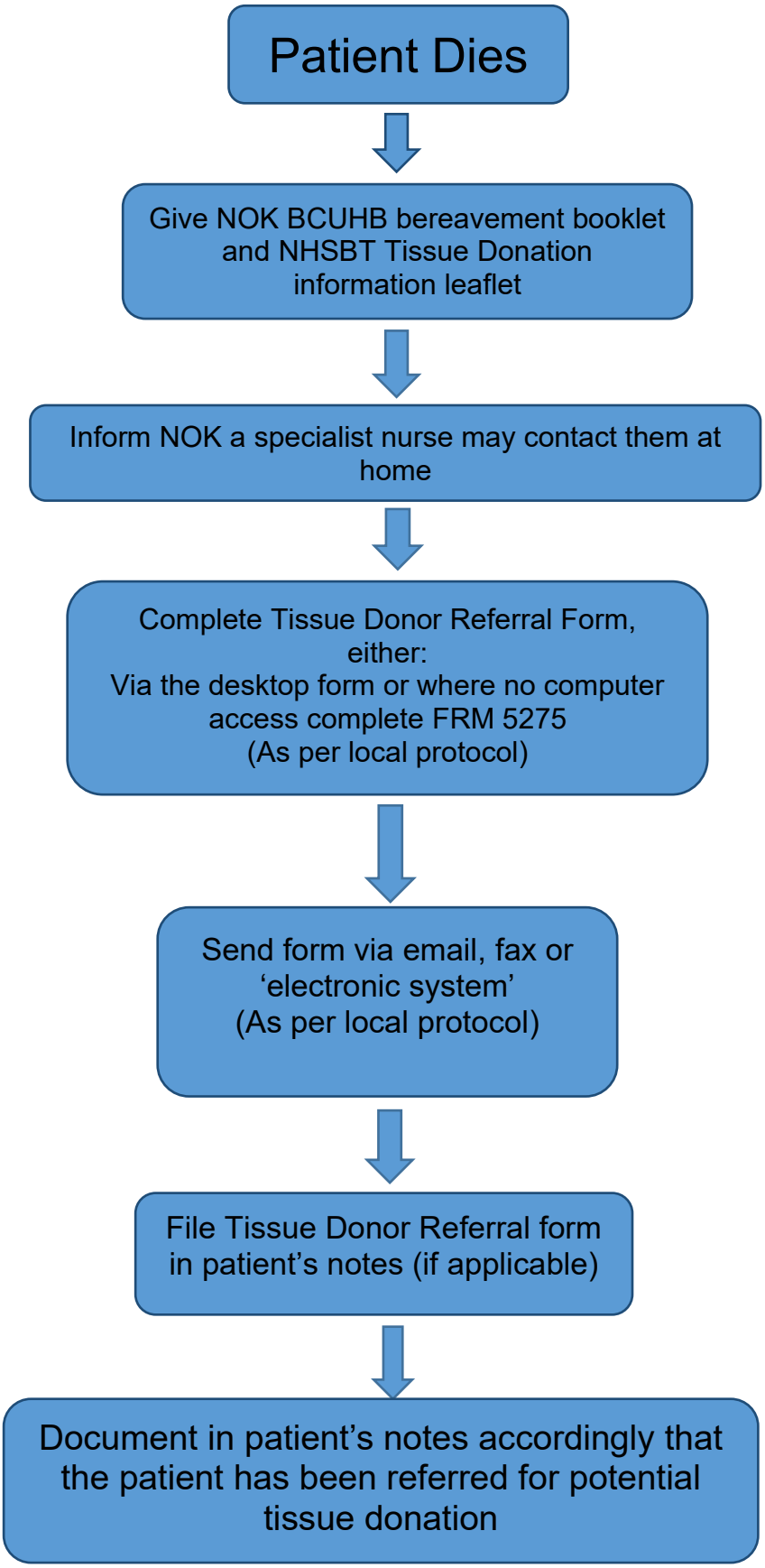
Name of referrer:		Position & Ward:	
Referring Hospital:		Contact No.	
Date and time of referral:			

Tissue and Eye Services Only:

[Template Version 01 (1.0)]

Cross-Referenced in Primary Document: MPD394 | Page 1 of 1

APPENDIX 9


Patient Dies
Give NOK BCUHB bereavement booklet and NHSBT Tissue Donation information leaflet
Inform NOK a specialist nurse may contact them at home
Complete Tissue Donor Referral Form, either:
Via the desktop form or where no computer access complete FRM 5275
(As per local protocol)
Send form via email, fax or 'electronic system'
(As per local protocol)
File Tissue Donor Referral form in patient's notes (if applicable)
Document in patient's notes accordingly that the patient has been referred for potential tissue donation

Members of the Working Group:

Name	Title
Dr Pierre Peyrasse	Consultant Anesthetist, Clinical Lead Organ Donation.
Dr David Southern	Consultant Anesthetist, Clinical Lead Organ Donation.
Dr Andrew Foulkes	Consultant Anesthetist, Clinical Lead Organ Donation.
Helen Bullock	Specialist Nurse Organ Donation.
Abi Roberts	Specialist Nurse Organ Donation.
Phil Jones	Specialist Nurse Organ Donation.

Engagement has taken place with:

Name	Title	Date Consulted
Maureen Wain	Hospital Director (East)	15/04/19-07/05/19
Dr Stephen Stanaway	Hospital Medical Director (East)	15/04/19-07/05/19
Ellen Greer	Hospital Director (Centre)	15/04/19-07/05/19
Dr Emma Jane Hosking	Hospital Medical Director (Centre)	15/04/19-07/05/19
Dr Karen Mottart	Hospital Medical Director (West)	15/04/19-07/05/19
Barry Williams	Interim Hospital Director (West)	15/04/19-07/05/19
Danny Jones	Critical Care Matron (East)	15/04/19-07/05/19
Heather Piggott	Head Of Nursing Medical Directorate - Secondary Care (East)	15/04/19-07/05/19
Dr Khaled Elfituri	Consultant in ICM & Anaesthesia- Clinical Lead Critical Care (East)	15/04/19-07/05/19
Mark Williams-Jones	Critical Care Matron (Centre)	15/04/19-07/05/19
David Bevan	Theatre Manager (East)	15/04/19-07/05/19
Alison Ingham	Regional Clinical Lead for Organ Donation (North West) Consultant in Anaesthesia and intensive care medicine	15/04/19-07/05/19
Clinical Site Managers	East, West and Centre	15/04/19-07/05/19
Medwyn Jones	Interim DGM Medicine (East)	15/04/19-07/05/19

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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?	BCU organ and tissue donation policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The policy describes the management of patients who are going to donate organs or tissues after death. The patients concerned are in patients within BCU.
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?	Adrian Thomas, Executive director for therapy and health science
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	**Human Tissue Act (HTA, 2004)** **Human tissue Authority (2013) The human transplantation (Wales) Act.** **Mental Capacity Act 2005** **GMC 2010: treatment and care toward the end of life** **NICE guidelines 2011** **Academy of Medical Royal Colleges (2008) Code of practice for the diagnosis and confirmation of death.**
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Staffs in ITU, ED, Theatre, some medical wards. Physiotherapists and echographists.

6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Training of relevant staff is already in place and monitored. Collaborative approach is key factor to succeed.

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	N		
Disability	N		
Gender Reassignment	N		
Marriage & Civil Partnership	N		
Pregnancy & Maternity	N		
Race / Ethnicity	N		
Religion or Belief	N		
Sex	N		
Sexual Orientation	N		
Welsh Language	N		
Human Rights	N		

<u>Guidance on completing Form 2:</u> 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 <u>scale</u> 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	All patients will be considered for organ donation based on clinical ground
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Not relevant
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It required good communication with minority and religious groups in order to achieve the highest consent rate possible.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	BCU organ and tissue donation policy

2. Brief Aims and Objectives: (Copy from Form 1)	The policy describes the management of patients who are going to donate organs or tissues after death. The patients concerned are in patients within BCU.

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	No X

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?	
	Yes	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details: None	
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?	On going audit of activity, processes and outcome
	Who is responsible?	Adrian Thomas
	What information is being used?	existing reports/data, clinical information from NHSBT and transplant team
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Same date the policy is reviewed

7. Where will your decision or policy be forwarded for approval?	Organ and Tissue Donation Committee, Secondary Care Quality Group, Quality and Safety Group,

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Organ Donation is the object of ongoing discussion within clinical teams involved in the process.

	Name	Title/Role

9. Names of all parties involved in undertaking this Equality Impact Assessment:		
	Dr Peyrasse	Consultant in Critical care Medicine, Clinical lead for organ donation, 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:	NA		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None for now		
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?	None identified		
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.	NA		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Engagement with religious and ethnic minority groups already part of NHSBT action plan	NHSBT board Local SNOD and CLOD	On Going

Quality, Safety & Experience Committee **24.9.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Policy for the use of Handcuffs (Specific to Ty Llywelyn Medium Secure Unit)
Report Author:	Mr Paul Hanna, Head of Nursing & Simon Allen Service Manager
Responsible Director:	Mr Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	Ratification
Approval / Scrutiny Route Prior to Presentation:	MHLD Policy Implementation Group MHLD Divisional Q-SEEL MHLD Divisional Directors Professional Advisory Group – Chairs Approval Quality Safety Group
Governance issues / risks:	Mental Health Act 1983: Section 17 – Leave for Restrictive Patients Mental Health Act 1983: Code of Practice Chapter 26 - Mechanical Restraint 26.75 - Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, for the primary purpose of behavioural control. 26.76 – Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principles of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing. Authority 26:77 – The use of mechanical restraint should be approved following multi disciplinary consultation (which should include Independent mental health advocates where the patient has one. The nature of the multi disciplinary team should be defined in a provider's policies. Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan (or equivalent). This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting. Authority 26:79 – Staff applying mechanical restraint devices should have appropriate training in their application and use. Lawful use of Handcuffs

	Common Law The use of Handcuffs (and other restraint equipment) is normally Governed under the Common Law as a 'common law use of force option'. Under Common Law any person may use force to protect their private right. As such a handcuff (or other restraining device) is considered a 'temporary restraining measure' to prevent harm to self or others or to prevent the escape of a person lawfully detained (see also Article 5(1)(c) of the Human Rights Act 1998). (This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Health Board – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion. This section should also indicate whether due regard has been taken of any potential equal opportunity implications arising from matters addressed in the report. Some proposals, particularly those relating to policies, procedures, or delivery of services may require an equality impact assessment to be carried out. This section should include brief details of the outcome of such assessments, and confirm whether any mitigating actions will need to be taken as a result and associated milestones / timeframe.) **HUMAN RIGHTS LEGISLATION** The Human Rights Act 1998 came into effect on 2nd October 2000. Under Articles 2, 3 and 5 the following needs to be taken into consideration if handcuffs are to be authorised for use by the organisation and applied by its staff. Article 2(1) – Right To Life Article 2(1) of the Human Rights Act provides for us the positive obligation for public authorities to promote the right to life giving a high value to everyone's right to Life. Article 2(1) also promotes the positive obligation to preserve life. This means that if there is a risk to life and something can be done to eliminate or reduce that risk to life then that absolutely should be done. Article 3 - Prohibition Of Torture "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." This article concerns itself with freedom from torture, inhumane treatment, degrading treatment, inhumane punishment and degrading punishment. The protections of article 3 cannot be derogated from in any circumstances, even during war or public emergency. Everyone is entitled to the protection of article 3, regardless of their own conduct
Financial Implications:	Annual update for Ty Llywelyn 'train the trainers' (1 day, group cost)
Recommendation:	The QSE Committee is asked to ratify the policy.

FINAL Version

MHLD 0041

Mental Health & Learning Disabilities Division
POLICY FOR THE USE OF HANDCUFFS
(Specific to Ty Llywelyn Medium Secure Unit)

Author & Title	Paul Hanna, Head of Nursing Simon Allen, Service Manager				
Responsible Dept / Director:	Director of Mental Health and Learning Disabilities Division				
Type of Document	Policy				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval QSG 11.09.19				
Date approved:	QSE				
Date activated (live):	June 2019				
Documents to be read alongside this document:	• Health Offender Partnerships 2007 Best Practice Guidance: Specification for Adult Medium Secure Services • Crown Prosecution Service: Handcuffing of Defendants 2008 • Association Chief Police Officers England, Wales and Northern Ireland 2006: Guidance on the Use of Handcuffs Mentally Disordered Offenders: the restricted patient system				
Date of next review:	May 2022				
Date EqIA completed / reviewed:	April 2018				
First operational:	September 2018				
Previously reviewed:					
Changes made yes/no:					
Details of changes since last review					

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

~~1.~~ INTRODUCTION

1.1 The aims of this policy are to provide information and guidance for staff concerning:

- The reasons for the use of handcuffs;
- The requirement for appropriate assessment and justification before their use; and
- Their roles and responsibilities in relation to the use of handcuffs.

1.2 Handcuffs will be required for the maintenance of security and/or safety in certain circumstances, as directed by the Ministry of Justice, when patients are being escorted outside a secure perimeter or transferred to another unit or establishment. The most common example is when there is a significant risk that a patient may attempt to abscond whilst escorted to an external appointment. Another is when there is a significant risk that a patient will attempt to cause harm while being escorted outside or being transferred.

1.3 At the pre-admission meeting before a service user is admitted the issue of emergency leave and whether the use of handcuffs needs to be considered will be agreed and documented by the Multi-Disciplinary Team and a lead from the Positive Interventions Clinical Support Service (PICSS).

1.4 Despite the above points, it is important to note, ~~that~~ the guiding principle is that patients will not have handcuffs applied routinely while being escorted or transferred. In order to adhere to this principle and to comply with relevant guidance and legislation, an individual risk assessment should take place before any use of handcuffs. These assessments should take into account the following points.

- The patient's circumstances and background;
- Their current and recent presentations;
- The circumstances and environment of the proposed trip outside a secure perimeter;
- risks to the safety of the patient;
- risks to the safety of the escorting staff;
- risks to the safety of other professionals;
- risks to the safety of the public

1.5 Ordinarily those who undertake this assessment will be members of the patient's multi-disciplinary team (MDT), including where possible, the person who will be the Lead Nurse for the secure escort and the person who will apply the handcuffs. The assessing members of staff should be satisfied that, acting in good faith, they have considered

matters objectively and come to a decision that they believe to be defensible should it be questioned or challenged.

1.6 For planned occasions when a patient will be escorted to a non-secure environment and there will be (or may be) a requirement to remove the handcuffs, there should be a management plan that addresses this in detail.

1.7 Mental Health Act Code of Practice for Wales (revised 2016) states that in some exceptional circumstances where the patient's behaviour leads to the identification of the need for some form of mechanical restraint, such restraint may, in certain circumstances, be agreed by the hospital managers.

1.8 As outlined above, the use of handcuffs is not the first line method of managing disturbed or violent behaviour within Betsi Cadwalader University Health Board. As the use of handcuffs undoubtedly constitutes a form of mechanical restraint, this policy is intended to satisfy the *Code of Practice* requirement for a policy to be in place governing handcuff use.

1.9 The application of handcuffs will be considered a use of force. This means that each application of handcuffs to a patient must be reasonable, necessary and proportionate intervention for each individual occasion. Intentional application of force to a person will constitute an assault if it is not justifiable.

1.10 The principal legal authority that is relevant to such instances stems from Section 3(1) Criminal Law Act 1967 and from Common Law (re: self defence and preventing a breach of the peace). The members of staff who escort a patient may use force in order to prevent crime and to stop a patient from becoming unlawfully at large. When secure transfers are undertaken, section 137 MHA 1983, `Provisions as to custody, conveyance and detention`, is also relevant. The members of staff who undertake a secure transfer may use reasonable force in order to stop a patient from escaping from legal custody.

1.11 Written confirmation of use of handcuffs must be completed on the relevant form, `Record of Use of Handcuffs'. This confirmation will be undertaken jointly by the Lead Nurse for the escort and the member of staff who applies the handcuffs. However, it is important that both understand their contributions to this.

1.12 As the application of handcuffs will be considered a use of force, the following points apply to the person who applies the handcuffs:

- She or he must be aware of all relevant facts, including the risk assessment,
- She or he must believe the use of handcuffs to be appropriate and reasonable on that occasion.

These matters are essential because she or he is responsible for her/his actions.

1.13 The Lead Nurse for the escort/ transfer has overall responsibility and accountability for the escort so:

- She or he must also be aware of all relevant facts, including the risk assessment,
- She or he must also believe the use of handcuffs to be appropriate and reasonable on occasion.

1.14 The person whom the patient will be handcuffed to should be willing to undertake this role. Also,

- She or he must also be aware of all relevant facts, including the risk assessment,
- She or he must also believe the use of handcuffs to be appropriate and reasonable on that occasion.

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~~2.~~ SCOPE

This policy applies to all staff working clinically with patients, or involved in authorisation for/ application of handcuffs in the Ty LLywelyn Forensic Service.

~~3.~~ DUTIES

3.1 Chief Executive

The Chief Executive is responsible for ensuring the Health Board has appropriate policies in place and complies with its legal and regulatory obligations.

3.2 Accountable Director

The Executive Director for Mental Health Services is the responsible Director for this policy and has overall responsibility for ensuring that the security policy and practice within the Ty LLywelyn Forensic Service to legislative requirements and the Clinical Security Framework.

3.3 Multi Disciplinary Teams

As far as practicable, multi-disciplinary teams are responsible for discussing and planning leave (including secure escorts/transfers), and completing a risk assessment prior to the leave commencing. In relevant cases, the risk assessment will include consideration of whether or not use of handcuffs is appropriate.

3.4 The Positive Interventions Clinical Support Service

The Positive Interventions Clinical Support Service will be a standing member of the MDT when the use of handcuffs is being considered. They will support the Handcuff

Monitoring group that will meet on a quarterly basis to review the use of handcuffs in the period.

3.5. The escorting team of staff

3.5.1 When handcuffs are used to escort or transfer a patient the escorting team of staff will have at least 3 members. On almost all occasions a vehicle will be used, and when this is the case the team of 3 will not include the driver in its number.

3.5.2 All members of staff who make up the secure escort team must attend a briefing prior to escorting a patient in handcuffs. As far as practicable, the briefing should involve the Clinical team managing the service user's care. This can be done by contacting the relevant Security Department in advance and it's to ensure consistency in the undertaking of secure escorts and transfers. Where it is not practicable to have someone from the Clinical team. involved, a briefing should still take place and include all members of staff who will form the escorting team. Even in the event of an unplanned/ emergency escort the members of staff involved in escorting the patient should be made aware of the plan for the occasion and their roles and responsibilities. They must also know about basic safety procedures in the event that the service user becomes difficult to manage while attached to a member of staff.

3.5.3 As mentioned at 1.5. above, if there will be or may be a requirement to remove the handcuffs during the episode of leave there should be a management plan that addresses that in detail. When handcuffs are used (or might be used) for a prolonged period – such as an inpatient stay in a general hospital – the management plan must include regular reviews of the use of the handcuffs. The reviews will include reviewing use of escort chains if these have been used (e.g. for a patient admitted to a general hospital. The Lead Nurse for the escort will be responsible and accountable for ensuring reviews are undertaken and recorded clearly. As a guide, reviews should be undertaken at least every day and when circumstances alter.

3.6 Staff at the secure reception

Staff at the secure reception will be responsible for issuing and receiving returned handcuffs, escort chains and keys. They will also be responsible for maintaining inventories of these.

4. JUSTIFICATION OF THE USE OF HANDCUFFS

4.1 As mentioned in Section 1 above, patients who are being escorted outside secure buildings will not have handcuffs applied routinely. An individual risk assessment should be undertaken in each case and this should lead to a professional, defensible decision being made. Any use of handcuffs must be justifiable.

4.2 As a guide for staff, the situations listed below may lead to decisions to use handcuffs.

4.2.1 Where it is assessed that the application of handcuffs is necessary to prevent the patient from trying to escape from our custody whilst outside a secure perimeter.

4.2.2 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to others (e.g. escorting staff, members of the public) while being escorted or transferred.

4.2.3 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to herself / himself while being escorted or transferred.

5. USE OF HANDCUFFS FOR PLANNED LEAVE

5.1 Relatively few episodes of leave within Ty LLywelyn require *secure* escort / transfer arrangements and the use of handcuffs, but of those that do, a distinction can be made between “planned” and “unplanned / emergency” occasions.

5.2 Episodes of planned leave that require secure escorting arrangements will be subject to thorough and documented risk assessment before they go ahead. This includes attending medical treatment that is not considered to be “urgent” or an “emergency”.

5.3 Generally, transfers that require secure arrangements will always be planned and not be emergencies so they too will be subject to thorough and documented risk assessment before they go ahead.

5.4 Both the decision to use handcuffs and the rationale for this should be documented clearly in the patient’s electronic record (Paragon).

5.5 All relevant authorisation must be complete and available to the escorting team of staff before the planned secure leave or secure transfer occurs. E.g; Section 17 form when applicable.

5.6 Patients who are subject to restriction orders also require suitable authorisation from the Ministry of Justice (MoJ) for leave.

5.6.1 If such leave has been granted in the past it must be checked whether or not the leave granted covers this particular episode. If it does not, or if the leave has since been revoked, further permission will be required.

5.6.2 For episodes of leave for medical treatment for restricted patients, MoJ document Annex B – *Medical leave application for restricted patients* – should be completed and submitted in advance.

5.6.3 If there is any doubt concerning MoJ authorisation, the MoJ should be contacted before the leave takes place in order to clarify matters.

5.7 In cases of transfer of patients subject to restriction orders, a warrant for transfer will be required from the MoJ.

5.8 The escorting team of staff should see and check all relevant paperwork as part of their briefing and prior to taking the patient out of the secure perimeter. They should not escort a handcuffed patient outside the secure perimeter unless they are satisfied that all is in order and all arrangements are clear to them.

5.9 The use of handcuffs should be explained to the patient prior to the leave or transfer. Wherever possible, s/he should be involved in the plan.

5.10 If there are any concerns that discussing the plan with the patient will increase the risk of her / him attempting to abscond or cause harm during the leave, or that it might cause her / him distress, staff should agree to limit the information that they provide. Matters discussed with the patient should be recorded in electronic records (Paragon) and the escorting team of staff must be made aware of what has and what has not been discussed with the patient.

5.11 The lead nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The lead nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

5.12 During a planned secure escort in which handcuffs have been applied, they should only be removed if:

- their removal is stipulated for these circumstances on the management plan, or,
- in extreme circumstances, if there are clear grounds to justify this (e.g. if handcuffs are impeding essential examination or treatment).

The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

5.13 If neither of the above apply, but there appears to be a reason to remove the handcuffs, authorisation for their removal should be sought via telephone contact with a senior nurse (Modern Matron, Service manager or Bronze manager on-Call) or someone in a more senior position than this.

5.14 Generally, handcuffs will not be removed during secure transfers. On arrival at the destination they should be removed only when in a secure part of the receiving unit / facility and following agreement with the receiving staff. In the event of extreme circumstances en route, if there were clear grounds to justify removal (e.g. if handcuffs were impeding essential examination or treatment) they could be removed. The Lead Nurse for the escort would be responsible and accountable for the decisions and actions undertaken.

5.15 If handcuffs have been removed during a secure escort or transfer, whether because this formed part of the management plan, following authorisation via the telephone or because of extreme circumstances, they should remain off only for as long as is necessary. The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

6. USE OF HANDCUFFS FOR UNPLANNED / EMERGENCY LEAVE

6.1 Unplanned secure *transfers* of patients to other units / facilities should not take place.

6.2 As a guide, unplanned *leave* that requires secure escorting arrangements and the use of handcuffs should not take place. However, in emergencies, such as when a patient who has no leave appears to require urgent or emergency medical treatment and this cannot be provided inside the relevant unit, secure escort should be facilitated.

6.3 As far as is practicable, an immediate risk assessment will be required prior to this unplanned / emergency leave so that suitable risk management arrangements can be put in place. E.g. use of handcuffs if indicated by the risk assessment, a suitable number of escorts, a secure vehicle if available.

6.4 As far as is practicable, the immediate risk assessment will be undertaken by the Nurse in Charge, the members of staff who will form the escort team and the Unit Co-ordinator. Wherever possible it should also be discussed with the Service manager or the Bronze manager on Call. The outcome of this assessment, including the rationale, plus details of those involved must then be documented by the Unit Co-ordinator in her / his report **and** by the Nurse in Charge (or a delegated Registered Nurse) in the patient's electronic record (Paragon). The Duty Senior Nurse of the unit and the Bronze on Call should also make a record of his/her involvement.

6.5 The risk assessment must balance the apparent risk to the patient with the heightened risk posed by such unplanned leave e.g. risk of absconding, risk to the public, risk to the escorting member of staff.

6.6 In extreme cases, such as when a patient is unconscious or immobile, in may be inappropriate to use handcuffs but appropriate to take them. This is in case the circumstances alter and the patient regains full consciousness or mobility.

6.7 Staff should be aware that a minority of patients might feign ill health or harm themselves intentionally in order to be taken out of a secure environment.

6.8 The lead nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The lead nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

6.9 During an unplanned secure escort/ in which handcuffs have been applied, they should only be removed if there are clear grounds to justify this (e.g. if they are impending essential medical examination or treatment). They should remain off only for as long as is necessary.

6.10 Relevant members of staff should be precise in recording the times and details of Contact and events: i.e. contents of discussions and subsequent decisions, times of handcuff removal and handcuff re-application etc.

6.11 If unplanned/emergency leave is required for a patient who is subject to a restriction order, MOJ authority should be obtained beforehand wherever possible. Where this is

not practicable, the MOJ should be informed as soon as it is practicable. The Ministry should also be informed as soon as it is practicable. The Ministry should also be updated on the risk management arrangements and, when it takes place, the return of the patient within the secure perimeter.

7. RECORDS OF THE USE OF HANDCUFFS

7.1 It is important that the exact times of events are recorded clearly and sequentially:

The exact time at which the handcuffs were applied;

The exact time the patient (with escorting staff) left the secure building;

The exact time and place at which they were removed; and

Any other applications and removals that take place during the episode of secure level or transfer.

7.2 The names of staff involved and the patient must be documented clearly as per requirements on the relevant paperwork.

7.3 When the secure escort/transfer has been completed the Lead Nurse for the escort is responsible and accountable for overseeing the completion and then the distribution of copies of the forms.

8. ISSUE AND RETURN OF HANDCUFFS

8.1 Staff at the relevant secure reception will issue the handcuffs and keys to a member of the escorting team, and maintain a record of this. They will also record the return of the items when the escorting team return them..

9. TRAINING

9.1 Training in the use of handcuffs will be provided by Ty Llewelyn in house trainers who have undertaken Ashworth Hospital accredited Train the Trainers course. This will be funded by Regional services and will be through BCUHB procurement processes.

9.2 All staff whose role may involve the use of handcuffs will be required to attend and complete approved in house training. Updates/ refreshers should be completed (by meeting the set training criteria) every 2 years.

9.3 If more than 2 years has lapsed for a member of staff, she/he will not be ‘live’ in relation to handcuff training. As far as practicable, members of staff who are no longer on the ‘live’ register should not apply handcuffs to a patient nor be handcuffed to a patient.

9.4 Ty LLywelyn Handcuff trainers are required to maintain their skills via attendance and completion of trainers' training updates via:

Security Training Department
Merseyside NHS Foundation Trust
Indigo Building
Ashworth Hospital
Maghull
Merseyside
L31 1HW

10. MONITORING AND REVIEW

10.1 Ty Llywelyn will produce a *Use of Handcuffs* report quarterly which provides details of when handcuffs have been used in the service. Reports are distributed to Service Directors and Senior Managers and to the County Wide Services Senior Management meeting at its monthly meeting. The report will be reviewed by the leadership team with the support of the Centre Positive Interventions Clinical Support Service team.

10.2 In the instances of emergency handcuff use consideration will be given to completion of DATIX.

10.3 This policy will be reviewed every 3 years, or sooner where a need is identified. The Service Manager is responsible for ensuring the reviews are carried out

11. SUPPORTING DOCUMENTS/BIBLIOGRAPHY

Criminal Law Act 1967

Department of Health (2008) *Code of Practice, Mental Health Act 1983*: TSO

Department of Health (2008) *Reference Guide to the Mental Health Act 1983* London: TSO

Human Rights Act 1998

Mental Health Act 1983 (amended 2007)

Mental Health Act Code of Practice for Wales (2016)

MOJ form (Annex B), *Medical Leave application for restricted patients R (on the application of Graham) v Secretary of State for Justice [2007]*

[This provides interesting insight into a ruling on whether or not the handcuffs of a prisoner who was escorted for hospital treatment could constitute and infringement of his rights under Article 3 of the European Convention on Human Rights. Article 3 forbids torture and inhuman or degrading treatment.]

Appendix 1

Use of Handcuffs – Application for Authorisation Record Sheet

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Reason for request for use:

Risk Assessment:	
Current Leave Status:	**Destination:**
Nature of Escort:	**Need for Escort:** **Low** **Medium** **High**
Index Offence:	
Past/recent history of absconding:	**Risk to public, staff or self:**

Current Mental State:	
Patients current physical state, (particularly conditions relevant to handcuff use, e.g. muscular-skeletal injuries):	
Risk assessment of destination/ Things to consider:	
Circumstances in which handcuffs may be removed & reapplied while outside of secure services:	
Staff escort number:	**Ratio and gender of staff to patient:**
Risk assessment related to risk of escape from the secure perimeter:	
Date:	**Completed by Print & sign:**

Authorisation 09:00 – 17:00 hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**
Declined by: (Name)	**Signature:**	**Date:**

Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Authorisation Out of Hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Appendix 2

Use of handcuffs – Use form

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Handcuffs applied by (Name):	**Signature**	**Date:**
Secure Transport used: **YES** ☐ **NO** ☐ **Handcuff use directs the use of secure transportation.**		
DETAILS OF EVENT / INCIDENT & GENERAL SAFETY PROCEDURES CARRIED OUT:		
Handcuffs removed by (Name):	**Signature:**	**Date:**

ANY INJURIES SUSTAINED:	**YES** ☐ **NO** ☐
IF YES, PLEASE GIVE DETAILS INCLUDING CAUSE OF INJURY:	
SEEN BY DOCTOR:	**YES** ☐ **NO** ☐
DATIX COMPLETED:	**YES** ☐ **NO** ☐

COPY AND SEND TO:	
Locality Manager Forensics	☐
Modern Matron Forensics	☐
Ward Manager	☐

Appendix 3

Handcuff use -Handcuff Condition Log Daily Check

Date:	Time:	Checked by: (print name)	Condition of Handcuffs/ Action Taken:	Signature:

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?	Use of Handcuffs in Ty Llywelyn Medium Secure Unit
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This is an assessment of the impact of the implementation the Use of Handcuffs in Ty Llywelyn Medium Secure Unit Policy for Forensic Mental Health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when utilising high risk escorted leave that require planned use of Handcuffs.
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?	Forensic Service Management team
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Therapeutic Engagement and Observation Policy Ty Llywelyn Security Policy Ty Llywelyn Escort Policy Ty Llywelyn Section 17 Therapeutic Leave Policy Code of Practice for Wales 2016
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	BCUHB MSU Patient Group Families and Carers Ministry of Justice
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Patient awareness sessions

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		Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy for both staff and patients.
Disability	Neutral		Disability will be taken account for patients, staff and others by way of regular risk assessment of any individuals residing or working in Ty Llywelyn who has a recognised disability which requires adjustments to be made.
Gender Reassignment	N/A		Gender reassignment would be taken into account for the patient on admission and for staff following pre leave planning stage, risk assessment.
Pregnancy & Maternity	Neutral		No impact to patient group – All male. Escorting staff will require risk assessment to ensure high risk escort and application of handcuffs is appropriate in line with BCUHB policy.
Race / Ethnicity	N/A		An individual's race / ethnicity will be fully taken into account during care and treatment planning and leave risk assessment.
Religion or Belief	N/A		Religion and belief would be taken into account on admission and included in the care and treatment plan. Consideration given to escorting staff beliefs and religious ideation when planning leaves, although no impact when using handcuffs.
Sex	N/A		The gender of any escorting staff will be taken into account and included in any risk assessment carried out prior to leave out of the unit being authorised however the use of handcuffs should not have an impact on gender.
Sexual Orientation	N/A		Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation although this will not impact on any individual staff member or patient.
Welsh Language	Neutral		The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning Welsh language will be taken into account when planning all leaves and explanations of policy use can be provided in the medium of welsh if required.

Human Rights	Neutral		Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice.

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 policy operates within the mental health act code of Practice legislation and use of handcuffs will be pre planned and care planned following documented risk assessment from the clinical team.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Enables staff to reduce the risks presented to the patient and others when utilising high risk leave outside of the secure perimeter of the medium secure unit when accessing additional treatment, supporting court attendance and hospital transfer.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of collaboration and support between Forensic services, Wider BCUHB services, Police, Probation the Courts and Prison service.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Use of Handcuff in Ty Llywelyn Medium Secure Unit

2. Brief Aims and Objectives: (Copy from Form 1)	This is an assessment of the impact of the implementation of Use of Handcuff in Ty Llywelyn Medium Secure Unit Policy for forensic mental health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when planning, applying for and implementing safe use of Handcuffs within Ty Llywelyn, Medium Secure Unit.

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 your document or proposal?	Yes X	No
	How is it being monitored?	All incidents of Handcuff use will be reviewed by Ty Llywelyn clinical team and datix completed for review by Mental Health division governance / Putting things right team.
	Who is responsible?	Ty Llywelyn Clinical team
	What information is being used?	Existing record keeping process within the medium secure unit including risk assessments, use of handcuff documentation to be reviewed by modern matron.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	During next policy review

7. Where will your decision or policy be forwarded for approval?	MH/LD divisional policy meeting

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Policy approved by BCUHB, Forensic senior management team, Health inspectorate Wales and WHSSC also involved. Policy also went for Consultation with Ty Llywelyn staff group.

9. Names of all parties	Name	Title/Role

involved in undertaking this Equality Impact Assessment:		
	Simon Allen	Service manager
	Paul Hanna	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:			
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.	Circulation and communication of the Policy document Staff training and awareness Patient awareness sessions	Modern Matron / Ward Managers	Following approval of policy

Quality, Safety & Experience Committee

24.9.19

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

To improve health and provide excellent care

Report Title:	Threats to the Person in Forensic Establishments Policy MHLD 0008
Report Author:	Ian Jones Practice Development Nurse/Security Lead Simon Allen Service Manager
Responsible Director:	Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	Ratification
Approval / Scrutiny Route Prior to Presentation:	MHLD Policy Implementation Group MHLD Divisional Q-SEEL MHLD Divisional Directors Professional Advisory Group – Chairs Approval Quality Safety Group
Governance issues / risks:	The Policy provides the framework for the management of specific high risk scenarios which would trigger the implementation of the Ty Llywelyn Medium Secure Unit Major Incident Protocol (MIP). Although these are not the only circumstances in which the MIP would be activated they are the high risk scenarios which would give concern for immediate threat to life and limb within the unit. The policy would be activated in the event of the following high risk scenarios at Ty Llywelyn: • Violent Disorder/Riot Situation • Hostage Situation • Detection of a firearm • Explosive Device Threat/Suspicious Packages
Financial Implications:	There would be no additional financial Implications
Recommendation:	The QSE Committee is asked to ratify the policy.

MHLD 0008

Threats to the Person in Forensic Establishments Policy

Author & Title	Ian Jones Practice Development Nurse/Security Lead Simon Allen Service Manager				
Responsible dept / director:	Mental Health/Learning Disability Division				
Type of Document	Policy				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval QSG 11.09.19				
Date approved:	As draft April 2019 whilst progressing through HB ratification				
Date activated (live):	April 2019				
Documents to be read alongside this document:	Ty Llywelyn Security Policy Ty Llywelyn Major Incident Protocol Fire Safety Policy Postal Packets Policy				
Date of next review:	February 2022				
Date EqIA completed:	March 2019				
First operational:	June 2016				
Previously reviewed:	Jan 2019				
Changes made yes/no:	No				
Details of changes since last review					

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

1. Introduction/Overview

Ty Llywelyn is a medium secure unit which accommodating male patients between the ages of 18-65, usually detained under the Mental Health Act (1983). Patients in Ty Llywelyn are deemed to require secure conditions in order to manage the risk that they pose to themselves and the wider public and to manage the potential for absconding.

The nature and function of the service requires the Health Board to have a policy in place to ensure that staff are aware of the processes in place to enable them to deal effectively and safely with a number of high risk, threat situations.

2. Policy Statement

The policy exists to provide a framework for the management of specific high risk scenarios which would trigger the implementation of the Ty Llywelyn Major Incident Protocol (MIP). Although these are not the only circumstances in which the MIP would be activated they are the high risk scenarios which would give concern for immediate threat to life and limb within the unit.

3. Aims/Purpose

The policy will provide a framework to enable staff to deal effectively and safely with these scenarios.

4. Objectives

The policy will enable staff to recognise and respond to incidents which would trigger the implementation of the Ty Llywelyn Major Incident Protocol.

5. Scope

- All staff employed within Ty Llywelyn Medium Secure Unit.
- Forensic Psychiatric Service Management.
- BCUHB Senior Management

6. Roles and Responsibilities

The enactment and escalation of the policy remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit. Forensic Service Management and BCUHB Management group.

7. Main Body

a) VIOLENT DISORDER/RIOT SITUATION

Violent Disorder/riots are exceedingly rare occurrences. They can be spontaneous or pre-planned outbreaks of determined disruption to the service by persons(s) using violence and/or acts of destruction and can be dangerous to public, patients, staff, visitors and others. There may also be a financial implication when damage occurs to buildings and internal fixtures and fittings

Violent Disorder/riot is defined as ‘A violent disturbance of the peace ’and ‘The breakdown of peaceful and law abiding behaviour’ (Oxford English Dictionary).Riot-Where twelve or more persons who are present together use or threaten unlawful violence for the purpose and conduct of them (taken together) is such that it would cause a person of reasonable firmness present at the scene to fear for his personal safety each of the persons using unlawful violence for the common purpose of riot.(Public Order Act 1986) Within Ty Llywelyn Medium Secure Unit this would manifest as a group of people acting collaboratively to cause harm to staff or fellow patients, to destroy / damage property and or attempt escape from the secure hospital.

Violent Disorder/riots can be unpredictable and so it can be difficult to plan specific responses in advance. This protocol is concerned with the prevention and management of riot / serious disturbance and returning the unit to normal operation as soon and safely as possible should the situation occur.

Prevention

All threats and/ or intelligence in relation to patient disorder must be taken seriously and reported immediately to the most senior member of staff on duty. Such a situation requires full assessment and patients may need to be isolated and moved around the unit as required to minimise the potential of riot or serious disturbance.

Occasionally, individual patients may resist planned interventions, or may become disturbed in their behaviour and be thought to be at increased risk of violence due to mental state. This policy is not intended to provide guidance for managing inpatient violence or aggression that would normally be considered in the patients risk management plan. Please refer to ‘Proactive Reduction and Therapeutic Management of behaviours which challenge’ Policy (MHLD 0049) for this guidance.

Management of Incident

Violent Disorder/riot is deemed to have occurred if:

- Individuals make a determined attempt to disrupt operation of the service, using violence and/or damage to property, to a level that puts the safety and well being of the public, themselves and/or others within the unit in jeopardy, or;
- Individuals threaten to breach security within or beyond the perimeter of the unit, and
- If It is beyond the resources of staff to restore safety and therapeutic mileu

Priority is to preserve the safety of as many people as possible by withdrawing from the immediate vicinity and directing non participating patients, staff and others to a safe area.

Staff must not engage if perpetrators are brandishing / purporting to or suspected of possessing weapons.

The most senior member of staff within Ty Llywelyn (Incident Officer) must determine whether the incident requires the instigation of the Ty Llywelyn Major Incident Protocol and activate the Protocol accordingly.

Local intervention may be implemented to restore order when:

i. The incident is contained.
ii. There is no further risk of serious injuries.
iii. Non-participants are not trapped within the vicinity.

iv. Damage to the environment is not extensive and poses no public safety risk.

If the situation does not meet any of these criteria, and there is little prospect of local resolution the Ty Llywelyn Major Incident Protocol must be activated.

Post Incident Management

Account for all patients and staff and determine their wellbeing and whether medical or other assistance is required, provide clean area for patients to reside whilst staff carry out post incident procedures and are able to resume normal patient supervision, which may involve transfer to other areas.

Assess riot participants and determine care, treatment and placement needs (this may include police custody).

If the Ty Llywelyn Major Incident Protocol has not been initiated staff may need to preserve evidence and photograph any damage. The area of the incident should only be cleared when given clearance from senior staff and following liaison with police and fire service.

Contact Estates to secure, remove or repair any unsafe items after damage has been recorded.

Arrange for senior staff to provide debrief sessions for staff and patients.

Ensure that all relevant documentation is completed with statements These will be collated by Modern Matron and provided to police as required.

b) HOSTAGE SITUATION

Definitions

This document will adopt the following definition for hostage situations :'A person seized or held as security for the fulfillment of a condition'(Oxford English Dictionary): 'an incident in which a person is unlawfully held against his/her will, usually through the use of threats or when actual physical force is used'(Cambridge English Dictionary).Hostage Taking. A person ,whatever his nationality who in the United Kingdom or elsewhere a) Detains any other person ("The Hostage") and b) in order to compel a State international or governmental organisation or person to do or abstain from doing any act, threaten to kill, injure, or continue to detain the hostage.(Taking of Hostages Act 1982). The perpetrator of the act will be referred to as the 'hostage-taker' and the victim as the 'hostage'. It is also worth remembering that there could, in situations of this nature, be more than one hostage-taker or hostage.

General Principles

Should a hostage situation develop anywhere within Ty Llywelyn, it must be regarded as serious by all staff members and lead to initiation of the Ty Llywelyn Major Incident Plan.

First-on-Scene

This term refers to the person discovering a hostage situation and is a crucial stage in determining a successful outcome.

Resist the temptation to intervene verbally or physically as this may inflame the situation and endanger any hostages.

Upon being made aware of a hostage situation staff must notify the Senior Nurse on the unit immediately, await instructions, and not return to the incident unless instructed to do so.

The most senior member of staff must initiate the Ty Llywelyn Major Incident Protocol and identify an Incident Manager

Incident Management

Evacuate the immediate area quickly and quietly and ensure that all staff, service users and visitors are safe and accounted for.

The incident area and immediate surroundings should be designated a secure area.

For the course of the hostage situation only key personnel should be allowed access into this area i.e. those who have a specific role or involvement in managing the incident.Staff must maintain safe distance from the hostage situation.

Non-essential staff, service users and visitors are not allowed in secure areas.

Once notified, the parameters of the secure area will be reviewed by the Incident Manager.

Observation

It is important to gather as much information as possible regarding the incident as this may help the police and Incident Manager in their overall strategies. Make a note of the following:

- What has happened?
- Who is involved .How many hostages or hostage takers are there involved .Gender of all involved.
- Where they are.
- Any weapons or barricades involved.
- Any injuries, including the hostage-taker.
- The mental state and mood of the hostage-taker and hostage.
- Any evidence that drugs or alcohol are involved.
- Any relevant environmental factors such as damage to the building, wet floors etc.
- Any relevant physical medical conditions history (angina, pregnancy etc)
- Have the hostage takers issued any demands /reasons.

Other Staff

The following are important points for other staff to note:

- Do not attend the scene unless specifically told to do so.
- Respond to all delegated tasks quickly and calmly.
- Keep phone-lines clear – make only essential calls and keep them brief.

Post-Incident Process

Post incident process should be followed as per Ty Llywelyn Major Incident Plan.

c) DETECTION OF A FIREARM

Ty Llywelyn maintains a restricted items list (Ty Llywelyn Security Policy) in order to prevent contraband items from entering the premises. Firearms, naturally, are contained within the list of contraband items and it remains incumbent upon all staff to apply procedures rigorously to deter attempts to introduce a firearm via any route. This procedure and the secure structures at the perimeter of the unit constitute one aspect of the clinic's preventative measures.

For other preventative measures please view Ty Llywelyn Security Policy.

However unlikely a firearm incident may appear, staff must remain conversant with this policy and retain a working knowledge of the following procedures.

(i) **Action to be taken upon discovering a firearm within the unit.**

If it is safe to leave the firearm undisturbed, whilst preventing access to it by others, then the area should be preserved as a scene-of-crime for police investigation. During regular office hours The Service Manager / Modern Matron On-Call Consultant should be contacted by the most senior staff member (Incident Officer) at the scene for advice. Do not touch the firearm. In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational on-call guidelines.

If it is not safe to leave the firearm in situ, preserve the scene as best you can, remove the firearm to the Incident Officer who should ensure that the firearm is removed to a non-clinical area. Make no attempt to unload or "make safe" the weapon. Treat the firearm as if it is loaded and ready to fire. Do not carry it by the trigger or with fingers inside the trigger guard. If you can avoid touching the firearm you should, to preserve forensic evidence, e.g. by carrying it inside a plastic bag. Staff should be aware that 'home-made' firearms do not always present as conventional weapons and caution should be adopted around the discovery of suspicious devices.

If you cannot avoid touching the firearm, carry it by the barrel with the barrel pointed at the floor. Wherever possible, obscure the firearm from view e.g. wrapped in paper/material. Never insert objects i.e. pens, into the barrel/trigger guard to carry the firearm.

The Incident Officer or delegated other will contact the police, advise them a firearm is being held and their attendance at scene is required.

Discovery of ammunition should be managed in the same cautious manner.

(ii) **Action to be taken should a person be known/suspected of being in possession of a Firearm within the Unit.**

Contact the police by ringing 999 advise them that we have activated the Major Incident Protocol as a firearm has been detected or an individual is known or suspected of being in possession of a firearm.

Whenever the Major Incident Protocol is activated in the suspicion of firearm possession Reception staff must be informed in order that they can facilitate police access and limit unnecessary access to the unit.

Under no circumstances should the person be challenged nor any attempt made to encourage surrender of the firearm nor to disarm them forcibly.

All other patients, visitors and staff should be removed from the vicinity of the individual suspected of being in possession of a firearm. Once the area has been evacuated staff should leave the area, locking access doors behind them, creating a contained zone. The area should be vacated as calmly and covertly as possible.

Upon Police attendance at the Unit the Incident Officer will appraise them as to events in the designated Incident Management Room.

Police should be advised of pertinent patient health issues that may have a bearing on their deployment and operation.

Unit staff will co-operate fully both during the incident, whilst re-establishing order and in related post incident investigations/criminal proceedings.

(iii) **Roles and Responsibilities**

For an outline of roles and responsibilities refer to core roles and responsibilities in Section 10 of the Major Incident Protocol.

d) EXPLOSIVE DEVICE THREAT/SUSPICIOUS PACKAGES

Explosive device threats whether genuine or ‘false alarms’ are regrettable hazards of modern living. The nature of Ty Llywelyn as a Medium Secure Unit renders it more likely to be the subject of an explosive device threat. It is Ty Llywelyn policy that all notifications of an explosive device are treated as genuine until such time they are demonstrated to be hoax/malicious.

Hoax/malicious phone calls reporting explosive devices are a criminal offence and as such must be reported to the police.

Calls reporting explosive devices fall in to two categories:

- Threats where no device has actually been planted:

Such hoaxes may not be merely malicious and consideration must be given to them being an attempt to test security, disrupt or create diversion.

- Threats warning of a genuine device:

These may be attempts to avoid casualties but they also enable individuals to blame others in the event of injury.

Genuine threats are frequently inaccurate with regard to where and when a device may explode and staff receiving a telephone threat may not be trained in respect of such calls. While staff may be unable to assess a threat accuracy or origin their recall and impressions of the caller could be important.

It is acknowledged that receiving such a threat may have an adverse affect on staff members who may require counseling /additional support following the incident.

Explosive device threats must be taken seriously taking in to account the service provided and security/safety implications for patients, visitors and staff.

(i). Primary Aims and Objectives

- To ensure the safety of patients, visitors, staff and general public
- Inform Emergency Services
- To maintain Unit security
- To identify/discount the threat at the earliest opportunity
- To return the Unit to normal operation as soon as is safely practical

(ii). On receipt of a Telephoned Threat

During regular office hours The Service Manager/Modern Matron, On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward .In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.

It is important to gain as much information from the caller as possible. Do not interrupt the caller; try to keep him/her talking. Note down: (See Appendix 1)

a) Sex and approximate age of the caller
b) The tone of voice (deep, soft, slurred, intoxicated, angry, happy, nervous, confident)
c) Any specific characteristics (accent, speech impediment, unusual pronunciation)
d) Background noises (traffic, machinery, music)
e) Nature of call /coin box whether caller number displayed (phone 1471 for caller ID)
f) Did the voice sound familiar?

(iii) Try to engage the caller in conversation by asking the following questions:

a) Where has the device been placed?
b) When will it explode?
c) What does it look like?
d) What type of explosive is it?
e) Why has the device been placed here?
f) Attempt to get the caller/ organisation name

(iv) .Follow on actions

a) Note the time of the call
b) Telephone Police using 999 giving details of the call/ Activate Ty Llywelyn Major Incident Protocol
c) Ring 1471 (If the telephone has that facility) or contact switchboard to attempt to trace caller number
d) During regular office hours The Service Manager/Modern Matron, On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward .In

the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.

e) Evacuate the area by activating fire alarm system and carry out the evacuation procedures as for fire

(v) .Letter Bombs /Parcels

Such devices could be delivered through normal postal services (Royal Mail, Courier) or by hand.

(vi) Staff suspicions may be aroused by:

a) Weight-If excessive for size and apparent contents
b) Grease marks on the wrapping exterior i.e. Seeping from inside the package

(vii) . If suspicions cannot be alleviated:

a) Do not attempt to open or tamper with the package/letter.
b) Inform the police immediately/Activate Ty Llywelyn Major Incident Protocol
c) Evacuate the area using fire alarm procedure.
d) Do not use Unit Radios/Pagers/Mobile phones within 30 metres as this could lead to device detonation.

8. Training

The importance of training cannot be over emphasised in terms of amelioration of the risk of threats to individuals within Forensic settings. It is recognised that the nature of risk can be fluid and therefore training and update of all staff is essential. This will be achieved through initial induction training and annual unit staff update as a facet of the in house Ty Llywelyn training plan

9. Audit

Annual audit will be undertaken through review of unit training records and DATIX incidents relating to threats towards the person in Forensic Establishments ie. Ty Llywelyn

10. Review

Every three years

11. Appendices

APPENDIX 1

EXPLOSIVE DEVICE THREAT TELEPHONE CALL INFORMATION SHEET

(Please retain in Reception/Ward Offices)

Date……..

Time Call Received…….hrs

Time caller hung up…….hrs

Exact words used by caller:
……
……
……
……
……
…….....

Questions to ask:

Where has the device been placed?

……

…….....

When will it detonate?.....(date/time)

What does it look like?

.....

What kind of explosive is it?

.....

Why did you place the device here?

.....

Name of caller/ Organisation involved

.....

DESCRIPTION OF CALLERS VOICE

Male/Female (Please circle)

Approximate age:

Young…… Middle Aged…… Elderly……

Tone of voice (deep, soft, slurred, intoxicated, angry, laughing, nervous, confident)

.....

.....

.....

Any special characteristics (accent, speech impediment or unusual pronunciation)

.....

.....

Background Noises (traffic, machinery, music)

.....

.....

.....

Call from a call/coin box and telephone number if shown on your telephone display screen:

.....

.....

.....

Did the voice sound familiar?

.....

.....

.....

If so who did it sound like?

.....

.....

.....

Give a summary of anything peculiar that you may have sensed or thought of during the call. Although it may not seem significant it could be of great value when associated with past or future calls of this nature.

Remarks:

.....

.....

.....

.....

.....

.....

Senior Staff Informed (Service Manager, Modern Matron, Consultant on Call, Bronze on call)

Details:

.....

.....

.....

Time Informed……..hrs

Person receiving threat phone call:

.....

(If necessary please use other side for additional info)

- **References**

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice 2008
The Mental Health Act Reference Guide 2008

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	**Title**
Simon Allen	Service Manager
Lisa Jones	Modern Matron
Ian Jones	Practice Development Nurse
Greg Yates	Ward Manager

Engagement has taken place with:

Name	**Title**	**Date Consulted**
North Wales Police		January 2019
Ty Llywelyn Staff		January 2019
BCUHB Fire Officer		January 2019

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.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. 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 equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Threats to the Person Procedures in Forensic Establishments	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.	
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 Divisional Directors Forensic Mental Health Service Management Team	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Ian Jones	Practice Development Nurse/Security Lead
		ISimon Allen	Service Manager
		Lisa Jones	Modern Matron
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013) National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RPsych 2010) Firearms Act 1968	

6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

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 (3) any other information that has informed your assessment of Potential Impact.
	Positive (**+**) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	(N)	Neutral (N)	Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Disability	(N)	Neutral (N)	Disability will be taken account of for patients, staff and others by way of regular risk assessment if an indivudal in the environment to which the policy applies has a disability which requires adjustments to be made. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Gender Reassignment	(N/a)	Neutral (N)	The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	Any pregnant women working in the environment to which the policy applies will have an up to date risk assessment in place. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Race / Ethnicity	(N)	Neutral (N)	An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy this policy. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account as far as is safe and practical to do so. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.

Religion or Belief	(N)	Neutral (N)	There is a risk that implementation of this policy might result in triggering of the Ty Llywelyn Major Incident Plan. This might in turn might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which this policy caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident. Any disruption to the environment which has an impact upon any individals ability to adhere to the customs of their faith will be managed accordingly to allow for worship as soon as is safe. The ability to adhere to principles of faith during an incident where security is acutely compromised cannot be guaranteed. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Sex	(N)	Neutral (N)	The in patient unit currently has single sex facilities only but during implementation of this policy we cannot guarantee that any change in the environment in which the individual is temporarily cared for will be single sex. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the policy. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.
Welsh Language	(-)	Low positive (+)	The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of this policy we cannot guarantee that a change in the environment in which the individual is temporarily cared for may not comply with the Welsh Language Act. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.

Human Rights	(N)	Neutral (N)	Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm.

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 the table below 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.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

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 policy is designed to protect vulnerable individuals from incidents which present immediate risk of harm to life and limb. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm. Regardless of age, gender, religon, disability, sexual orentation, race and ethinicty no individual is exempt under UK Law.
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)	It provides an approach that strengthens the concept of co-working and collaboration between different partner organisations to ensure achieving a common aim of patient and public safety and security.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Threats to the Person Procedures in Forensic Establishments

2. Brief Aims and Objectives:	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes ☒	No ☐
3b. Could any of the protected groups be negatively affected?	Yes ☒	No ☐
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes ☐	No ☒

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? There may be an impact upon the ability to care for people through the Welsh language as the Mutual Aid acute dispersal plan which could be activated if the Major Incident Plan is triggered indicates that patients will be moved to a hospital in England whilst Ty Llywelyn in out of use. BCUHB will endeavour to send Welsh speaking staff with these patients wherever it is possible to do so and will prioritise this issue.	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☒	Not applicable ☐
	Record Details:		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Robust multi agency debriefing process post incident
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	December 2021

7. Where will your decision or policy be forwarded for approval?	BCUHB Board Level

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Distribution of policy for comment to MH/LD Division BCUHB / North Wales Police / BCUHB Fire Officer

	Name	Title/Role

9. Name/role of person responsible for this Impact Assessment	Simon Allen Ian Jones	IService Manager Practice Development Nurse
10. Name/role of person approving this Impact Assessment	Statutory compliance committee	
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 (or have already made) to your document or proposal as a result of the EqIA?			
3a. Where negative impact(s) 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 impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

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Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Quality, Safety & Experience Committee

24.9.19

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

To improve health and provide excellent care

Report Title:	Major Incident Protocol – Ty Llywelyn Medium Secure Unit
Report Author:	Ian Jones Practice Development Nurse/Security Lead Simon Allen Service Manager
Responsible Director:	Mr Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	Ratification
Approval / Scrutiny Route Prior to Presentation:	MHLD Policy Implementation Group MHLD Divisional Q-SEEL MHLD Divisional Directors Professional Advisory Group – Chairs Approval The protocol involved consultation and agreement with Elysium Healthcare (Spinney Hospital,Atherton, Manchester) in terms of signed off mutual aid agreement
Governance issues / risks:	This protocol developed with partner agencies provides guidance in the event of a major incident affecting the provision of services at Ty Llywelyn Medium Secure Unit, Llanfairfechan.In the event of the unit having to be evacuated there is a clear plan in terms of alternative accommodation for patients based on legal status and clinical issues.This A mutual aid agreement is in place with Elysium Healthcare who have a Medium Secure Facility in Atherton ,Manchester.
Financial Implications:	It is not envisaged that there would be additional financial implications.
Recommendation:	The QSE Committee is asked to ratify the document

MHLD 0009

MAJOR INCIDENT PROTOCOL - TY LLYWELYN MEDIUM SECURE UNIT

Author & Title	Ian Jones Forensic Practice Development Nurse Simon Allen Service Manager
Responsible dept / director:	Director of Mental Health & Learning Disability Division
Approved by:	MHLD Policy Implementation Group – 7th May 2019 MHLD Q-SEEL 16th May 2019 PAG August 2019 Chairs Approval QSG September 2019 QSE
Date approved:	16th May 2019 as draft whilst progressing through Health Board processes
Date activated (live):	May 2019
Documents to be read alongside this document:	• Ty Llywelyn Mutual Aid Agreement • Forensic Service Business Continuity Plan • Ty Llywelyn Operational Policy • Ty Llywelyn Security Policy • Fire Procedure • Threats to the Person in Forensic Establishments Policy
Date of next review:	May 2020
Date EqIA completed:	January 2019

First operational:	2014				
Previously reviewed:					
Changes made yes/no:					

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

1. Introduction/Overview

Clinical services for mentally disordered offenders in North Wales are provided by the Forensic Mental Health Services.

Tŷ Llywelyn is a 25 bedded purpose-built Medium Secure Unit on the Bryn y Neuadd Hospital site, Llanfairfechan.

The Unit provides assessment, treatment and rehabilitation for patients who, with the appropriate balance of care, are considered likely to recover and ultimately return to their own communities.

Referrals are taken from a variety of sources including the generic Mental Health Services, Criminal Justice System, GPs, Prison Services, Special Hospitals and Social Services.

The care and treatment of every patient is planned and regularly reviewed by a team which includes Consultant Psychiatrists, Nurses, Social Workers, Therapists and Psychologists.

The standards for MSU's specify that all Units should have contingency / major incident protocol, and that this must be agreed with the Police and other Emergency Services covering as a minimum Hostage Taking, Serious Disorder, Riot and Escape (NICE 25,Ty Llywelyn Threats to the Person in Forensic Establishments Policy). The purpose of such a protocol is to ensure the safety of patients, visitors, staff and others in addition to:

- Maintaining security
- Discovering or discounting the threat at the earliest opportunity
- Returning the unit to normal routine as soon as safely possible
- Assisting the Police in establishing the origin of the threat

2. Protocol Statement

The Major Incident Protocol provides BCUHB with the framework for the most effective response to significant incidents and adverse circumstances which have the potential to occur within the secure in-patient environment of Ty Llywelyn Medium Secure Unit. It also guides the organisation through the crisis response phase of a major incident and towards the implementation of a Business Continuity and Service Recovery Plan.

3. Aims/Purpose

The Major Incident Protocol (MIP) is aligned to a series of procedures specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn that have the potential to occur. These scenarios could include, amongst others:

1. Fire
2. Hostage
3. Bomb threat
4. Firearms

5. Violent Disorder / Riot
6. High risk absconsion

These scenarios have their own specific procedures to confirm and direct action appropriate / specific to the nature of the scenario. These all dovetail the Major Incident Protocol (MIP), which acts as the overarching protocol for the co-ordination and management of any Major Incident Scenario. The MIP provides a framework for the most effective response to the above scenarios plus any additional scenarios that would render the entire MSU or part thereof uninhabitable to inpatients and unsuitable for staff occupation. The management of any scenario or type of major incident with the MIP will be in accordance with available resources and aim to ensure the most prompt return to normal operational status and practice. In order to ensure a response appropriate to the nature of the Major Incident and in acknowledgement of the variance between the above scenarios, the various agencies and departments with a role and function sign up to 'Memorandums of Intent' and in doing so they commit to the details within the Protocol ensuring the safety of both MSU patients and members of the public, thereby maintaining an effective and fast response to the major Incident situation.

The MIP advises partner agencies and organisations of the MHLD Divisions responsibilities, protocols and specific procedures for co-coordinating a response to a Major Incident. These partner agencies include Welsh Government, HIW, WHSSC, neighboring general hospitals and mental health units, Local Authorities and Emergency Services.

4. Objectives

The document provides the framework for a safe, effective coordinated response to a major incident occurring within Ty Llywelyn Medium Secure Unit and where the transfer of patients to appropriate alternative accommodation indicated

5. Scope

The document relates to all staff employed within Ty Llywelyn Medium Secure Unit.
Forensic Service Management team
BCUHB senior management

6. Roles and Responsibilities

The enactment and escalation of the protocol remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit, Forensic Service Management and the wider BCUHB Management group.

7. Main Body

7.1 Prevention

The above events are extremely rare occurrences within MSU's. Tŷ Llywelyn operates as a secure environment in line with Royal College of Psychiatry Minimum Standards for Medium Secure Units which include:

- A physical environment incorporating security features such as perimeter fencing, locked areas and external/internal CCTV.

- A high level of security awareness and relational security training amongst staff.
- Detailed pre-admission assessments highlighting prior risk of offending behaviour.
- Comprehensive multi-disciplinary individual patients risk assessments.
- Appropriate levels of observation whilst patients are both within the MSU and the community.
- Provision of high quality patient care in line with the Mental Health Measure (Wales).
- Fostering a positive culture between staff and patients in which patients can feel influential over their care and the environment.
- Adequate staffing levels.
- Adherence to local and organisational policies and procedures

7.2 Categorisation of Incident

An incident within the secure perimeter of the MSU resulting in the entire loss of the clinical environment and requiring the immediate safe transfer of all patients is categorised as a **CLASS A INCIDENT.**

An incident within the secure perimeter of the MSU, that results in only a partial loss of the clinical environment requiring the safe transfer of only some of the patients to alternative temporary accommodation is categorised as a **CLASS B INCIDENT**.

7.3 Categorisation of Patient

MSU patients present various levels of risk, which, in association with the legal requirements for safe custody of all patients will necessitate the need for a clear classification system to denote the risk profile for each patient. This specific risk profile will exist only for the purposes of the MIP and will not be used to assist day to day clinical management of the patient population.

It is the responsibility of the Responsible Clinician / Multi-Disciplinary Team to establish each patient's risk profile which will be recorded in the patient's notes, the MIP Incident Bag. Categorisation will take place prior to admission to Ty Llywelyn and be reviewed and recorded in clinical notes fortnightly at the Clinical Team Meeting.

Category 1 Patients

This group of patients would be those most likely to abscond, be detained under a restriction order, have no leave outside the unit or whose mental state would be seen as currently having deteriorated to such a degree as to pose a high risk. Included in this category would be patients on trial leave from high secure hospital and prisoners transferred to hospital for assessment also patients where there has been a high level of media attention or issues of sensitivity relating to their offence. This group will require a highest level of security in transfer to any temporary placement alternative appropriate custody.

Category 2 Patients

This group of patients would be those who would require close monitoring, may be subject to restriction orders and have some degree of escorted leave outside the unit. Some of these patients could be accommodated temporarily in alternative

appropriate accommodation. This may include a Psychiatric Intensive Care (PICU) placement or alternative medium or low secure placement.

Category 3 Patients

This patient group would be at a stage where they already have unescorted grounds / community leaves and, as such, are deemed a lower risk. These patients would be able to be grouped together to enable their movement to temporary accommodation with a much reduced escorting resource and might typically be placed within an open acute ward within the Division or a psychiatric rehabilitation unit. Some of these patients may have commenced their graduated discharge plans to areas of lesser security and, with MOJ permission; these patients could be temporarily advanced to the appropriate placement.

7.4 Transfer and Conveyance

The MOJ must be contacted and provided with details of detained patients under Court Section, together with the location where these patients are to be temporarily detained. The MOJ will then give verbal authorisation and if necessary confirmation via email to the effect that a Warrant has been issued for the transfer of such patients to the alternative appropriate environment. The MOJ has a 24 hour telephone number (020 70 35 48 48).

- Patients should be grouped according to their categorisation status with the first consideration being to move Category 1 patients securely and safely off the premises to their temporary accommodation.

- These patients will be given priority by MSU Staff, Police and additional Emergency Services in attendance and, wherever practicable, will be placed in health vehicles for safe transfer.

- Category 2 and 3 Patients can then follow supported by remaining MSU staff and Emergency Services until all Patients have been safely evacuated from the Unit.

- Should a decision be made to transfer a patient by emergency service vehicles, MSU staff will remain in attendance as a health escort unless otherwise indicated by emergency services risk assessment.

- Patients being transferred out of Tŷ Llywelyn MSU to temporary alternative appropriate environments will be supervised by Tŷ Llywelyn staff wherever necessary. Observation levels need to be maintained in line with individual Patient's Care and Treatment Plans / MHM documentation.

- The care of transferred detained Patients from the MSU remains the responsibility of the MHLD Division / BCU, even if in temporary Police custody or an alternative public sector or private secure environment. (See Mutual Aid Agreement)

  Staff will ensure that appropriate vehicles will be used dependent on level of risk; the division has agreed all available vehicles will be handed over. Ty Llywelyn Community Team pool car keys are held in the upstairs team office in Ty Llywelyn

7.5 Activating Major Incident Protocol

The MIP will be activated by telephoning the Emergency Services via 3333 whereby Reception will then contact the emergency services stating that the 'Major Incident Protocol' needs to be activated for the Tŷ Llywelyn MSU because of:

- Fire
- Hostage
- Bomb threat
- Firearms
- Violent Disorder / Riot
- High Risk Absconsion

The caller should request that the Force Incident Manager (FIM) initiate a response in line with the agreed MIP. This will enable the emergency services to recognise the call as:

- Genuine
- Of Serious Nature
- Requiring a pre-agreed response
- Necessary to ensure public protection

The emergency services will set into motion appropriate responses according to the incident type which may result in the deployment of police officers and other emergency services as necessary, to the MSU in response to the incident.

The strategies required of the Police / emergency services and Tŷ Llywelyn staff will be different for each specific type of Incident and are described under the separate procedures for each incident. These should be read and followed in conjunction with the MIP once the Major Incident Protocol has been activated. MSU staff should cross reference between documents as applicable.

Awareness of the content of the MIP is not sufficient in preparation to deal with each of the six types of incident listed above. All MSU staff needs to maintain a high level of awareness of the content of each of these separate procedures in addition to the Major Incident Protocol.

7.6 Stakeholder Responses

In the event that Police intervention is required, the authority to act will be determined by the North Wales Police Command and Control Structure.

In all cases of a major incident, the relevant emergency service (in accordance with incident type) may deploy to Tŷ Llywelyn MSU, but will not automatically take charge of the incident or Unit. There are many areas where the emergency services can assist in restoring control of an incident without taking direct action or being the lead responsible agency.

If it is decided that an emergency service needs to be the lead agency and take direct action, they must first be granted permission to intervene by the MHLD Division / BCU. If required control of the unit can be signed over to emergency services by the most senior member of staff on duty. This document is to be retained

by the relevant emergency service which 'signs over' the unit to them allowing emergency services to enter and take the required action (Appendix 2). Prior to signing over the unit, the MHLD Division retains responsibility for events within the unit. A similar process and document needs to be signed upon conclusion of a major incident to confirm that control and responsibility has reverted back to the MHLD Division.

7.7 Major Incident Room

A Major Incident room should be established as soon as the MIP is activated. The location of the room will depend upon the extent of any damage to the MSU, risk to staff or need to locate the room elsewhere, e.g. on the Bryn Y Neuadd Site or another location The location of the room will be determined by the Incident Manager.

In the event of a Category A Major Incident affecting the whole of the MSU, the switchboard function, which operates from the Unit for the Bryn Y Neuadd site, would be transferred to another District General Hospital. The telephone number for the unit would be 01248 682101.Once the Major Incident Room is established, the main phone contact number must be communicated to all agencies. If mobile phones are required the ward mobiles can be collected from reception and used.

7.8 Roles and Responsibilities

Core roles and responsibilities have been identified to support successful activation of MIP (Appendix 1).

First on Scene
The role and responsibility of the first on scene is:

Preservation of life, safety and security.
Activation of internal alarm systems.
To advise the person in charge of the unit and take instruction.

The roles and responsibilities of specific individuals within the MIP are contained within Role Cards (Appendix 2).

These main roles are:

Major Incident Officer
(Take charge of the incident and establish a structured management plan in relation to the incident).

Staffing Coordinator
(Support and deploy staff as directed by the Major Incident Officer).

Communications Officer
(Ensure effective communication links across all agencies; carry out briefings as directed by the Major Incident Officer).

7.9 Post Incident

Once the major incident has been brought under control arrangements will be made to ensure the MSU can return to its normal operational function at the earliest

opportunity. Staff will be briefed as to timescales, any interim arrangements and adjustments specific to MSU patients temporarily located elsewhere and the impact on their roles, shifts and base.

Staff may be required, on a temporary basis, to work at another location within or outside BCUHB and will be supported by line managers to facilitate this. Staff will be expected to engage with any associated investigation indicated in the aftermath of a Major Incident. Staff will be supported by line managers and appropriate BCUHB Workforce and Organisational Development Department (WODD) who will give advice, guidance and support as necessary.

Anyone involved in a major incident may suffer the impact of trauma and stress, including professionals and patients. De-briefing allows for an assessment of the potential impact to be considered and following this Initial Impact Assessment the MHLD Division in association with Partner Divisions, WOD and the BCUHB Health at Work Department will develop and provide a programme of counseling and support in response to identified need.

7.10 Staff Awareness

It is the responsibility of all staff working within the North Wales Forensic Service to evidence appropriate knowledge and awareness of the MIP and associated specific procedures for various incidents

7.11 Mutual Aid Plan

Any activation of the MIP might require the instigation of the Mutual Aid Plan. The North Wales Forensic Service Manager / Modern Matron or senior clinician will confirm activation of the Mutual Aid Plan.

8. Equality including Welsh Language

EQIA completed
There is a risk that the implementation of the plan might result in an individual being temporarily cared for in an environment which might not address their immediate religious/faith needs. The nature of major incidents to which the plan refers means a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.

The organisational commitment to supporting the Welsh Language Act and service user language preferences are identified through assessment and care and treatment planning. However during implementation of the Major Incident Protocol it cannot be guaranteed that a change in the environment in which the individual is temporarily cared for may comply with the Welsh Language Act.

Application of this pathway will take in to account:

- Mental Health Measure(Wales 2010)
- Revised Adult Mental Health Services National Frame work
- Guidance for the Commissioners of Forensic Mental Health Services (2013)
- National Policing Improvement Agency Guidance on Command and Control

- Minimum Standards for Medium Secure Units (RPsych 2010)
- Mental Health Act 1983
- Code of Practice
- Human Rights Act 1998
- Mental Capacity Act 2005-Code of Practice
- Deprivation of Liberty Safeguards-Code of Practice

9. Resources

- Mutual aid agreement between BCUHB and The Spinney
- Ongoing in house staff security training.
- Ongoing liaison with Emergency services/partner agencies

10. Training

Ongoing in house staff security training takes place during staff induction and annually as part of security update training.

Training coordinated by Modern Matron/practice development .

Audit will take place annually as a facet of the training review

11. Implementation

The Major Incident Protocol (MIP) is aligned to a series of in house procedures/protocols specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn.

The document will be implemented when a high risk scenario occurs within Ty Llywelyn Medium Secure Unit, namely:

- Fire
- Hostage situation
- Explosive Device/Suspicious package
- Detection of a firearm
- Violent Disorder / Riot
- High Risk Absconsion.

12. Further Information - Clinical Documents

- Ty Llywelyn Operational Policy
- Ty Llywelyn Security Policy
- Fire Procedure
- Threats to the Person in Forensic Establishments Policy -
  (Hostage situation)
  (Explosive Device /Suspicious package Detection of firearms)
  (Violent Disorder / Riot)
  (High Risk Absconsion)

13. Audit

Audit will take place annually as a facet of the training review

Ward Managers and Modern Matron retain the responsibility to ensure staff receive training and update in respect of the situations and processes pertaining to the implementation of the Major Incident Protocol within Ty Llywelyn
It is envisaged that in the implementation of the Major Incident Protocol formal review of the processes would take place.

14. Review

Review will take place on a 3 year basis.

15. References

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice 2008
The Mental Health Act Reference Guide 2008

18. Appendices

Appendix 1 Role Cards
Appendix 2 Operational Handover Document
Appendix 3 Ty Llywelyn Major Incident Communications Log
Appendix 4 Major Incident Plan Evacuation and Movement Matrix
Appendix 5 Contingency/Mutual Aid Plan
Appendix 6 AWOL Form

MAJOR INCIDENT OFFICER	MAJOR INCIDENT ACTION CARD 1
Normal Role	Will always be the most senior member of staff at the location when an incident occurs. The role of Major Incident Officer may be handed over to a more senior member of staff at any time during the incident.
Major Incident Role	Establish the Incident control room
	To lead the major incident control team
	Coordinate strategic response to an incident until such time that the On-call Command and Control procedures are in place at the scene
The Major Incident Officer will take charge of the incident and establish a structured way in which to manage the incident	

Essential Actions

- Establish a major incident room as soon as the MIP is activated.
- Collect major incident bag which will contain essential equipment for incident coordination.
- Clarify with first on scene that contact with police has been made with Police by telephoning the Emergency Services via 3333 / 999 emergency number and that the Force Incident Manager has been instructed that the 'major incident protocol' needs to be activated.
- Appoint staff to the required roles of Staffing Co-ordinator and Communications Officer.
- Implement and adhere to the procedures specific to the nature of the major incident as each requires a variable response.
- Brief Police and other emergency services on their arrival and ensure that the Staffing Co-ordinator facilitates the establishment of respective emergency services 'Mobile Control Posts' and any casualty clearing stations and ambulance loading areas if necessary.
- If required, adhere to Division agreements for the authorisation of immediate expenditure as required.
- Following the conclusion of a major incident the Major Incident Officer should seize and secure any documentation generated by Health Board staff during the course of the incident.
- The Major Incident Officer should complete a Datix report outlining the course of the events and indicating where all evidential / seized documentation are located to assist with further investigations.
- Brief emergency services on issues relating to the layout of the building, patient / staff locations and assist in the creation of a dynamic operation risk assessment.
- Collate all relevant clinical documentation which will inform stakeholders in relation to clinical presentation, risk and legal status of the patient population.
- Ensure that Communications Officer has established links with the Ministry of Justice.

STAFFING CO-ORDINATOR	MAJOR INCIDENT ACTION CARD 2
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	To deploy staff to appropriate areas as directed by Major Incident Officer / Incident Control Room
	To ensure that the whereabouts of all responding BCUHB staff are known at all times
The Staffing Co-ordinator will ensure that the responding staff carry out all directions with unified approach, and act in accordance with guidance given by emergency services.	

Essential Actions

- Support and deploy staff in association with Major Incident Officer to ensure appropriate levels of clinical supervision are provided for patients being transferred or re-located.
- Assess staff in relation to skill mix, their location during initial incident response and the co-ordination of staff both entering and leaving the incident area.
- Assess the need for additional staff including relief staff, staff re-deployment or central nursing agency staff.
- Consider issues relating to staff welfare including; breaks, meals and if required transportation and accommodation.
- Arrange any necessary patient transfers in association with the Major Incident Officer.
- Ensure staffing deployment is in-line with the procedures specific to the nature of the major incident as each requires a variable response.

This is a critical role in a major incident and requires knowledge of the Major Incident Protocol, the different areas of the DIVISION / Health Board and of individual staff capabilities. The role must be established early after a Major Incident is declared, and can be handed over to a more senior staff member if available.

COMMUNICATIONS OFFICER ACTION CARD 3	MAJOR INCIDENT
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	Ensure good communications across a wide range of agencies
	Maintain a comprehensive, contemporaneous chronology of events,
Communication in the event of a major incident should be expected to be extremely difficult. It is important that the communications officer is able to identify, prioritize and maintain essential lines of communication	

Essential Actions

- Contact the Ministry of Justice at the earliest opportunity and inform them of the potential need to re-locate patients due to a major incident.
- Brief senior staff as required; including BCUHB Command and Control staff (Bronze, Silver and Gold On-Call)
- Assist Major Incident Officer to brief emergency services.
- Prepare responses to internal queries from partner agencies.
- Liaise with commissioners as applicable.
- Arrange for immediate supply needs to be met.
- Divert Press & Media enquiries to Senior Management Team or Bronze on-call.
- Maintain a comprehensive, contemporaneous chronology of events to include;

All telephone communications, incoming and out-going.
Verbal and non-Verbal communications.

Appendix 2 – Operational Handover Document

HANDOVER PROCEDURE TO BE USED IN THE EVENT THAT FULL OPERATIONAL CONTROL OF THE UNIT NEEDS TO BE HANDED OVER THE A REPRESENTATIVE FROM THE EMERGENCY SERVICES	
BCUHB ROLE :	
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
HANDED OVER TO :	(e.g. North Wales Police)
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
REASON FOR HANDOVER :	
UNIT SIGNED BACK TO BCUHB VIA: (STATE PERSONS NAME / TITLE)	
SIGNATURE:	
DATE:	
TIME:	

Appendix 3 –Ty Llywelyn Major Incident Communications Log

THIS DOCUMENT MUST BE

DATE	TIME	COMMUNICATION TYPE (email etc)	MADE BY	MADE TO	DESCRIPTION
12/4/2019	**18:00**	**Telephone**	**J. Smith (Incident Officer)**	**North Wales Police**	**Report Major Incident**

PRESERVED AS EVIDENCE FOLLOWING THE CONCLUSION OF THE INCIDENT AND HANDED TO THE MAJOR INCIDENT OFFICER

Appendix 4 – Conveyance Matrix

MAJOR INCIDENT PROTOCOL – EVACUATION & MOVEMENT MATRIX

EVACUATION LOCATION CODE →	RED	AMBER	GREEN
DETAILS OF PREFERRED / COMPULSORY EVACUATION DETAILS AND ESSENTIALS ACTIONS	WHENEVER POSSIBLE THE PATIENT SHOULD REMAIN IN TY LLYWELYN MEDIUM SECURE UNIT THE PATIENT MUST ONLY BE MOVED IN SECURE TRANSPORT. THE PATIENT MUST NOT BE TRANSPORTED IN THE COMPANY OF OTHER PATIENTS. THE PATIENT WILL BE MOVED NON-STOP TO AN ALTERNATIVE SECURE ENVIRONMENT WHICH MAY INCLUDE:- ALTERNATIVE MEDIUM SECURE UNIT. IF APPROPRIATE RETURN TO HIGH SECURITY. POLICE CUSTODY IF APPROPRIATE RETURN TO PRISON NO PATIENT ASSESSED BELOW CATERGORY 1 WILL BE EVACUATED TO A RED LOCATION OTHER THAN A MEDIUM SECURE UNIT	CONSIDERATION TO BE GIVEN TO THE PATIENT REMAINING IN TY LLYWELYN MEDIUM SECURE UNIT. THE PATIENT CAN BE MOVED IN BOTH SECURE AND NON-SECURE TRANSPORT (WITH CONSIDERATION GIVEN TO ESCORTS). WHEN APPROPRIATE THE PATIENT CAN SHARE TRANSPORT, DEPENDENT ON CLINICAL RISK ETC. THE PATIENT CAN BE MOVED TO THE FOLLOWING:- A LOCALITY ACUTE MENTAL HEALTH PICU. LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM SECURE UNIT / PROVIDER. (ASSESS NEED FOR HEIGHTENED OBSERVATION ON ARRIVAL)	TO BE RE-LOCATED WHENEVER THE NEED ARISES. THE PATIENT CAN BE MOVED IN A STANDARD VEHICLE, AND CAN BE MOVED AS PART OF A GROUP. THE PATIENT CAN BE MOVED TO THE FOLLOWING LOCATIONS: A LOCALITY ACUTE MENTAL HEALTH PICU. LOCALITY ACUTE MENTAL HEALTH WARD (WITH ESCORTS) LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM / LOW SECURE UNIT PROVIDER.
PATIENT CAT. CHECK →	CATEGORY 1	CATEGORY 2	CATEGORY 3

THEM BY THE LEGAL SYSTEM

(SOPO, RESTRAINING ORDER) OR BY THE MINISTRY OF JUSTICE (RESTRICTION ORDER).

Appendix 5 – Mutual Aid Plan

Contingency Plan
Emergency bed contingency

Introduction
As part of the provision for secure in-patient facilities there is the need to ensure that probity around this is maintained when major incidents occur, which render part, or all, of the facilities as unusable.

The contingency plan allows for the transfer of patients to temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

The following procedure has been established to maintain communication between services and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.
The following document represents the agreements in place with these providers, in situations of this nature and considers the major aspects of these operations in terms of:

- Communication
- Decision making
- Clinical risk
- Transportation
- In-house/local operational provision
- Future planning
- Staffing
- Funding

The purpose of the document is to consider these factors in a systematic way to provide clear guidance and support in dealing with these emergency situations.

The scenarios will be subject to desktop exercises with the providers included, and the procedures agreed within, will be developed following these.

These plans will also be reviewed and ratified on an annual basis which will capture any changes in functions, or, to buildings that may impact on this agreement.

The agreement has been reached with providers to satisfy the contingency needs of these individual units involved, as well as supporting the wider contingency plans of the specialised commissioning team. Crucially, the commissioners contingent needs can only be met by provider units agreeing to support each other in these circumstances, so this agreement also has their support in place.

Key components of the shared agreement are:

- The plans for each unit in their decision making around the movement of the service users, were agreed around them being non-prescriptive at this stage, it was felt that decisions would be best made on the day and that functioning in the capacity of each

unit in providing support was the most appropriate way forward.

- It is understood, that the agreement is only for the first 72 hours of any such situation and that any agreed plans would be appropriate to these circumstances/timescales.

- Buy-in around transport arrangements was crucial, in that any services that are affected by these types of situations, should expect that partners involved in the agreement will prioritise this need and respond accordingly with its support. This was agreed by partners.

- Each unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

Plans for decant:
The unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

The Spinney
Related policies include:
- Serious Untoward Incident
- Business continuity.

Introduction

The contingency plan allows an option for the transfer of male patients to The Spinney for temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

There may also be some service users whose risk profile can be catered for in conditions of lesser security, i.e. LSU, so we would use the document Appendix A to quantify the individual need and utlise the provision there if appropriate, and other LSU beds where appropriate.

The following procedure has been established to maintain communication between services involved and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.

The Procedure

The Spinney providing assistance

In the event that the building or part thereof of one of the partner Hospital is declared unfit and full or partial evacuation is required to The Spinney; there will be contact with the Site Co-ordinator/Senior Nurse On Call via 01942 885300. ROCG on call will then be contacted to oversee the contingency.

Senior Nurse On Call/ROCG on call (The Spinney) will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which The Spinney may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at The Spinney.

The Spinney Senior Nurse on Call will contact the Site Co-ordinator to notify and appraise them of the situation and give them the details obtained from Emergency Coordinator.

The Senior Nurse on Call will activate the response contingency plans i.e. transportation of mattresses to the social room/main gym (as appropriate), make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The Spinney Maintenance will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

The Spinney will arrange for the receipt of any high risk service users expected and make arrangements for their clinical care for the duration. The visiting hospital will identify the individual needs of each high risk service user, including their staffing requirements. They will be responsible for providing care/medical staff for these service users. Any high risk service user, who cannot be safely accommodated in the main gym and social room area, should be transferred to a ward/s if beds can be found for them. Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

Senior Nurse on Call at The Spinney will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. Senior Nurse on call will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to The Spinney, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Specific Considerations for The Spinney
The outline plan is for wards to be used as temporary, emergency accommodation. If there are no beds available, mattresses will be used in the gym/social room as appropriate.

Mattresses and some bedding are stored in the housekeeping department and arrangements will need to be made to bring these to the designated place at The Spinney

The gymnasium/social room if to be used will need to be prepared; some tables and chairs can remain (enough to accommodate the people coming), the remainder will be removed and secured by the maintenance department.

Check any vacancies/spare beds on the wards to accommodate the high risk patients.

Arrange for a quick key and security induction for the staff shortly after arrival at the unit, to facilitate movement around The Spinney

Ensure that appropriate staff is informed as soon as possible so that all meetings/functions booked for the social room/main gym is cancelled with immediate effect and until further notice.

The visiting hospital Manager to ensure they make contact with the nurse in charge of the patients and further ensure that this contact is maintained through shift changes throughout their stay.

As soon as possible after arrival, the site coordinator should engage the nurse in charge of the service users to ascertain any special pharmacy requirements; special needs requirements (e.g. diet) and assist in meeting their needs. (Partnerships in Care will recharge any NHS Trust for any out of pocket expenses incurred during the emergency).

- The gymnasium/social room will provide the following accommodation: Floor space which can accommodate approximately up to 12 mattresses
- Floor space can also accommodate some chairs and tables; there is a television aerial and electrical socket.
- There is access to gent's toilet – there are no bathroom/shower facilities. These are to be shared with The Spinney service users and staff.
- The dining room has refreshment facilities.

Within the first 8 hours of the transfer, it is imperative that the visiting hospitals Directorate Senior Managers and Elysium corporate senior managers/Incident Management Team meet together to review the transfer and look to further planning and resource implications etc.

It is imperative that high quality communications are maintained between senior managers and duty managers to ensure the smooth running of, what will be a difficult and ever changing situation.

Ty Llywelyn

It should be noted that Ty Llywelyn is a male only facility.

Ty Llywelyn has 25 beds and will only be able to accommodate utilizing the gymnasium environment. It would be unsuitable for Ty Llywelyn to accept high risk transfers from the affected hospital during the period of mutual aid.

Ty Llywelyn providing assistance

In the event that the building or part thereof of The Spinney is declared unfit and full or partial evacuation is required to Ty Llywelyn; there will be contact with the Modern Matron / Senior Nurse On Duty or Unit Coordinator via 01248 682682. The senior member of staff on duty will then oversee the contingency. Ty Llywelyn is able to offer assistance with the temporary transfer of up to 10 service users between 12 and 72 hours.

The senior member of staff will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which Ty Llywelyn may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at Ty Llywelyn.

The senior nurse at Ty Llywelyn will notify and apprise the Forensic Service Senior Management Team of the situation and give them the details obtained from Emergency Coordinator.

The senior nurse will activate the response contingency plans i.e. transportation of mattresses to the gym, make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The senior nurse will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

The senior nurse at Ty Llywelyn will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. The senior nurse will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to Ty Llywelyn, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Out Of Hours
If the Mutual Aid agreement should be required to be activated outside of normal working hours the following process should be used:

Ty LLywelyn offering assistance:

- Spinney Hospital to contact the Unit Coordinator at Ty Llywelyn.
- Unit Coordinator to inform Bronze On Call Manager for Mental Health/Learning Disabilities Division that the Mutual Aid Agreement is being activated.
- The Bronze On Call Manager will then assist the Unit Coordinator in following the actions as outlined above (Ty Llywelyn Providing Assistance) and report to the Forensic Service Senior Management Team when appropriate.
- The Bronze On Call Manager will make the decision to call in extra staff if required to assist with carrying out the Mutual Aid Agreement safely.

Contact details The Spinney

The Spinney Hospital
Everest Rd,
Atherton,
M469NT

Tel-01942 885300
Fax-01942 885301

Interim Hospital Director	Sandy Adams-Thompson	07393 460802
Regional Operations Director	Mike Bennett	07771 767404

Contact details Ty Llywelyn

Ty Llywelyn MSU
Bryn Y Neuadd Hospital
Llanfairfechan
LL33 0HH

Tel: 01248 682682
Fax: 682146
Service Manager: 07798924964
Modern Matron: 01248 682682

<table>
<tr><td colspan="4">The Procedure for Each Transfer</td></tr>
<tr><td>Date</td><td>Number of Staff Required</td><td>Description of Incident/status of building</td><td>How many Service Users at current location</td></tr>
<tr><td></td><td></td><td rowspan="4"></td><td></td></tr>
<tr><td>Time</td><td>Call received from</td><td rowspan="3"></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Description of Patient being transferred</td><td>Any other Requirements (catering/pharmacy)</td><td>Transport and Time of Arrival</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Signed</td><td colspan="2"></td><td>Date:</td></tr>
</table>

Appendix 6 – AWOL Form

Date of Admission		Section			
Date Form Completed					
Details Updated		Current Named Nurse			
Updated By					
Patient's Title		Date Of Birth			
Surname					
Previous Surname		Sex			
First Name					
Other Names		Marital Status		Ethnicity	
Aliases					
Index Offence		Date Of Offence			
Categorisation under Major Incident Procedure (1,2,3)					
Home Address		Telephone Numbers			
Description/Distinguishing Features		Height	Weight (if known)		
		Hair Colour	Eyes Colour		
Front View Full		Head Picture			
Side View Left		Side View Right			
Date Pictures Taken					
Next Of Kin		Next Of Kin Address			
Relationship to Patient					

Family Address if different to Next Of Kin	Telephone Numbers including Mobile Phone
Significant Other/Person/s at Risk	Address
Relationship To Patient	

Psychiatric Condition/ History/ Physical Issues

Current Psychiatric Medication	Current Other Medication
	Haloperidol, Lorazepam, Procyclidine

Allergies

Specific Risk Factors

Previous Absconding	Date	
	Outcome	

Any Other Information

DETAILS OF INCIDENT

Date Of Incident	
Time Reported Missing	
Place Last Seen	
Time Last Seen	

Current Mental State

Current Description (including Clothing if known)				
Any Other Relevant Information				
Specific Information; i.e. Passport Number, Bank Book Number etc				
Name Of Incident Officer/N.I.C.				Grade
Time Unit Coordinator Informed				
Time Senior Nurse Informed				
Details Faxed/E-mailed to Police				Time Sent
Faxed		E-Mailed		
North Wales Police Fax Number				
North Wales E-Mail Address				

Members of the Working Group:

Name	Title
Simon Allen	Service Manager
Ian Jones	Practice Development Nurse
Lisa Jones	Modern Matron
Dr Caroline Mulligan	Consultant Forensic Psychiatrist
Dr Faoud Bassa	Consultant Forensic Psychiatrist
Louise Llewelyn	OT Service Manager
Dr Julia Wane	Consultant Clinical Psychologist
Dr Katie Elliott	Consultant Clinical Psychologist
Paul Grimshaw	Reception Supervisor
Anne Hills Jones	Administration Manager
Greg Yates	Ward Manager
Harri Roberts	Ward Manager
Nicky Jones	Ward Manager
Gareth Griffiths	BCUHB Fire Officer

Engagement has taken place with:

Name	Title	Date Consulted
North Wales Fire Service		January 2019
Welsh Ambulance Service		January 2019
North Wales Police		January 2019
MH & LDS Division		

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.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. 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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University Health Board

Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Forensic Service Major Incident Plan	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The is an assessment of the impact of the implementation of an major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB. The major incident plan is designed to outline process and procedures to be followed in the event of a major incident within services as defined by the plan. A major incident is categorised as: Fire, Bomb, Hostage, Firearm, Large Scale Disorder, Multiple Escape.	
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?	Forensic Mental Health Service Management Team	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Ian Jones	Forensic Practice Development Nurse/Security Lead
		Simon Allen	Service Manager
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Measure (Wales 2010) 'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013) National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RPsych 2010)	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust	

		Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

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 (3) any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	Neutral		Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the plan.
Disability	Negative		There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.
Gender Reassignment	Neutral		
Pregnancy & Maternity	N/A		
Race / Ethnicity	Neutral		An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy the major incident plan. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account.
Religion or Belief	Negative		There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.
Sex	Neutral		The in patient unit currently has single sex facilities only but during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will be single sex.
Sexual Orientation	Neutral		Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the plan.
Welsh Language	Negative		The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will comply with the Welsh Language Act.
Human Rights	Neutral		Application of this pathway would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice

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 the table below 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.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

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	We are ensuring that this document does not unlawfully discriminate, harass or victimise through a robust system of review and maintenance of the plan in accordance with the patient population profile.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	By ensuring that continual access to forensic services is ensured to both service users and other professionals and is available as a clinical option for service users in line with assessment and eligibility despite disruptions in core service continuity.

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of co-working and collaboration between different partner organisations to ensure achieving a common aim of patient and public safety and security.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Forensic Service Major Incident Plan

2. Brief Aims and Objectives:	To assess the impact of the implementation of major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB.

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 x	No
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes x	No

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No x
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? Low negative identified with regards to religion and belief, disability and Welsh language characteristics which would be covered within assessment and care and treatment planning and appropriate liaison with other services relevant to the service user's care. Implementation of the Major Incident Plan might result in the temporary inability to cater for the needs of the characteristics above but these would be considered as a matter of urgency for each individual affected by the incident. The needs of the patient population will be reviewed on a regular basis and the detail of the management of a major incident adapted to meet their needs whenever possible within the caveat that there may potentially be an overriding responsibility to safety and security for a limited period of time.	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☒	No ☐	Not applicable ☐
	As indicated above .		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Robust multi agency debriefing process post incident.
	Who is responsible?	Forensic Mental Health Services Management Group
	What information is being used?	Factual information post incident. Key stakeholder feedback on the implementation of methodologies contained within the plan.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	January 2022

7. Where will your decision or policy be forwarded for approval?	MH & LDS Division

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	In developing the document due consideration has been given to the various protective characteristics and their protection within clinical practice. Key stakeholder agencies have been involved in the construction of the plan and retain their own responsibilities for implementing strategies to manage major incidents aligned with the plan. The EQIA will be circulated alongside the Procedure document for broader consultation

	Name	Title/Role
9. Name/role of person responsible for this Impact Assessment	Ian Jones Simon Allen	Forensic Practice Development Nurse/Security Lead Service Manager
10. Name/role of person approving this Impact Assessment	Statutory compliance committee	
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 (or have already made) to your document or proposal as a result of the EqIA?	Ensure inclusion in individual patient profiles any needs under the protective factors of: disability, religion/belief, Welsh language.		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	As above.		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impact(s) 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.	Implementation of document	Ian Jones Simon Allen	March 2019

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

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Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Quality, Safety & Experience Committee

24.9.19

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 Gill Harris, 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 16.7.19 • 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