Bundle Quality, Safety & Experience Committee 1 November 2022

1 OPENING ADMINISTRATION

1.1 09:30 - QS22.266 - Welcome, introductions and apologies for absence - Chair - Information - Verbal report

1.2 09:31 - QS22.267 - Declarations of interest on current agenda - Chair - Decision - Verbal Report

1.3 09:32 - QS22.268 - Minutes of last meeting – 6 September 2022 - Chair - Decision - Paper

QS22.268 - QSE Minutes 06.09.22 V0.2 - LR amends.doc

1.4 09:34 - QS22.269 - Action log - Chair - Decision - Paper

Summary Action Log QSE Public - Revised 26.10.22.docx

Action Log - Appendix A.docx

1.5 09:39 - QS22.270 - Patient or Staff Story - Executive Director of Nursing & Midwifery - Assurance - Video

QS22.270 - QSE - Nov 2022 - Patient Story.docx

1.7 09:54 - QS22.271 - Report of the Lead Executive - Executive Director of Nursing & Midwifery - Assurance - Paper

QS22.271 - APPROVED - QSE - Nov 2022 - Lead Execuitve Paper.docx

2 STRATEGY AND POLICY

As required :
Endorsing of Quality policies requiring Board approval
Approval of quality policies for committee approval
Twice yearly policy update status report

2.1 09:59 - QS22.272 - Corporate Risk Register To include pending or risks under review - Board Secretary - Assurance - Paper

QS22.272 - DRAFT QSE Committee Coversheet - Corporate Risk Register v4.1.docx

QS22.272 - Appendix v1- Quality, Safety and Experience Committee Corporate Risk Register Report.pdf

QS22.272 - Appendix v2 - Newly Escalated Risks.pdf

QS22.272 - Appendix v3 - Full List of Corporate Risks.pdf

QS22.272 - Appendix v4 - Risk Key Field Guidance.pdf

2.2 10:09 - QS22.273 - Policies for Approval - Lead Executives - Assurance - Paper

- *IPC05 Outbreak Reporting and Control Policy*
- *All Wales Thromboprophylaxis Policy*

Coversheet - All Wales Thromboprophylaxis Policy - V0.1.docx

Equality Impact Assessment Screening-All Wales VTE Policy V1.0.docx

Ref number TBC -Draft - All Wales TP Policy V22 - 20.01.2020 (003) BCUHB updated October 2022 - V0.5.docx

QSE - Nov 2022 - IPC05 Coversheet.docx

QSE - Nov 2022 IPC05 Outbreak Reporting and Control Policy Appendix 1.doc.docx

QSE - Nov 2022 IPC05 Policy Appendix 5 BCU Outbreak Agenda - Appendix 2.pptx

QSE - Nov 2022 - IPC05 Outbreak Policy Appendix 5 Outbreak Agenda - Appendix 3.pptx

QSE - Nov 2022 IPC05 Policy Appendix 8 - End of outbreak summary slide - Appendix 4.pptx

3 QUALITY SAFETY AND IMPROVEMENT

3.1 10:19 - QS22.274 - Mental Health Outcomes and Improvements update - Executive Director of Public Health - Assurance - Paper

QS22.274 - MHLD Divisional Improvement Plan Board Report 20221014 v0.3 FINAL.docx

QS22.274 - Appendix 1 - MHLD Imp Plan V18 Navigation.pdf

QS22.274 - Appendix 2 - MHLD Div Imp Plan V18 Timescales.pdf

QS22.274 - Appendix 3 MHLD Div Imp Plan V18 House.pdf

QS22.274 - Appendix 4 MHLD DIP Driver Diagram.pdf

QS22.274 - Appendix 5 MHLD Div Imp Plan V18 Tier Work Stream.pdf

QS22.274 - Appendix 6 MHLD Div Imp Plan Tier 2 Sub Themes.pdf

QS22.274 - Appendix 7 MHLD Div Imp Plan Tier 3 Task Level Detail.pdf

QS22.274 - Appendix 8 - MHLD Div Imp Plan Key Performance Indicators.pdf

QS22.274 - Appendix 9 - MHLD Div Imp Plan Example Power BI Dashboard.pdf

QS22.274 - Appendix 10 - MHLD Div Imp Plan Example on a page.pdf

QS22.274 - Appendix 11 - MHLD Div Imp Plan Phases.pdf

3.2 10:29 - QS22.275 - YGC Improvement Plan Update - Deputy CEO/Executive Director Of Integrated Clinical Services/ Executive Director Transformation, Strategic Planning and Commissioning/ Programme Director Clinical Safety Improvement - Assurance - Paper

QS22.275 - YGC QSE Paper 1st November Final.docx

3.3 10:39 - QS22.276 - Vascular Improvement Plan Update - Executive Medical Director - Assurance - Paper

QS22.276 - QSE.Vascular update.FINAL.20221021.docx

3.4 10:49 - QS22.277 - Urology Improvement Plan Update - Deputy CEO/Executive Director Of Integrated Clinical Services - Assurance - Paper

Paper withdrawn

3.5 10:49 - QS22.278 - Quality & Performance Report - Executive Director of Finance - Assurance - Paper

Paper withdrawn

3.6 10:49 - QS22.279 - Patient Safety Report (to include near misses) - Executive Director of Nursing & Midwifery - Assurance - Paper

QS22.279 - APPROVED - QSE - Nov 2022 - Patient Safety Report V3.docx

3.7 10:59 - QS22.280 - Human Tissue Act - Executive Medical Director - Assurance - Paper

QS22.280 - 0 Board Committee Coversheet - HTA compliance report October 2022.docx

QS22.280 - 1 - HTA Inspection Report July 2022.pdf

QS22.280 - 2 - HTA CAPA plan July 2022.docx

3.8 11:09 - QS22.281 - HIW update - Executive Director of Nursing & Midwifery - Assurance - Paper

QS22.281 - APPROVED - QSE - Nov 2022 - HIW.docx

QS22.281 - APPROVED - QSE - Nov 2022 - HIW - Appendix.pdf

3.8.1 11:19 - Comfort Break

3.9 11:29 - QS22.282 - Quality/Safety Awards and Achievements Executive Director of Nursing & Midwifery - Consent - Paper

QS22.282 - QSE - Nov 2022 - Quality Recognition.docx

3.11 11:30 - QS22.284 - Sepsis Review - Executive Medical Director - Assurance - Paper

QS22.284 - 0 - Board Committee Coversheet - Sepsis v0.4.docx

QS22.284 - Appendix 1 BCU SEPSIS PATHWAY V1.2.pdf

3.12 11:40 - QS22.285 - Her Majesty's Inspectorate of Prisons (HMIP) inspection of HMP Berwyn Report - Deputy CEO/Executive Director Of Integrated Clinical Services - Assurance - Paper

(response to inspectorate report)

QS22.285 - QSE - HMP Berwyn HMIP Report v2.docx

3.13 11:50 - QS22.286 - RCGP Report - Executive Medical Director - Assurance - Paper

QS22.286 - 20221020.QSE.RCGP primary care final report.docx

QS22.286 - BCUHB Interim Report FINAL - September 2022.pdf

QS22.286 Multidisciplinary Framework for Education and competencies (2).pdf

3.14 12:00 - QS22.287 - GP Out of Hours UPC Peer Review - Deputy CEO/Executive Director Of Integrated Clinical Services - Assurance - Paper

Paper to follow

3.15 12:10 - QS22.288 - Psychological Interventions (including Psychological Therapies) for Children and Young People - Acting Executive Director Therapies and Health Sciences

QSE Children and Young People Psychological Interventions 1 Nov 2022 final 1.pdf

Appendix 1 005-Matrics Plant Document-Eng.pdf

Appendix 2 Matrics Plant Implementation Plan Template-Eng.pdf

Appendix 3 NEST Framework What You Need To Know Final Version May 2021(1).pdf

Appendix 4 Framework-on-embedding-a-whole-school-approach-to-emotional-and-mental-well-being.pdf

Appendix 5 NoWrongDoor_FINAL_EN230620.pdf

Appendix 6 NWD Executive Summary vFinal SENT (002).pdf

Appendix 6 NWD Executive Summary vFinal SENT.pdf

Appendix 7 BCUHB Baseline Data Collection Matrics Plant Implementation Plan October 2022.pdf

Appendix 8 Extract Part 1b Performance Report September 2022.pdf

3.16 12:20 - QS22.289 - Ophthalmology Update (how we are managing the risk stratification) - Deputy CEO/Executive Director Of Integrated Clinical Services - Assurance - Paper

QS22.289 - ophthalmology paper QSEFD.docx

QS22.289 - Appendix 1-Ophthalmology action plan for secondary careFD.pdf

4 REPORTS

4.1 12:30 - QS22.291 - Chair’s Assurance Reports from Strategic and Tactical Delivery Groups - Lead Executives - Consent - Paper

Vascular Steering Group
Clinical Effectiveness Group
Patient and Carer Experience Group
Infection Prevention Steering Group

QS22.291 - QSE VSG paper.V3.20221018.docx

QS22.291 - APPROVED - QSE - Nov 2022 - PSQ Chair Report.docx

QS22.291 - Chairs Assurance Report QSE October 2022 - Draft V1.3.docx

QS22.291 - Clinical Effectiveness Group Appendix - Clinical Audit Report for Q1 2022-23 v1.1 current.pdf

QS22.291 - QSE - Nov 2022 IPSG Committee Chair's Assurance Report.docx

4.2 12:31 - QS22.292 - Public Interest Ombudsman report - Executive Director of Nursing & Midwifery - Assurance - Paper

QS22.292 - QSE - Nov 2022 - PSOW PIR.docx

QS22.292 - QSE - Nov 2022 - PSOW PIR - Appendix A Report.pdf

QS22292 - QSE - Nov 2022 - PSOW PIR - Appendix B Action Plan.docx

5 CLOSING BUSINESS

5.1 12:41 - QS22.293 - Issues Discussed in Previous Private Session - Chair - Assurance - Paper

5.2 12:42 - QS22.294 - Exclusion of Press and Public - Chair - Information - Verbal Report

5.3 12:43 - QS22.295 - Date of Next Meeting - Chair - Information - Verbal Report

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 6 September 2022
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl Carlisle	Independent Member
Jacqueline Hughes	Independent Member
John Gallanders	Independent Member
Hugh Evans	Independent Member

In Attendance:

Gareth Evans	Acting Executive Director Of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Dave Harris	Head of Internal Audit
Emma Jane Hosking	Acting Deputy Medical Director
Matthew Joyes	Acting Associate Director of Quality Assurance
Phil Meakin	Associate Director of Governance, Governance & Communications
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Chris Stockport	Executive Director of Transformation, Strategic Planning and Commissioning
Dino Tedaldi	Urology Network Manager (part meeting)
Gaynor Thomason	Programme Director for Clinical Safety Improvement
Amanda Lonsdale	Director Of Performance
Hilary Owen	Head Of Governance and Compliance, Mental Health & Learning Disabilities
Alberto Salmoiraghi	Medical Director, Mental Health & Learning Disabilities
Heledd Thomas	Audit Wales
Iain Wilkie	Interim Director Mental Health & Learning Disabilities
Angela Wood	Executive Director of Nursing and Midwifery

Agenda Item	**Action**
QS22.229 – Welcome, Introductions and Apologies for Absence Apologies were received from Gill Harris, Adrian Thomas, Nick Lyons and Molly Marcu. The Interim Director Mental Health & Learning Disabilities, Associate Director of	

Governance, Governance & Communications and Acting Deputy Medical Director introduced themselves and explained their attendance at the meeting. The Chair welcomed the Executive Director of Nursing and Midwifery to her first meeting, it was noted that conversations with regards to the Lead Executive for the Committee were ongoing but the Lead Executive's report would be received from the Executive Director of Nursing and Midwifery in the absence of the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive.	
QS22.230 Declarations of Interest on current agenda **QS22.230.1** Jacqueline Hughes declared an interest in agenda item QS22.251 Regulation 28 Update as one of the notices related to a family member. **QS22.230.2** The Chair noted that there were many recurring themes in numerous reports before the Committee and that many of the same themes dated back to at least 2016, and that this was unacceptable. The Chair advised that the objective of the Committee was to provide the Board with assurance over the quality and safety of services across the Health Board and that patient experience is at the heart of service development. The Chair noted that the Committee could not provide any such assurance to the Board at the moment. The Chair recognised that improvement work was ongoing, but the steps laid out in the reports presented to the Committee were still too focused on policies and training being the answer to remedy these failings. The Chair referred to the advice from Counsel, following the criticisms from HSE, that policies should be the foundation but people will not always comply with policy. The Chair stated that she understood that mistakes happen, and that staff are human and working in a high risk environment under considerable pressure, however, systems and processes must be as robust as possible rather than being overly dependent on person controls. The Chair asked that when reports were being presented it was made clear how the proposals were different from what had been previously received. The Chair advised that she would escalate these concerns to the formal Board meeting later in the month and requested that the Executives consider how they intended to respond when it was escalated, in a manner that could be clearly measured and evidenced so that the same discussions do not reoccur.	
QS22.231 Minutes of Previous Meeting Held in Public for Accuracy **QS22.231.1** The minutes of the meeting held on 5 July were approved subject to Cheryl Carlisle's last name being included and John Gallanders' role be added. **QS22.231.2 It was resolved that** the minutes were approved as an accurate record of the meeting held on 5 July 2022.	
QS22.232 Matters Arising and Table of Actions **QS22/232.1** The Committee reviewed the action log and closed actions where appropriate.	
QS22.233 - Patient Story	

QS22.233.1 The Committee received an account from the staff and stakeholders involved in the Long-COVID Recovery Programme. It was noted that from the outset, the Health Board adopted a strong principal of co-design working closely with patients, stakeholders and clinical practitioners to design a pathway that meets the needs and expectations of people experiencing Long COVID. **QS22.233.2** Some patients expressed an interest in becoming Long COVID Lived Experience Representatives and joined a partnership group to ensure the voice of the patient is heard throughout the development of this new service, building a true approach of co-production. **QS22.233.3** Acting Associate Director of Quality Assurance highlighted that the Health Board was leading the way nationally with regards to the tool and that on the back of this work the Health Board had been shortlisted for three national awards for the service. **QS22.233.4** An Independent Member queried the longevity of the service in relation to resources, what were the number of referrals received to date and how a service would be taken forward for children. The Acting Associate Director of Quality Assurance advised that the number of referrals to date was over 1000 but would circulate the details after the meeting and that referrals for children were going to Alder Hey. The Executive Director of Transformation, Strategic Planning and Commissioning confirmed that there was long term commitment for Long Covid Funding. **QS22.233.5 It was resolved that** the Committee receive and reflect upon the story [Gareth Evans joined the meeting]	MJ
QS22.234 Report of the Lead Executive **QS22.234.1** The Executive Director of Nursing and Midwifery presented the report, highlighting that the report identified her new role and summarised the reportable incidents. Falls and Pressure Ulcers were discussed and the Committee noted that the Executive Director of Nursing and Midwifery would be reviewing Falls and looking into a Multi-Disciplinary Team approach and whether this could be cascaded. **QS22.234.2** The report noted that there had been one new Never Event in the reportable period and no new regulation 28 notices. Complaints closed within the targeted timescale were below 75% and the Executive Director of Nursing and Midwifery stated that this would be an area of focus alongside serious incidents. **QS22.234.3** An Independent Member raised concerns with regards to missing targets on complaints responses. It was noted that this had been a recurring issue for 6/7 years and would be impacting on the quality of provision to patients and asked why this had been such a long-standing issue and what the problem was in relation to resolving it.	

QS22.234.4 The Executive Director of Nursing and Midwifery advised that she would be doing some due diligence on the issues and that collaborative working to support the corporate teams was required to ensure that early resolution meeting with complainants to resolve issues quickly would be required. The Executive Director for Nursing and Midwifery advised that she come back to the Committee with a proposed way forward of how improvements could be made. The Chair noted that the delay in complaint responses was also resulting in inquests being delayed which was unacceptable. **QS22.234.5** An Independent Member welcomed the Executive Director for Nursing and Midwifery to the Committee and wanted confirmation that if patients made a complaint their care was not compromised in any way. Executive Director for Nursing and Midwifery stated that a policy should not be required to make sure that this did not happen and that it was not something that would be accepted. The Acting Associate Director of Quality Assurance confirmed that changes were made the previous year and that if this is identified at all it is reported directly to him. To date, no cases had been reported. **QS22.234.6 It was resolved** that the Committee received the report.	
QS22.235 Quality Aspects of IMTP **QS22.235.1** Executive Director of Transformation, Strategic Planning and Commissioning noted that although the IMTP was not approved as a three-year plan by Welsh Government there had been change in the plan produced with some deliberate steps to build the plan around quality. It was noted that patient experience runs through the entire plan. The commitment to the clinical services strategy and the work currently underway with regards to the Quality Strategy was highlighted and the development of the plan was already in a different place in comparison to previous years. The feedback received was around the narrative on the high-risk areas, that it was a strong start in terms of the new approach and that there was an expectation to see more quality language and thinking going forward. **QS22.235.2** The Chair noted that the initial outcomes highlighted in relation to Health and Safety Statutory Compliance were all staff related. The Executive Director of Transformation, Strategic Planning and Commissioning advised that in the paper presented they were staff related but in the full IMTP they were not and the Executive Director of Workforce and Organisational Development agreed. **QS22.235.3** The Chair queried if video consultations across clinical services were being maximised. The Executive Director of Transformation, Strategic Planning and Commissioning suggested that the question could be widened to capture all virtual consultations and that the whole virtual agenda required more thought and attention but that work was being done with further work to do. The Committee noted that it was imperative that the Health Board did not revert back to pre-Covid ways. **QS22.235.4** The Acting Executive Director of Therapies and Health Science noted that it was important to get the balance right and clinicians need to be	

happy with the service they provide. It was noted that therapies had been successful because they had a digital strategy, however, digital systems need to catch up to support the strategy. **QS22.235.4 It was resolved** that the Committee received the report and noted the areas requiring further development and assurance.	
QS22.236 Board Assurance Framework **QS22.236.1** The Associate Director of Governance, Governance & Communications presented the report on behalf of the Interim Board Secretary. The Committee noted that the mitigations needed to be further refined and tested to ensure they could be relied upon. It was noted that further risks around Urgent care fall within the scope of PFIG and that there would be a review on how the detailed papers for the associated mitigations are aligned in the future to the cycle of business for both committees. **QS22.236.2 It was resolved** that the Committee noted and reviewed the BAF risks that fall within the remit of the Quality, Safety and Experience Committee.	
QS22.237 Corporate Risk Register **QS22.237.1** The Acting Deputy Medical Director presented the Corporate Risk Register on behalf of the Executive Medical Director. It was noted that the Corporate Risk Register was in a dynamic situation and a number of key risks needed to be consolidated to bring them into one place. Several risks that are now on the register are about the new operating model given the significant changes in staff. It was noted that the risk management group would be chaired by the CEO and a full report would return to Committee. The Committee noted that there were 27 risks sitting at tier one, five of them were new and a number have reduced. The mental health risks were highlighted and it was noted that these would be discussed further on in the meeting. **QS22.237.2** The Associate Director of Governance, Governance and Communications advised that he had taken the opportunity to look back over the last three QSE Committee meetings and noted that there were a number of risks that are on Datix but didn't score high enough to be on the Corporate Risk Register, however what was identified was that there were often a number of risks relating to one area that might need to be consolidated. He advised that with regards to the governance and assurance framework, he attended the Executive Team meeting every fortnight. **QS22.237.3** An Independent Member queried how support to Care Homes was being measured and what was being done to reduce risk and also wanted to know if the diabetic retinopathy pathway was in place and how that was impacting on the delivery of care to patents. The Acting Deputy Medical Director advised that she would respond outside of the meeting on these specific points and also how the access to care homes would be taken forward given that it is impacting on patient flow.	EJH

QS22.237.4 An Independent Member requested that a timeline for risk 18113, Position of Trust and Section 5 (Professional Allegations) Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014] be shared with the Committee. **QS22.237.5** Concern was raised that the Health Board was not acting within a legal framework in relation to Fire and Asbestos and that there did not seem to be significant effort to rectify the situation. An Independent Member raised the fact that there had not been an evacuation drill at the Wrexham Maelor Hospital there had not been a pilot evacuation for six years. The Executive Director of Workforce and Organisational Development agreed and highlighted that there was a gap analysis done against 33 pieces of legislation which identified significant gaps, clarity has been given about what needs to be done. The Committee were informed that there was significant work underway with regards to Fire Safety being led by Estates and audited by the Workforce and Organisational Development team, the practice evacuation and alarm testing had been reintroduced but significant capital investment is required. Concern was raised that the evacuation drills was documented as a key control whereas it should be identified as a gap in controls. Furthermore, there was no remedial action noted to address the gap. The Executive Director of Workforce and Organisational Development advised that this was one of the reasons the risk score has not been reduced and that this had been picked up and an audit was being undertaken. The Committee discussed the capital plan and the absence of capital funding at a national level, it was noted that direct approaches to Welsh Government for capital investment had been done without success. **QS22.237.6** The Committee noted that the target risk dates need to be reviewed and flagged when they would not be met. It was agreed that the report could only give the Committee partial assurance. The Associate Director of Governance, Governance and Communications advised that he would take forward the Committee's concerns and that the Risk Management Group would receive the specific feedback and return to the Committee. **QS22.237.7 It was resolved** that the committee reviewed and discussed the report.	PM PM
QS22.238 Mental Health Outcomes and Improvements [Gaynor Thomason joined the meeting] **QS22.238.1** The Executive Director of Public Health introduced the paper, noting that in previous meetings the Committee had not been able to take assurance about the plans in place and that the Committee had now been provided with all the details. It was noted that the difference now was that the division was no longer working in isolation, that other directorates have been involved in producing the plan which puts patients at the top. The next phase of the plan was to make it more user friendly and easier to monitor progress by working on the cogs and drivers.	

QS22.238.2 The Interim Director Mental Health & Learning Disabilities reiterated that patient care and experience were at the front of the plan and highlighted the portfolio of six themes. The Committee were informed that the plan made sure that patients were worked with rather than being done to, that engagement and ownership from staff had been forthcoming to ensure that learning needs were understood which had been the issue in the past. It was highlighted that the Programme Director for Clinical Safety Improvement would be leading the work around the notice of contravention and that the specifics from the contravention are incorporated with the work streams and that the plan was a live and evolving document.	
QS22.238.3 An Independent Member advised that he would share some feedback outside of the meeting, but queried how things would be different. It was noted that the Transformation Team being involved should be helping to embed changes across the Health Board. An Independent Member highlighted that there were 100+ references to staff and only 30/40 to patients in the paper. He requested that the paper makes it explicit that patients come first over staff.	JG
QS22.238.4 Concern was raised about the commitments made as a Board to both HIW and the coroner and these were not being embedded within the plan, that the Board required some levels of assurance specifically around ligatures. A query was raised as to why an external trainer was required and why there was reference to phasing given that some actions have been around for six years.	
QS22.238.5 An Independent member highlighted staffing and recruitment and vacancies and how patient safety would be met if recruitment to those positions was not. The Committee noted record keeping being raised again and how staff not complying with standards would be handled.	
QS22.238.6 An Independent Member raised the 2018 £8.5m programme of work on ligature reductions reported on in response to the Ockenden Report and if an accurate report had been given at the time given this additional work now being identified.	
QS22.238.7 The Executive Director of Public Health suggested that she and the Independent member met after the Committee but highlighted that the Transformation Team were critical to the success of Mental Health Services within the Health Board and that their involvement was enabling a different approach. It was noted that a diagnostic session would be held similarly to the one used for the YGC programme and that despite it feeling similar to previous plans there was a commitment to change and implement the plan this time to make it easier for patients.	TO
QS22.238.8 The Executive Director of Public Health clarified that there was a monthly meeting between CAMHS and Adult Mental health and that there was good support in place for both teams but that the plan in front of the Committee was an adult plan only.	
QS22.238.9 The Executive Director of Public Health responded to the query around mandatory training and advised that it needed to be made easier to	

undertake but that mandatory training in Mental Health had been good. **QS22.238.10** In response to the query around phasing it was noted that this would be reviewed but as previously highlighted it was a live document. **QS22.238.11** The Committee discussed the recruitment to the 200 vacancies and an Independent Member asked why rolling recruitment policies were not being considered. The Executive Director of Workforce and Organisational Development explained that there was little evidence to demonstrate that rolling recruitment works and that it can undermine the reputation of the organisation. The Executive Director of Nursing and Midwifery agreed and said that a targeted recruitment campaign was more effective. She advised the Committee that she had managed to reduce nursing vacancies to nil at her previous Trust. The Independent Member asked for consideration to be given to rolling recruitment campaigns given the large number of vacancies and concerns raised over delays in recruitment processes. It was agreed that a review of conversion from advert to appointment was needed to maximise opportunities. It was noted that trainee to consultant rates were good. **QS22.238.12** The Executive Director of Public Health updated on the Estates and Ligature work noting that work on ligatures had moved on. **QS22.238.13** The Committee noted that with regards to Listening Leads there was ongoing work the patient safety group. **QS22.238.14** The Interim Director Mental Health & Learning Disabilities highlighted that the main difference in comparison to previous plans was that the patients are the focus, that there are more of the right people in the right place doing the right things, that communication was better as was transparency and that there would be no unacceptable practice allowed. It was noted that monthly summit meetings with Executives were challenging but supportive and accountability meetings had been reinstated which were good honest and safe meetings. **QS22.238.15** The Chair concluded that she could see changes in the plan, that she thought it was stronger and welcomed the involvement of the Programme Director for Clinical Safety Improvement but asked for more focus on the outcome measurements and improvements for patients. **QS22.238.16 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	
QS22.239 YGC Improvement Plan to include the HIW Action Plan **QS22.239.1** The Programme Director for Clinical Safety Improvement presented her report to the Committee advising that the paper was presented to the Cabinet Committee and the programme is now called the Journey to Excellence. The Committee noted that the Integrated Health Communities were launched on 1 August 2022 and the Urgent and Unscheduled Care Pathways were launched the on 5 September 2022. The five themes were identified, and the Committee were	

informed that the Make it Safes were implemented and that the next steps were to ensure that these were the right thing to do and are embedded. It was noted that there was a need to create an Urgent Primary Care Centre, that there are 50 Cogs in development relevant to service delivery. **QS22.239.2** The Programme Director for Clinical Safety Improvement advised that a Programme Management office for Targeted Intervention at YGC had been created and two programme officers had been appointed who were setting up workshops with those delivering the pathways. It was noted that workforce and recruitment was the biggest issue, and the Committee were informed of the detail around this. The Committee were advised that as the pathways were developed there would be a requirement to look at what workforce was required. **QS22.239.3** An Independent Member said that the launch on 5 September 2022 was really positive and that there was a difficult balancing act noting that there was some negativity in some places but that overall it is really positive for staff. **QS22.239.4** The Programme Director for Clinical Safety Improvement advised that because there was an understanding of the staffing issues a forward look at the rota had been requested to identify what can be done as an interim measure to make sure they are prepared for winter. The Chair noted that nationally there were staff shortages and that the Welsh Government were aware of this. **QS22.239.5 It was resolved** that the Committee noted the progress made to date on the YGC Improvement Plan.	
QS22.240 Vascular Improvement Plan **QS22.240.1** The Acting Deputy Medical Director presented the Vascular Improvement Plan noting that it had been received at the Cabinet meeting the previous week. She highlighted that the make safes had been introduced following escalations received from the Vascular Quality Panel. Dual consultant operating for planned and on call remains and the Committee noted that for the vast majority of the time this can be achieved, however support from North West colleagues has only been required a couple of times. It was noted that wide engagement to ensure that everyone is up to speed was occurring. **QS22.240.2** An Independent member raised concern that the coroner had not been made aware of some of the deaths previously and the Acting Deputy Medical Director advised that this was being reviewed at the Vascular Quality Panel. **QS22.240.3** The Committee discussed recruitment, it was noted that the recruitment to the Clinical Director post had not been successful, that the substantive consultants would take on elements of the leadership portfolio and the overall management of the service would fall under the surgical directorate for the time being. An Independent Member queried where this decision had been made, it was agreed to discuss the detail outside of the Meeting. **QS22.240.4** The Acting Deputy Medical Director advised that the audit on note	EJH/CC

keeping on site was showing improvement.

QS22.240.5 The Chair noted that there was a lot more work that was required in terms of the improvement plan as some actions were down as complete but with no end date and some had been superceded but had not been updated as such. She asked if there had been a review on completed actions to ensure that they had been completed. The Chair also highlighted that shorthand had been used in the plan which weakened the audit trail.

QS22.240.6 It was resolved that the Committee:

- noted the progress in delivery of the Vascular Improvement Plan and commencement of work to align the Improvement methodology with the wider Targeted Intervention framework approach
- noted that the Board has received Escalations from the Vascular Quality Panel and that immediate make safes, introduced on July 8th 2022 remain in place.
- noted the current contingency planning through an Emergency Preparedness, Resilience and Response (EPRR) response to the short and medium term fragility of the north Wales vascular service.
- noted the development of an updated engagement plan to ensure partners, staff and patients are informed of current issues within the service.
- Noted the review of vascular services by Healthcare Inspectorate Wales to take place over the coming weeks

QS22.241 Urology Improvement Plan

[Dino Tedaldi joined the meeting]

QS22.241.1 An Independent Member thanked the Urology Network Manager for the paper noting that he was doing a walk about in the Urology Department at the Wrexham Maelor Hospital the following day. He observed that the review had taken a long time to commence and raised a query about the Robot.

QS22.241.2 The Urology Network Manager advised that the Royal College review would commence at the end of October/beginning of November. With regards to robotic assisted surgery, it was noted that this was situated at Ysbyty Gwynedd and that the consultant supporting the surgery was going on a three day training programme in October and the first surgery would take place in November.

QS22.241.3 The Chair concluded that the Committee had longstanding serious concerns about the Urology Service and the improvements need to be progressed.

QS22.241.4 It was resolved that the Committee to scrutinised the report considered if any areas should be escalated for consideration by the Board.

QS22.242 Quality and Performance Report [Amanda Lonsdale joined the meeting] **QS22.242.1** The Director of Performance presented the report noting that the Performance Report now links to the Corporate Risks, that the format of the report had changed but that at a further Board Workshop session on 20 September it would be decided what measures are reported to each Committee. It was noted that on 13 October there would be a Board workshop on making data count. **QS22.242.2** The Chair noted that the graphs were better, and the narrative improved. She advised that she had concerns around sepsis and had raised this in a number of meetings and wanted clarity about what was being done to address the problem. The Acting Deputy Medical Director noted that this would be raised in the next report and that further investigation was required to understand if the issues were a failure to recognise pathways or vulnerability but that it was not going in the right direction. She agreed to follow up on the matter highlighting the Committee's concerns, noting that the other Acting Deputy Medical Director was leading on the work. **QS22.242.3** An Independent Member raised concerns around the declining position for young diabetic people. The Executive Director of Nursing and Midwifery agreed to look at the pathway and identify the issues. **QS22.242.4 It was resolved** that the Committee received the report.	EJH AW
QS22.243 Patient Safety Report **QS22.243.1** An Independent Member advised that there were issues with inadequate recording and issues around reports generally not being completed, he noted that there were three wards where the Health and Safety Executive felt that there was room for improvement. **QS22.243.2** An Independent Member queried whether projects which were apparently delivery good results, such as the joint community falls project were being rolled out. The Executive Director of Transformation, Strategic Planning and Commissioning advised that in the past there had been an issue that schemes had been started without consideration of where they would end up, but that the Executives were absolutely clear that the current position is not where they would want to be and the revised business case process had been streamlined and clarity has been given that a business case is not about setting something up. **QS22.243.3** The Acting Associate Director of Quality Assurance clarified how methodology for the improvement work had been identified and that the Health and Safety Executive had been to observe the work. The approach had been collaborative and the Health and Safety Executive were in agreement that it was the correct method and way forward. **QS22.243.4** The Chair noted that she had raised a number of questions outside the	

meeting on the report and expected those to be responded to. [Dave Harries left the meeting] **QS22.243.5** The Chair raised concerns about a number of statements that had been made in the report, the first was about a patient waiting in an ambulance for 17 hours and the reason for this being reported as the ED was over stretched. Secondly with regards to the ophthalmology case, the paper states that the harm caused was unavoidable due to the lack of capacity. The Chair raised that neither of these statement could be made. The Acting Associate Director of Quality Assurance agreed that the Chair's points were valid, and the language used was clumsy. **QS22.243.6** The Chair noted that there was no learning identified again and therefore the Committee could not take assurance. She highlighted that she had previously requested that near misses be included in the report and that the dates of incidents in relation to the claims should be provided. Neither had been addressed. The Acting Associate Director of Quality Assurance apologised for not advising the Chair in advanced that the information previously requested would not be able to be brought at that time. **QS22.243.7** An Independent member raised concerns about two incidents and the Executive Director of Nursing and Midwifery advised that she would provide an update for him outside of the meeting. **QS22.243.8 It was resolved** that the Committee received the report.	MJ AW
QS22.244 Patient & Carer Experience Report **QS22.244.1** The Committee received the report, an Independent Member asked if the report under section 2.7 was referring to 436 patient complaints being overdue in July, how many people submitted FOI's and whether the Ombudsman complaints had been cross referenced. He also queried how many complaints came from MP/MS correspondence. **QS22.244.2** The Executive Director of Nursing and Midwifery advised that she hoped to be in a significantly different position in a few months' time. The Acting Associate Director of Quality Assurance advised that the position the Health Board is in now in terms of overdue complaints is very similar to when he arrived. He said that significant improvements had been made and that there is a plan in place to address the numbers. He noted that with regards to the Ombudsman, what was included was the annual level and that the Health Board had the highest rate of referrals. The Committee noted that the way that the data was presented was not necessarily helpful. **QS22.244.3** An Independent Member noted that the HMP Berwyn complaints had increased and asked how support for carers and family members was being taken forward. The Acting Associate Director of Quality Assurance advised that from a carers perspective there was a carers engagement officer and from the work undertaken within that role a plan has been formulated which will be taken forward.	

The Director of Communications and Engagement has been tasked with reviewing how telephony within the Health Board can be improved. **QS22.244.4 It was resolved** that the Committee received the report.	
QS22.245 Quality/Safety Awards and Achievements **QS22.245.1 It was resolved** that the Committee received the report on Quality/Safety Awards and Achievements and attendees were asked to raise any questions outside of the meeting.	
QS22.246 Health and Safety Executive (HSE) Compliance Update **QS22.246.1** An Independent Member queried, with regards to the mental health issues and the estates, what assurance could the Health Board give to the public and patients that what has been picked up by HSE have now been fully addressed. The Executive Director of Workforce and Organisational Development could not provide the Board with full or acceptable assurance that it could be evidenced that there was a safe system in place at the time of the meeting but confirmed that as for a level of reassurance, significant work was being undertaken to remediate the position. **QS22.246.2** The Executive Director of Public Health advised that a significant amount of work has been undertaken by the team since they had been involved, the Improvement and Development Group has been created and will be key for activity going forward and will report through QSE. **QS22.246.3** The Chair advised that there would be a more detailed discussion in the private session due to patient identifiable information and the advice given under legal privilege. **QS22.246.4** The Chair noted that the Board had been previously advised that policies were updated and embedded, however, the response letter to the HSE says that they are being worked through. The Executive Director of Workforce and Organisational Development advised that advice was taken on the matter and because there was no way of evidencing that they were embedded, they were unable to say so in the response. The Interim Director Mental Health and Learning Disabilities advised that the policies had been updated but that the process was a live and ongoing one. The Chair noted with concern that the Health Board was in this position and confirmed that further discussion would take place in the private session and report to the Board. **QS22.246.5 It was resolved** that the Committee: • noted the detailed breaches and response issued on 11 August 2022 • noted the measures to provide additional oversight of the work underway to address the breaches identified by the Health & Safety Executive	
QS22.247 Mortality Review Update	

QS22.247.1 The Acting Deputy Medical Director presented the paper highlighting that a higher percentage of deaths are being returned back to the Health Board for review. The detail was shared and it was noted that Sepsis had been highlighted as an area requiring further investigation. The Committee were informed that there was a lot of work ongoing on and that the Health Board is in a better place than previously. **QS22.247.2** The Committee discussed that the mortality reviews only relate to cases where the death is on site and therefore deaths in the community are not incorporated currently. The Acting Deputy Medical Director advised that if the family has raised a concern however then the case is picked up. **QS22.247.3** The Chair noted that Mortality reviews are on the public Board Agenda Meeting later in the month. **QS22.247.4 it was resolved** that the Committee noted the report.	
QS22.248 Chairs Assurance Reports from Strategic and Tactical Delivery Groups **QS22.248.1 It was resolved** that the Committee receive Chair's Assurance Reports and attendees were asked to raise any questions outside of the meeting.	
QS22.249 HMP Berwyn – Annual Report **QS22.249.1 The Committee resolved** to receive the HMP Berwyn Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.250 Safeguarding Annual Report **QS22.250.1 It was resolved** that the Committee received the Safeguarding Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.251 Regulation 28 Update **QS22.251.1** The Acting Associate Director of Quality Assurance reminded the Committee that at the meeting in July an interim position had been shared and the update being received was the outcome of this work. It was noted that prior to 2020 a different system had been in place. The paper themed the Regulation 28 notices and the Committee were informed that a significant number had been received on unscheduled care pressures and that given the different system prior to 2020, it had had been difficult to get evidence of action. It was noted that the changes in ambulance handovers would be monitored to ensure that a clear and robust plan can be provided to address the issues. **QS22.251.2** The Chair queried the assurance level of the paper noting that it had been identified as acceptable, however, given the number of notices where evidence could not be provided this seemed to be overly confident. The Acting Associate Director of Quality Assurance advised that the authors of the paper had	MJ

reviewed the evidence and identified the assurance level as acceptable. It was noted that the falls pathway language needed clarification and that an update be received following CEG. **QS22.251.3 It was resolved** that the Committee noted the report.	
QS22.252 – Infection Prevention Annual Report **QS22.252.1 It was resolved** that the Committee received the Infection Prevention Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.253 HIW Update **QS22.253.1** The Chair noted that the report did not provide any assurance that previous themes arising from HIW inspections have been addressed because there is insufficient information provided. The Executive Director of Nursing and Midwifery agreed with the Chair and advised that she and the Acting Associate Director of Quality Assurance would be doing an historical review of action plans to ensure that there is assurance and that the evidence is in place. **QS22.253.2** The Chair raised her concerns about the YGC Action plan and the Executive Director of Nursing and Midwifery noted that she would be working with the Programme Director for Clinical Safety Improvement and her team to ensure that robust evidence could be provided. **QS22.253.3 It was resolved** that the Committee received the report	
QS22.254 Issues Discussed in Previous Private Session **QS22.254.1** The Chair noted that the Health and Safety Executive and Regulation 28 had been received at the previous meeting in Private. **QS22.254.2 It was resolved** that the Committee noted the issues discussed in the QSE Private Session of 6 July 2022.	
QS22.255 Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 1 November 2022.	
QS22.256 Exclusion of Press and Public **QS22/256.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

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

				3/5/22 This should be in a position to complete in time for the next committee. At the time of writing the Policy is scheduled to be circulated by the end of the week.	
	6th July 2021				
2	~~K Williams~~ S Hill	**QS21/97.4 QPR** The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this	August	31.8.21 the separate COVID reports routinely include information on GP consultations. 7.9.21 L Reid did not feel the update above answered the original point which was that the QaPR included a narrative comment about GP consultation performance but did not include actual data. She felt this reduced the integrity of the report. This to be fed back to the Acting Director of Performance. 2.11.21 S Hill to follow up and ensure this action can be closed off. 05.01.22 The Performance team will include actual GP consultation activity in the next report. 05.03.22 To remain open as it is being tested by other Committees first. CS has discussed this with the Performance Team and this is being picked up within the current re-working of the report. Suggest close	
	6 July 2022				

3	G Evans	**QS22/114 Matters Arising and Table of Actions** The Acting Executive Director Of Therapies & Health Science to reconcile between the outcomes of the actions against the original report had not been concluded.	Nov 2022	25.08.22 Delayed due to unforeseen absence in senior Psychology service leadership to complete this work. Children's services (Matrics Plant) mapping to be presented to Nov 22 QSE. This item is on the agenda Suggest Close	
4	N Lyons	**QS22/127 Human Tissue Authority Preparedness Report** A briefing before the next meeting be shared on HTA given the concerns around safety, best practice and the lack of Human Tissue Reportable Incidents.	Nov 22	This item is on the agenda Suggest Close	
	6 September 2022				
5	M Joyes	**QS22.233 Patient Story** Share the number of Long Covid referrals with the Committee.		As of 17 October 2022, the service has received 1,273 referrals since it opened to referrals in December 2021. Suggest Close	
6	EJ Hosking	**QS22.237 Corporate Risk Register** Share the detail around support and access to care homes and what was being done to reduce the risk.		**Care Home Access** The number of people awaiting care home placement accounts for 33% of the total MFFD reported. Of these, 41% are waiting for nursing care homes and 59% for residential care homes. People awaiting domiciliary care	

				packages accounts for 42% of the total MFFD reported to the DU. Current Initiatives: · Block purchasing of additional care home capacity for step down and step up care · Advanced Nurse Practitioner support to care homes · Airedale programme to provide telemedicine support to care homes · New guidance on the 'Reluctant Discharge' · Training and education programme for care homes with and without nursing including e.g End of life care, infection prevention and control · Registering with CIW in order to provide domiciliary care Suggest close	
7	EJ Hosking	**QS22.237 Corporate Risk Register** Share the detail around the diabetic retinoic pathway and it is impacting on the delivery of care to patents		Patients with diabetic retinopathy now have an integrated pathway providing care closer to home and timelier access to treatment for R1 (the most urgent) patients. 40-60 patients per site per month are referred from secondary care to high street optometrists for diabetic retinopathy review. Optometrists use advanced techniques (previously not available in community / high street care settings). They can then give additional information in their referral letters to enable ophthalmologists to stream patients with diabetic retinopathy based on risk within 48 hours of receipt.	

				Suggest close	
8	P Meakin	**QS22.237 Corporate Risk Register** Share a timeline for risk 18113, Position of Trust and Section 5 (Professional Allegations) Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014]		The timeline is attached as appendix A: Suggest close	
9	P Meakin	**QS22.237 Corporate Risk Register** Review the risk paper to include target risk dates and flag when they would not be met, note and feedback to the RMG that the report could only give the committee partial assurance.		PM discussed this at the RMG in October 2022 and in principal it was agreed as an enhancement to the RM process. There is a report going to the RMG on 4 December to propose to finalise implementation from 1 January 2023 Suggest close	
10	J Gallanders	**QS22.238 Mental Health Outcomes and Improvements** John Gallanders to give feedback outside of the meeting,		Feedback given on 28/10/22. Suggest close	
11	T Owen	**QS22.238 Mental Health Outcomes and Improvements**		Meeting has been arranged for 31st October 2022.	

		T Owen to arrange to meet with J Gallanders.		Suggest close	
12	EJ Hosking	**QS22.240 Vascular Improvement Plan** Share the detail around the decision to not go back out to recruitment for the Clinical Director and how the decision to implement the new way of managing the service were made.		The health board had attempted to recruit a clinical director externally but without success. Two internal candidates were interviewed for the position, but neither were felt to be appointable at this time. After discussion with the SRO for vascular surgery and the operational team it was agreed to extend the responsibilities of the existing clinical director for surgery, anaesthesia and critical care to vascular surgery. This decision will be reviewed at 12 months. Other members of the consultant team have been assigned specific leadership roles and are working on these with support from the medical education team, the governance team and with Bangor University. Suggest close	
13	EJ Hosking	**QS22.242 Quality and Performance Report** EJH to respond to concerns raised around sepsis and what was being done to address the problem		The STEAR group continue to roll out their sepsis improvement plan which includes the adoption of a new assessment and treatment pathway which reflects latest evidence about triggers for diagnosis of sepsis. The new tool will reduce inappropriate antimicrobial use and allow greater focus on these patients who have true sepsis and need to follow the Sepsis 6	

				pathway. This is a pan-BCU initiative with robust clinical leadership. Suggest close	
14	A Wood	**QS22.242 Quality and Performance Report** AW to look into the pathway and identify issues in relation to the declining position for young diabetic people.	January	As this is a new measure, the Performance Team are undertaking a deeper look into the issue and plans, and will report back for the January meeting of the Committee.	
15	M Joyes	**QS22.243 Patient Safety Report** MJ to include learning identified, near misses and the dates of incidents in future Patient Safety reports.		Near miss section included in the report and dates of claims now included. Suggest Close	
16	A Wood	**QS22.243 Patient Safety Report** AW to update JG on the two patient identifiable incidents raised in the meeting		Information provided to JG regarding the incidents post meeting Suggest Close	
17	M Joyes	**QS22.251 Regulation 28 Update** The falls pathway language be clarified and an update be received following CEG.		As confirmed at the meeting, the falls pathway was updated at the time of the R28 Notice however the more recent work arising from the HSE Notice has prompted further review. The ADQ is meeting the EMD to discuss the reporting format of the further work being undertaken by CEG for future reporting to QSE.	

				Suggest Close	

RAG Status	
P	Complete
G	On track
A	Slippage on delivery
R	Delivery not on track

Purpose	Response to a request for a timeline from QSE Risk Action ID 18113
From	Safeguarding and Public Protection
Date	Requested 26.10.22 Submitted 27.10.22

CRR21-15; There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Wellbeing (Wales) Act 2014
(SSW)

Risk Action 18113; Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].

Which is aligned to the; Position of Trust and Section 5 (Professional Allegations) Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014.

Position	Action	Date
Historical First Operational SOP V01.00	Procedure - Allegation of Abuse to a Child/Young Person by a BCUHB Employee	November 2016
Change in Legislation Change in legislation: • Wales Safeguarding Procedures (2019) Section 5: Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust. The Procedures are underpinned by the; • Social Services & Well-Being (Wales) Act (2014) and the Social Services & Well-Being (Wales) Act 2014: Working Together to Safeguard People Volume 5 (Children) and Volume 6 (Adults)	• NW Safeguarding Board – expressed concern regarding the subjectivity of the; Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust – Section 5. • North Wales Safeguarding Board agreed to support the National discussions to develop operational guidance. • North Wales LAs agreed to discuss the procedure to determine a date of full implementation and training. • BCUHB SoP required review and update. • Requires collaboration and alignment with National and Regional developments and the development of any operational guidance.	April 2019

This new legislation in Wales brought an end to the Part IV process and introduced Section 5		
BCUHB Draft V01.01	• Proactive activity to prepare for National and Regional operational guidance. • BCUHB Standard Operating Procedure (SOP) – Safeguarding Allegations / Concerns about Practitioners and Those in Positions of Trust Work commenced on developing a new SOP which would reflect the Wales Safeguarding Procedures Section 5	May 2019
Agenda item – Safeguarding Senior Leads Forum	• First Draft version listed for discussion at Senior Leads following consultation within the Corporate Safeguarding Team	June 2019
Agenda Item- Safeguarding Senior Leads Forum	• Second Draft discussed at Senior Leads. Further work required	October 2019
Workshop activity – N0 1	Reviewed for further development of the SOP	July 2020
Workshop activity – N0 2	• Reviewed for further development of the SOP • Agreed Suite of documents to be developed to support the SoP.	July 2020
EQIA	Completed an EQIA for the Standard Operating Procedure (SOP) – Safeguarding Allegations / Concerns about Practitioners and Those in Positions of Trust	July 2020
BCUHB Draft V01.02 Internal consultation within the Corporate Safeguarding Team	Revised SOP and suite of Documents; • Director of Safeguarding & Public Protection for review • 2nd Consultation – Noted the paper – concern expressed regarding the delayed position of the development of a North Wales Multi-agency Procedure.	September 2020

	• 3rd Consultation – Heads of Safeguarding satisfied and supportive of the document following final amendments. • Further comments received and considered.	
Draft V01.02 Agenda item- Safeguarding Governance and Performance Group [SGPG] for ratification	Action from Safeguarding Governance and Performance Group [SGPG] to re disseminate the SOP for further comments. • Disseminated to all SGPG members on 14/10/20. To be returned by 27/10/20. • Further dissemination 22/10/20 no comments received in preparation to submit to Patient Safety & Quality Group [PSQG] on the 6th November 2020	October 2020 (14/10/20)
• BCUHB Draft V 00.02 Revision in line with Reporting Framework presented at Corporate Safeguarding Senior Leads Meeting. • Delay of all National work due to COViD resulting in staffing and logistical challenges. • Local Authorities as lead agencies adapted the Sec 5 guidance. (It is noted the 6 LAs have a different threshold for holding a Sec 5 and due to the subjectivity interpret the guidance differently).	• Not submitted for PSQG Agenda, required further consideration of the actions and direction of the North Wales Safeguarding Board. • Aware Local Authorities and other partner agencies are concerned that the Section 5 Guidance is too subjective. • NW Safeguarding Board agreed not to implement section 5 but to follow the key principles of Part 8 (Professional Allegation). Legal advice was sought, and agreed this was a safe option while National discussions were taking place. • Discussions continued and led by the NW Safeguarding Board on a National Footprint. • Discussions ongoing with noted progress and agreement for North Wales Safeguarding Board to develop a multi-agency procedure.	November 2020

• BCUHB continue to follow reporting under sec 5, Professional Regulation/Code of Conduct/BCUHBs key values and internal procedures.	• Director Safeguarding and Public Protection agreed the internal SoP remains on hold due to possible conflict with the NW Safeguarding board procedures. • Professional allegation reports submitted to the Local Authorities by BCUHB in line with Wales Safeguarding Procedures (2019) Section 5: Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust	
• BCUHB V01.02 remains on hold until National and Regional activities provide and update and expected timeline • National Task and Finish Group is established and is making reported progress.	• Development of a National Multi-agency Section 5, Persons in the Position of Trust National Guidance (unconfirmed title) • North Wales Safeguarding Board representative is a member of the National groups. • Reporting arrangements are to the NW Safeguarding Board Policy and Procedure Sub- Group. • Corporate Safeguarding have a 100% attendance at the NWSB P&P sub-group.	Summer 2021 – 12 months have passed.
• BCUHB V01.03 is in progress. • The National Task and Finish Group is actively engaged with the Safeguarding Boards in Wales, to develop a Section 5 Persons in the Position of Trust Guidance for Wales. • Next National Meeting November 22.	• Initiated internal activities and discussions to incorporate the learning from the implementation of the guidance by the 6 LAs. • Head of Safeguarding Governance, Quality and Risk has commenced collaboration with the Head of Workforce, Director of Professional Regulation with invitation to establish Trade Union engagement. • The learning and identification of trends and barriers is informing the revised internal guidance.	Monthly Updates – Following Reporting and Governance Arrangements. BCUHB Draft V00.03 Q3 Governed by the timing of the National work

	• Key objective to develop internal processes in light of the new BCUHB Operating Model Q3. • Internal activities monitored following the Safeguarding Governance and Reporting Framework. • Updates and monitoring of Risks/Controls and actions. • Progress update to be an agenda item on monthly Safeguarding Senior Meetings. • BCUHB SoP to be aligned to the National and Regional Guidance.	

Teitl adroddiad: ***Report title:***	Patient Story			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	A patient story is presented to the Board to bring the voice of the patient directly into the meeting. The digital patient story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

In line with best practice, the patient story is presented to the Board; it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	BAF21-10 - Listening and Learning

gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board
Falls Response Team

A video story told by staff from WAST and Occupational Therapy Service at Betsi Cadwaladr University Health Board.

Overview of Patient Story

The story is a collection of experiences from staff from WAST and BCUHB Occupational Therapy Service describing the Falls Response Team pilot.

Last year WAST received 55,000 calls in relation to falls and frailty which put significant demand on their service. In response to managing the demand locally a Falls Response Team was created in co-production between WAST and BCUHB covering Wrexham and Flintshire. This was a pilot project run over a 4-month period.

As part of the pilot, the team respond to calls where an elderly person has fallen with a view to managing the patient in their own home environment to help reduce unnecessary hospital admission. The Falls Response Team provide a holistic approach to supporting patients who have fallen or who are at risk of falling in their home.

Recent patient feedback has shown this service is of great benefit to both patients and their unpaid carers.

Summary of Learning and Improvement

The outcomes of the pilot have been positive. The service has since received an extension of funding which has enabled them to expand into the Conwy and Denbighshire area.

Key learning points shared:

- An example of strong partnership working between WAST and BCUHB on shared priorities.
- Improved communication and easier access to specialist support for patients.
- Person centred care, supporting the patient in his or her own environment.
- Access to localised care reducing the need for patients to access Secondary Care services.
- A good practise model that can be replicated across Wales.

This story highlights positive experiences and as part of our commitment to build a learning culture from patient experience, the learning from positive experience is equally important to ensure all people who use of services receive a consistently positive experience of their care.

The Patient and Carer Experience Team extend their gratitude and appreciation to all of the people who shared their experiences.

Teitl adroddiad: ***Report title:***	Executive Lead for Quality – Briefing Paper			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides the Committee with the Executive Lead for Quality Briefing Paper			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
The information presented in this report is underpinned by the detailed reports to the Committee.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	BAF21-10 - Listening and Learning			

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Lead Executive Report	

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Lead Executive Report to the QSE Committee August-September 2022

This paper offers a summary of key quality information for the preceding period between meetings. Detailed information is contained within the reports presented to the Committee.

The Committee is advised this report is live to the point of finalisation and therefore may present more detailed information than that within reports that cover a set reporting period.

Patient Safety

In brief, during June and July 2022, 25 nationally reportable incidents were reported to the Delivery Unit (compared to 24 in the prior period). Falls and pressure ulcers remain the highest prevalence harms. Improvement projects and groups are in place for both areas.

Within the period, three new Never Event was reported. In the current financial year, four never event have been reported compared to 7 in the same timescale in 2021/22.

The Patient Safety Report provides further detail of patient safety incidents.

Complaints

At the end of September 2022, performance remained below the All Wales target of 75% of complaints closed within 30 working days. On average, the number of complaints closed within the timeframe was 29%.

A recovery plan is in place and complaint compliance and improvement trajectories are a focus alongside incident management at Accountability Meetings with the Integrated Health Communities and Divisions. Each Integrated Health Community has submitted a trajectory of improvement which is being monitored by the Executive Director of Nursing and Midwifery.

One Public Interest Reports were received by the Ombudsman. This is detailed in a separate paper.

NHS Wales Awards

The Health Board was a finalist for the following awards -

- Delivering person-centred services - BCUHB Long COVID Service
- Empowering people to co-produce their care - Developing a heart failure remote monitoring digital app to empower patients co-produce their care

- Empowering people to co-produce their care - Long Covid Lived Experience Partnership Group

- Improving health and wellbeing - Community cardiology diagnostic vehicle. An innovative response to C19 and the future for cardiac diagnostics

- Improving health and wellbeing - Working in partnership to achieve person centred care in Learning Disability Services

On the night, the Health Board was successful in winning the awards for **Empowering people to co-produce their care** (for the Long Covid Lived Experience Partnership Group) and **Improving health and wellbeing** (for the Community cardiology diagnostic vehicle. An innovative response to C19 and the future for cardiac diagnostics).

We thank all the finalist teams and those who won. Of note, a strong theme of co-design and co-production is evident in all the finalist teams which reflects the improving approach to patient and carer experience across the Health Board.

Regulation 28 Notice

The Senior Coroner for North West Wales has indicated they will be issuing a Prevention of Future Deaths Notice following an inquest in October 2022. At the time of writing, the Notice has not been issued.

Quality Recognition

The Quality Awards and Achievements Paper highlights a range of successful quality initiatives and improvements. At the time of writing, the Health Board was looking forward to the NHS Wales Awards on 20 October 2022 – a verbal update will be provided to the Committee.

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to highlight the discussions which took place during the Risk Management Group meeting on the 4th October 2022 and to note the progress on the management of the Corporate Risk Register and the new escalated risks aligned to the Committee. In the Risk Management Strategy, the Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition, the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy. The QSE Committee will also review risks with a residual rating of 15-25, ***with a particular focus on risks to patient safety, quality and patient experience, taking into account risks identified through clinical and internal audit processes.***			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review and discuss the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin, Associate Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	See the individual risks for details of the related links to Strategic Objectives.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	See the individual risks for details of the related links to the Board Assurance Framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group met on the 4th October 2022 and further updates to the risks have been incorporated. Please see the individual progress notes on each risk.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: ***Next Steps:*** The Risk Management Group will be meeting on the 6th December 2022, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 20th January 2023.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 - Quality, Safety and Experience Committee Corporate Risk Register Report. Appendix 2 - Newly Escalated Risks Appendix 3 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score. Appendix 4 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels.	

Quality, Safety and Experience Committee
1st November 2022
Corporate Risk Register Report

1. Introduction/Background

1.1 The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

1.2 In the Risk Management Strategy, the Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition, the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy.

1.3 The QSE Committee will review risks with a residual rating of 15-25, ***with a particular focus on risks to patient safety, quality and patient experience, taking into account risks identified through clinical and internal audit processes. (Appendix 1)***

1.4 The Report author has agreed with the Chair of the Committee that given the Committee's role above it would be useful to report the full Corporate Risk Register to the Committee for information as well as to draw attention to the risks related to patient safety, quality and patient experience. Finally, a new section is introduced in this report that outlines "Emerging Risks" so that the Committee can see risks that are under development for formal inclusion in the CRR from the next Risk Management Group meeting in December.

(NB Work is underway to redesign Committee Risk and Board Assurance Framework reports as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments)

2. Body of report

2.1 The Risk Management Group met on the 4th October 2022 to review the Corporate Risk Register which included a "deep dive" into the below risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint.

- CRR21-16 – Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients. – The risk was presented to the group by the Head of Health, Safety and Security where compliance figures were discussed as currently lower than expected, training facilities were discussed. Current vacancies in relation to trainers are proving difficult due to the requirement for the trainers to be clinical staff.
- CRR22-23 – Inability to deliver safe, timely and effective care – The risk has moved over to the Integrated Health Community's from the Office of the Nurse Director due it being an Emergency Department risk. Clarity was sought whether the risk is an East

region only risk or a Pan –BCU risk as Central and West regions may feel the risk is not relevant for a pan BCU Corporate Risk. Following discussion at the group a continued deep dive into the risk was not completed.

- CRR22-24 - Potential gap in senior leadership capacity/capability during transition to the new Operating Model. – The risk was presented to the group and commented that the risk continues to be reviewed along with the action plan during continual development, suggested that the risk score isn't changed at this stage as there are still critical posts that need to be appointed to.

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting scheduled for the 6th December 2022.

2.2 Following discussion and support at the Risk Management Group during August 2022, risk CRR20-06 is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' has been developed, whilst work remains ongoing to develop a further 2 new risks for 'Timely and consistent patient care' and 'Digitisation, Workforce and Transition', which will include the transfer over of open actions from the current CRR20-06 and result in the archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'

2.5 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	27	0	5	1
Tier 2 (9-12)	400	68	54	84
Tier 3 (1-8)	231	33	31	107

3. Developing and Emerging Risks

3.1 This section outlines those risks that will formally be reported in the next RMG meeting in December 2022 following Executive approval. As well as those risks that have been identified as "developing risks" for consideration by an Executive for consideration by RMG in December 2022.

3.2 The following risks have been incorporated onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group have been included onto the Corporate Risk Register (Appendix 2).

- CRR22-25 – Risk of failure to provide full vascular services due to lack of available consultant workforce.

- CRR22-26 – Risk of significant patient harm as a consequence of sustainability of the acute vascular service
- CRR22-27 - Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.

3.3 The following risks have been incorporated onto the Health Board's risk register and following Executive approval, work continues to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model.

3.4 At the time of writing the report other risks have been identified as being potentially eligible to be included in the CRR. They have not been definitively defined and developed yet but relate to Public Health and Health and Safety. The purpose of highlighting this is to give the Committee a forward look on emerging risks and risks under further development. A further update can be given at the meeting.

3.5 The Associate Director of Governance is continuing to use the developing Integrated Governance Framework to highlight and amend risks that may not yet appear on the CRR. A notable update is the introduction of the Health Board Leadership Team (October 2022). The membership reflects the full breadth of BCUHB's Patient Facing Services and now includes a risk update report that requires the membership to consider risks that are not on the CRR but need to be further developed. A golden thread of this report has also been included in a revised Terms of Reference for the Executive Delivery Groups (agreed by HBLT on 19 October 2022) Terms. It will also be a feature of the Operational Delivery Groups that are currently under development. A further update can be provided by the report author in the Committee.

4. Budgetary / Financial Implications

4.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

5. Risk Management

5.1 See the document of risks related to QSE Committee in Appendix 1

5.2 See the document of newly escalated risks in Appendix 2

5.3 See the list of all CRR Risks in Appendix 3

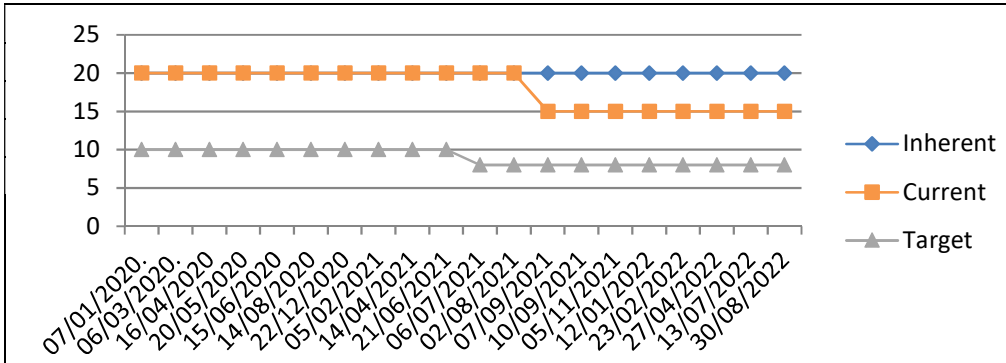
6. Equality and Diversity Implications

6.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

6.2 Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 – Quality, Safety and Experience Committee Corporate Risk Register Report.

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 30 August 2022
	Risk: Asbestos Management and Control	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2023
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, Health and Safety Executive enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. 2. Annual programme of re-inspection surveys undertaken. 3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available. 6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place. 8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 9. 5 year programme for the removal of high risk asbestos with monitoring at the Asbestos Group is in place with oversight at the Strategic Health and Safety Group. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. 11. Senior Estates Officer/Asbestos Management appointed and in place. Review of systems and procedures in line with the Asbestos management policy.	4. Internal Audit review undertaken against the gap analysis. 5. Self-assessment completed and submitted to Welsh Government which use specialist services to review the returns for consistence and compliance.

Gaps in Controls/mitigations
Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 80%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter one in 2022. Whilst it was anticipated that the target score would have been met by quarter 1, staff shortages due to COVID have been experienced which have influenced the ability to achieve the target.

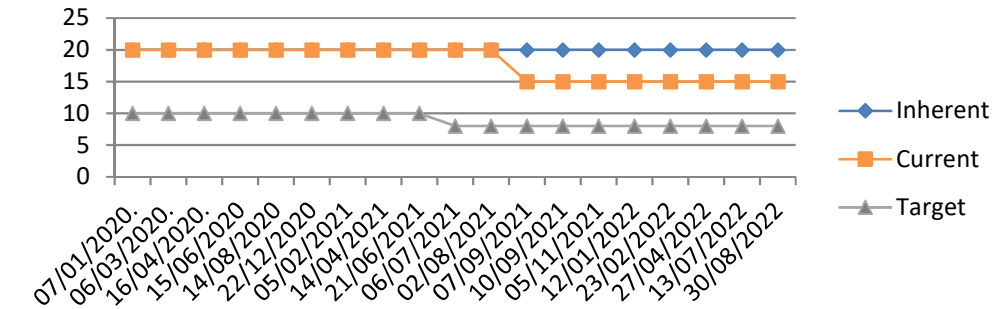
Progress since last submission
1. Controls in place reviewed to reflect current risk position. 2. Gaps in controls reviewed to reflect current risk position. 3. Asbestos Management Policy has been updated and revised version going for sign off at Quality, safety and Experience Committee on the 6th September. 4. Subject to the review by the newly appointed Senior Estates Officer and to no issues of significance identified, it is anticipated that a request to consider a reduction to the current risk score will be made at the next risk submission with consideration also to de-escalate the risk to a Tier 2 following the review.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates And Facilities	31/03/2023	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely. This information is currently held by a third party. With the implementation of the MiCAD system, this will digitalise the information held locally by the Health Board.	On track
	23728	Implement recommendations following the review by the new Senior Estates Officer/Asbestos Management.	Mr Arwel Hughes, Head of Operational Estates	31/03/2023	Provide assurance that the systems of controls are suitable and sufficient to meet the requirements of Asbestos Management Regulations.	On track

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 30 August 2022
	Risk: Contractor Management and Control	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2023

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Control of Contractors Procedure in place, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 2. Induction process being delivered to new contractors, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group. 8. Approved Contractors Framework for minor works across the Health Board in place, monitored quarterly as part the Contract Performance Review.	

Gaps in Controls/mitigations
Staff resources gap due to demand versus capacity. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors.

Progress since last submission
1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been updated to include the mitigation in place. 3. Proposal to extend the target risk due date from the 30/09/2022 to the 31/03/2023 to allow sufficient time for the purchase and implementation of the new framework software solution. 4. Approval by Information Governance and cyber security group to procure framework software solution. 5. Estates and Facilities will liaise with Corporate Health & Safety Team regarding the role out of practices of Estates & Facilities to other departments, the Corporate Health and Safety team will be invited to the next update of the risk for discussion. 6. Action ID 12252 – Action delayed as the action will fall in line with the implementation of the new operating model when roles and responsibilities will be confirmed. 7. Action ID 12256 – Action delayed with procurement in progress to purchase the SHE system, anticipated implementation by March 2023. 8. Action ID 12257 – Action delayed, brought to the attention of key groups and working with these areas to on board with system and processes that Estates and Facilities are currently developing and working to implement.

9. Action ID 12258 – Action delayed with finalisation following implementation of the new operating model when roles and responsibilities have been confirmed.
10. Action ID 12552 - Action closed as completed with regional framework of contractors for minor works reviewed, current paper based process confirmed as acceptable, this will be vastly improved following the introduction of the new SHE software which would introduce a live system for monitoring compliance.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and Health & Safety Management (within Health & Safety Policy).	Mr Rod Taylor, Director of Estates And Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to	Delay

					ensure compliance. August 2022 progress update - The action will fall in line with the implementation of the new operating model when roles and responsibilities will be confirmed.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Mr Rod Taylor, Director of Estates And Facilities	31/01/2022	Implementation of (SHE) - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board. August 2022 progress update – Information Governance and cyber security approval given and procurement in progress to purchase the SHE system, anticipated implementation by March 2023.	Delay
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates And Facilities	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health	Delay

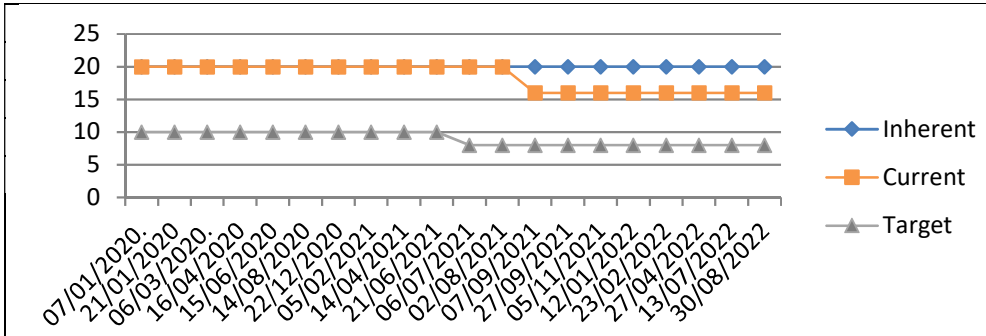
					Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. August 2022 progress update - Brought to the attention of key groups and working with these areas to on board system and processes that Estates and Facilities are currently developing and working to implement.	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates And Facilities	31/03/2022	Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and	Delay

					Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. August 2022 progress update - Finalisation following implementation of the new operating model when roles and responsibilities have been confirmed.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates And Facilities	30/09/2022	Action closed 30/08/2022 Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances	Completed

					Hazardous to Health and Inspection process to ensure compliance. August 2022 progress update - Regional framework of contractors for minor works reviewed, current paper based process confirmed as acceptable in that all contractors go through the standard induction process, this will be vastly improved following the introduction of the new SHE software which would introduce a live system for monitoring compliance.	

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 30 August 2022
	Risk: Legionella Management and Control.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2023

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group, which is reported to Infection Prevention Sub-Group and Quality and Safety Committee. 2. Risk assessment undertaken by clear water, with action and issues reported to the water Safety Group. 3. High risk engineering work completed in line with Clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas. 6. Authorising Engineer water safety in place who provides annual report.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group. 4. Quality, Safety and Patient Experience Committee.

7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team. 8. Water Safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken. 10. Alterations to water systems are now signed off by responsible person for water safety. 11. Local Infection Prevention Groups in place with oversight of water safety.	

Gaps in Controls/mitigations
1. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently unfunded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety, which forms part of the ongoing business case. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

Progress since last submission
1. Controls in place review to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Request to extend the target risk due date from the 30/09/2022 to the 31/03/2023 due to the identification of risks within the contractor provider software system and awaiting the findings of the authorising engineer water safety targeted audits which may identify items for mitigation. 4. Revised Water safety policy has been approved by the Water Safety group and Infection Prevention Sub Group and will be submitted to the Quality, Safety and Experience Committee in November 2022. 4. As part of the appointment of the authorising engineer, targeted audits are planned for each of the 3 operational areas which commences in August 2022 with completion by end of March 2023 (outcomes from these audits will be considered for areas of improvement and mitigation should they be required).

5. As a result of concerns raised during the transition of data from the existing software model to a new model a targeted intervention with the appointed water safety contractor was required. This work is ongoing with an anticipated completion date of the end of October 2022.
6. Standard Operating Procedure for management of little used outlets developed and approved by the water safety group and Infection Prevention Sub-Group.
7. Water Safety plan has been developed, signed off by water safety group and updated to the Infection Prevention Sub-Group and has been implemented.
8. Action ID 12262 – Action delayed due to the scale of implementation requirements for baseline CAD drawings at all Health Board owned property. The target completion date for the work is end of November 2022.
9. Action ID 12266 – Action closed as completed with the result tracking monitored by the water safety group.
10. Action ID 12267 – Action delayed, awareness training is included within the Infection Prevention mandatory training module.
11. Action ID 19015 – Action delayed, ongoing with Finance as there may be an allocation identified in the Intermediate Medium Term Plan for allocation within the current Financial year.
12. Identification of new action ID 24081 to provide an audit response following the Shared Services Authorised Engineer for Water Audit.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement	Mr Rod Taylor, Director of Estates And Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to	Delay

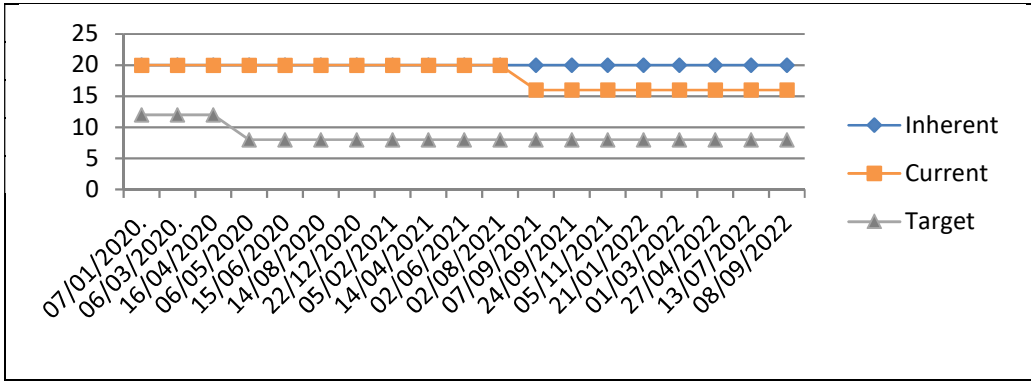
target risk score		MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.			MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021. August 2022 progress update - The current paper based solution although deemed compliant, will be replaced by an improved software based solution which has incurred a slight delay to the action completion date. Due to the scale of implementation requirements for baseline CAD drawings at all Health Board owned property. The target completion date for the work is end of November 2022. Until this work is complete schematic plans for water safety etc cannot be uploaded to the MiCAD, the action will not be completed prior to this period.	
	12266	Standardised result tracking, escalation and notification procedure in	Mr Rod Taylor, Director of	30/09/2022	Action Closed 30/08/2022 Escalation and notification	Completed

		place, with appropriate escalation route for exception reporting.	Estates And Facilities		process is contained within Policy for the Management of Safe Water Systems (Appendix B). August 2022 progress update - The result tracking is monitored by the water safety group and where necessary appropriate escalation, the process for which is described in the revised and approved Management of Water Safety policy. The current paper based solution although deemed compliant, will be replaced by an improved software based solution which has incurred a slight delay to the action due to the delay in implementation.	
	12267	Awareness and training programme in place to ensure all staff aware as part of Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates And Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board. August 2022 progress update - Awareness training is included	Delay

					within the Infection Prevention mandatory training module.	
	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Mr Rod Taylor, Director of Estates And Facilities	31/03/2022	Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on water safety and provide assurance of compliance to the water safety group. August 2022 progress update - Ongoing with Finance as there may be an allocation identified in the IMTP for allocation within the current Financial year.	Delay
	24081	Audit response following the Shared Services Authorised Engineer for Water Audit	Mr Rod Taylor, Director of Estates And Facilities	31/03/2023	Address any shortfalls identified as a result of the audit which will be required to be implemented.	On track

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 September 2022
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2025

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Fire Safety Policy established and implemented, annual report reported to Board and supported by Welsh Government. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken. 6. Escape routes identified and evacuation drills undertaken, established and implemented.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Annual Compliance returns submitted to Welsh Government.

7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff. 8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens. 9. Appointed Authorising Engineer for fire safety in place through NHS shared services (specialist estates services).	

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments. 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals. Ysbyty Gwynedd - Programme BC submitted to WG currently in discussion to secure capital for professional fees to develop a priority list of fire safety measures in advance of the site wide re-development. Wrexham Maelor Hospital - £40m allocated to the site which includes fire safety for active and passive fire safety measures.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Proposal to extend the target risk due date from the 30/09/2022 to the 31/03/2025, to enable the completion of the extent of work now required to achieve compliance with current and future regulations. 4. Action ID 12274 – Action closed as completed. 5. Action ID 12276 - Action delayed due to awaiting the all wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. 6. Action ID 15036 – Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023. 7. Action ID 21491 – Action closed as completed, Fire Safety Policy to be presented to Quality, Safety and Experience Committee on the 1st November 2022 for ratification.

8. Identification of new action ID 24142 to develop a Management structure to ensure adequate capacity to deliver Fire Safety requirements within the Health Board.

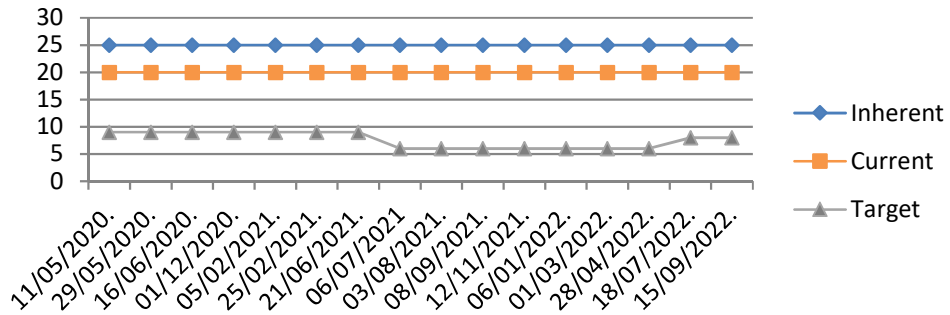
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12274	Identify how actions identified in the site Fire Risk Assessments are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/07/2022	Action Closed 08/09/2022 Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding. August 2022 progress update - Action closed as completed.	Completed
	12276	Consider how bariatric evacuation training is undertaken and define current plans for	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. August 2022 progress update -	Delay

		evacuation and how this is achieved.			Action delayed due to awaiting the all wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group.	
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order. August 2022 progress update - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023.	Delay
	21491	Review and refresh existing BCU Fire Safety Strategy.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Action Closed 08/09/2022 Fire Safety Strategy will bring all procedures, action plans etc. together to improve governance control and oversight of Fire Safety Management. August 2022 progress update - Action completed Fire Safety Policy to be presented to Quality, Safety and Experience Committee on the 1st November 2022 for ratification.	Completed

	24142	Develop a Management structure to ensure adequate capacity to deliver Fire Safety requirements within the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Ensure compliance with Fire Safety Legislation. Business case to be developed to secure funding to align with the new Fire Management structure.	On track

CRR20-05	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15th September 2022
	Risk: Timely access to care homes	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 September 2022
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Multi-Agency Oversight Group and Care Provider Operational Group continue to meet to oversee the ongoing Covid response, to support recovery and ensure sustainability of the sector to respond to care home and domiciliary care demand with clear pathways for escalation in place. 2. North Wales care homes single action plan provides the framework for the Multi-Agency response and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB).	1. Oversight via the Care Home Operational Group which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board.

3. Development of the Quality Assurance Framework - this work is overseen by a Multi-Agency Implementation Group with sign up from the 6 Local Authorities and the RPB. The work is supported by 6 work streams which picks up the ongoing work around Covid and recovery. This work is progressing well and risks are well managed and is now embedded into core work. 4. Continuing Health Care Operations Group in place to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees is also in place.	

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report has now been published in draft (subject to ratification by the Health Board and 6 Local Authorities by October 2022). Urgent demand and capacity work has commenced as part of the requirement to commission an additional community care placements by October 2022 (243 placements for North Wales). 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge, but insufficient domiciliary care provision to step down to. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report and as part of the additional community care placements. 3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. Work ongoing with IT and Performance to develop digital system which is currently being piloted. This will provide a more robust system of data collection, including delays by Local Authority. 4. No signed Pre Placement Agreement (PPA) - lack of controls in place for addressing concerns, monitoring quality - there is only informal voluntary co-operation. This gap in control is shared with the 6 Local Authorities. There is a joint PPA working group in place but failure to 'sign off' continues. Regional Commissioning Board has sought legal advice. The final draft PPA is currently with the LA commissioning teams, prior to being issued to independent providers in October. 5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards, but due to increasing economic pressures this is already being challenged as insufficient by providers. . 6. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to provide staff. In order to identify further mitigation the ‘Escalation Matrix’ which was developed during covid has been reviewed.

This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation

Progress since last submission
1. Due to the gaps in controls, and the current demands on patient flow, agreement for a review of this risk with the intention of splitting into two. One in relation to contracting and finance, and the second in relation to quality and assurance (including MFFD). This is still in progress. 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls updated to reflect that there is a work programme in place to review the discharge policy which will include a task and finish group to address the gaps in medically fit for discharge with a report providing a standardised approach for North Wales. In addition work progressing with IT looking at a national data set. 4. Assurances updated to reflect current risk position. 5. The Health and Social Care transition plan was updated on 18th July 2022, the extension to the Target risk due date will to allow time to interpret and implement the next stages required. 6. Pre-Placement Agreement is in the final stages by the 6 Local Authorities and Care Forum Wales and will be sent out to providers for signing in September. Consideration is being given to the implications of any provider refusing to sign the PPA with the aim of having a joint response plan for the 6 LAs and Health Board. 7. In response to recommendation 2 and 4 of the Welsh Audit Office report on Commissioning Older Person's Care, a workshop is being arranged for September. *Recommendation. 2 - The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.* *Recommendation 4 – North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and following this, develop an associated delivery plan.* 8. Action ID 18025 – the action remains delayed and is linked to action ID 20074. This was escalated to the Regional Workforce Board in July with the recommendation of appointing some dedicated support. 9. Action ID 20074 - Action closed as it is not considered deliverable. Point 6 above provides mitigation. 10. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk.

11. Significant progress has been made by the HB and partners in identifying 243 additional care placements (Gaps/ Controls). Capacity will be phased in from end of September. The schemes identified to achieve the additional capacity is being co-ordinated at Integrated Health Economy level, with the respective LAs, and will be subject to an assessment of deliverability (particularly focused on workforce availability). We will you now continue to work with social care, colleagues, colleagues in BCU and particularly work force, to ensure that there is no / minimal negative impact / destabilisation on other aspects of the Health and Social Care system. Reporting requirements and baselines are yet to be agreed.

Links to	
Strategic Priorities	**Principal Risks**
Primary and community care	BAF21-03

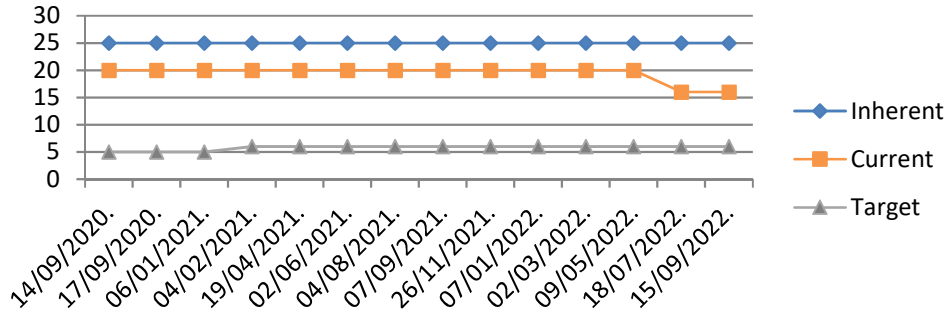
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/04/2022	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge. September 2022 progress update - Action delayed. This was escalated to the Regional Workforce Board In July with the recommendation of appointing some dedicated support.	Delay
	20074	Development of an interim relief bank for health and social care	Mrs Marianne Walmsley, Lead Nurse	31/01/2022	Allow flexibility in relation to staffing within homes.	Completed

			Primary and Community		Action closed as it is not considered deliverable. Pre-Placement Agreement is in the final stages by the 6 Local Authorities and Care Forum Wales and will be sent out to providers for signing in September. Consideration is being given to the implications of any provider refusing to sign the PPA with the aim of having a joint response plan for the 6 LAs and Health Board.	
	22182	Review and update Health Board Discharge policy.	Ms Jane Trowman, Care Home Programme Lead	30/09/2022	Discharge policy reviewed, updated and will support the assessment around medically fit for discharge patients.	On track

CRR20-08	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 September 2022
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 December 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Decreased		

Controls in place	Assurances
1. Outsourcing process and group in place to review progress against the contract.	

2. Cataract outsourcing - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. 'Once for North Wales' process is in place, partially across all sites, Cataract patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access. 4. Once for North Wales/mutual aid process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed. 5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites. 6. Monthly monitoring of the application of the Cataract Priority Targeting List (PTL) to ensure Pan BCU reduction of access inequity. 7. ODTC Single Tender Waiver enabled continuation of use of Primary Care Optometry (until September 2022). 8. Clinical condition dashboard now available for beta stage is live and implemented to support documentation and site self-management of clinical condition use to manage services. 9. Pan BCU Clinical Lead now appointed.	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators. 4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government. 5. Performance reviewed at Secondary Care Accountability Meetings.

Gaps in Controls/mitigations
1. Further table-top risk stratification is challenged by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of those at risk of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case. 2. Outsourcing of the cataract activity is in place along with additional temporary administration support, however, there is need for sustainability moving forward. 3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans. 4. National standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 2.8-3.6, differences in national standards between number of cataract procedures per list.

Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions. First session took place on the 28th February 2022. GIRFT (Get it right first time) to commence working with Ophthalmology in Autumn 2022.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. The service will look to disaggregate the risk by the clinical conditions which will enable the risks to reflect impact on patient safety/care by the clinical conditions. Risk 1 - Delay of care leading to increased potential risk of Irreversible Sight-Loss (Predominantly Glaucoma/Diabetic Retinopathy/AMD). Risk 2 - Delay of care leading to increased potential risk of reversible Sight-Loss/risk of social isolation/falls/poor quality of life (Predominantly Cataract). The service are to meet with the Senior Management Team for Eye Care to discuss the risks and further develop. It is anticipated that the revised risks will be submitted to the next Risk Management Group meeting in December 2022.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways Strengthen our wellbeing focus	BAF21-02 BAF21-04

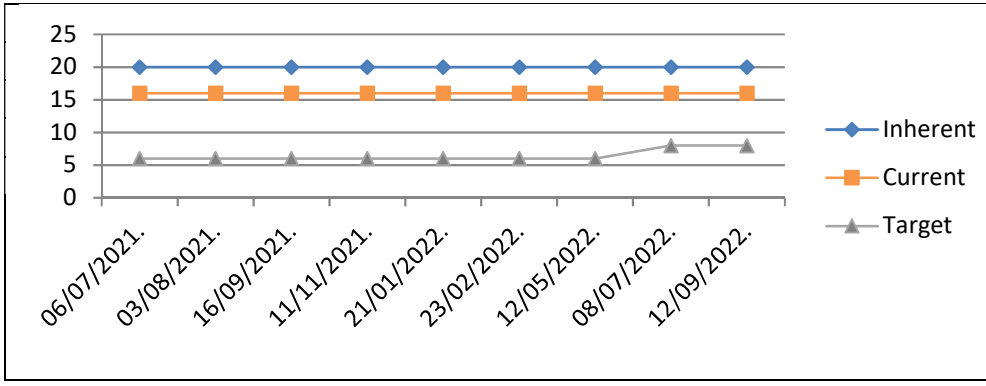
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	20392	Following approval of the internal eye care business case, recruitment to support additional Intra Vitreal Therapy capacity is ongoing as well as the digital programme.	Alyson Constantine, Site Acute Care Director	31/12/2021	Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation. August 2022 progress update - Partial recruitment mitigation, all sites recruited to all but Consultant posts. Consultant recruitment potential to be maximised through amalgamating vacancies to progress a Pan BCU post. Breakdown of current vacancies is being shared with pan BCU clinical lead who is exploring the potential of pan BCU posts with colleagues.	Delay

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 12 September 2022
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 December 2025

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board.
This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Workforce Recruitment and Retention Strategy in place and actively monitored with initiatives in place to maximise recruitment and retention across the nursing workforce. 2. Nurse Staffing Policies NU28/MHLD 0028/ outlines standards and escalation in relation to identifying and mitigating nurse staffing shortfalls across wards and departments. Nurse staffing vacancies and recruitment activity is monitored through the nursing recruitment and retention group which currently reports to the Strategic Workforce Group. 3. Bi-annual Nurse Staffing calculations are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing calculations are also undertaken in other areas of acute services such as admission portals, Emergency Departments and areas of high care. 4. A Strategic Recruitment and Retention Group in place to monitor and develop forward look recruitment and retention initiatives to mitigate nursing shortfall over the next 5 years. 5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to ensure roster performance is actively managed to enable maximum utilisation of nursing workforce across the Health Board. 6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised. 7. Utilisation of the SafeCare allocate system to provide a live/real time view of nurse staffing levels, skill mix, and patient demand. The system provides nurse managers with visibility across wards and areas enabling acuity based, safety driven decisions regarding nurse staffing and the deployment of staff. 8. BCUHB Nursing Career Framework in place and utilised to develop and train our existing nursing workforce to meet identified workforce gaps and meet succession plans across the Health Board. 9. Workforce planning and commissioning process in place to triangulate the requirements to develop and deliver the nursing pipeline to meet the current and future needs within the nursing workforce across BCUHB.	1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings. 2. Compliance with the Nurse Staffing Act and Nurse Staffing calculations are reported to the Board bi-annually (May/November) via the Quality, Safety and Experience Committee as the designated committee. 3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support 4. Monthly SafeCare compliance reports have been developed to identify areas in need of targeted support to enable a live view of nurse staffing levels, skill mix, and patient demand. 5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy 6. Monthly sickness absence reports produced by WOD, monitored via the workforce utilisation meetings, and managed locally by senior nursing teams.

10. Full representation and active participation in national policy and decisions making forums such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group.	

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to Key Performance Indicators e.g. Annual Leave/training. A Workforce Nursing Utilisation Dashboard has been developed and introduced to senior nursing teams to optimise nurse staffing rosters. 2. Whilst adult acute medical and surgical, and Area Teams Central and West have fully implemented the Safecare Allocate System, East Area, paediatrics and Mental Health are yet to implement. Although the Health Board has been using the system for some time there has been a significant change at matron and ward manager level and it is recognised that additional support is required to these areas to re-establish the discipline and compliance required to enable acuity based, safety driven decisions regarding nurse staffing. An implementation plan will oversee the roll out in outstanding areas. The All Wales SafeCare Standard Operating Procedure will further guide and strengthen the use of the system at an operational level. The newly appointed Nurse Staffing Programme Lead will oversee the implementation and associated training requirements relating to the SafeCare System. 3. Not all Nursing staff groups are on electronic rotas and not everyone is IT literate, due to personnel changes there is a requirement for refresher training. Plan being developed to move all nurse staff groups onto roster with a specific IT training plan aligned to this initiative. 4. Whilst the recruitment and retention strategy and plan are in place, this needs updating in line with the update of the Health Board's People strategy. Individual initiatives are in place to inform data analysis and the revised strategy will take these into account along with the wider All Wales recruitment and retention initiatives. This is being led by Director of Nursing for Workforce Staffing and Professional Standards. 5. There remains a gap in filling of nursing vacancies across the Health Board, continued advertising and recruitment and development of business case for the oversees programme and support within the nurse recruitment team.

Progress since last submission
1. Controls reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Appointment of the Nurse Staffing Programme Lead. The post is integral with regards to supporting areas and services with the implementation and use of the Safecare health roster. 4. The Autumn nurse staffing reviews are in progress and on track for completion by the end of September 2022. Nurse staffing calculations will be presented to the Executive Nurse Director in October 2022 in readiness for presentation to the Board in the November 2022 via the Quality, Safety and Experience Committee. 5. Plans in place to Corporately recruit Health Care support Workers in readiness for the winter surge. 6. Action ID 15635 – Action delayed pending the launch of the new People Operating Model (Workforce) which is expected to be in place by 30/09/2022. 7. Action ID 17433 – Action delayed to ensure this action aligns with the Chief Nursing Officer (CNO) Wales workforce priorities. 8. Action ID 18834 – Action delayed, existing workforce dashboards have been re-visited to include total staff availability and staff utilisation. 9. Action ID 22121 – Action delayed, nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated completion end of November 2022. 10. Action ID 22122 – Action delayed, pending the launch of the people strategy. Requires Board decision regarding investment in the oversees nurse recruitment programme and nurse recruitment team, anticipated completion by December 2022. 11. Identification of new action ID 24185 for Corporate recruitment of Health Care Support workers to close the vacancy gaps and provide a stable and resilient workforce ahead of winter pressures.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Effective alignment of our people (key enabler)	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	30/11/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and Key Performance Indicators of the business case are linked to the relevant sections of our corporate risk register. September 2022 progress update – this action is now delayed pending the launch of the new People Operating Model (Workforce) which is expected to be in place by 30/09/2022.	Delay
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.	Delay

		subsequently aspirant programmes.			In 2021/2022 the Health Board embarked on an ambitious three year people and organisational development journey (Mewn undod mae Nerth/Stronger Together). This was and is aimed at enabling the organisation to move forward and deliver its Clinical Strategy/Plan through delivery of its People Strategy and Plan – Stronger Together. The feedback from over 2,000 staff has informed the development of 5 programmes of work, one of which is 'the Best of our Abilities', this includes the development of an integrated Leadership & Management Development Framework for all professional groups, aligned to a new Learning and Education Academy. The risk associated with the development of specific leadership offers related to specific staff groups, i.e. Head of Nursing and Ward Manager programmes will be reviewed as part of this work, with a	

					proposal to develop a new Framework which will be inclusive of all professions and will provide a more streamlined, multi-disciplinary approach. September 2022 - Action to be reviewed to ensure this action aligns with the Chief Nursing Officer (CNO) Wales workforce priorities	
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development September 2022 progress update - Meeting scheduled for August 2022 was cancelled, this issue will be raised at the next planned meeting for Autumn.	On track
	18834	Introduce targeted monitoring across rosters, through Key Performance	Mr Nick Graham, Workforce	30/09/2022	Effective utilisation of substantive staff.	Delay

		Indicators management to reduce agency expenditure and maximise substantive staff usage.	Optimisation Advisor		September 2022 progress update - Existing workforce dashboards have been re-visited to include total staff availability and staff utilisation., the dashboard has been presented to PCRTG workforce group and will be presented in further workforce groups over the next few weeks. The nursing workforce dashboard will support future workforce utilisation meetings led by the Director of Nursing Workforce/Nurse Staffing programme lead.	
	18835	Support and progress existing band 4 roles through to fastrack nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mrs Alison Griffiths, Director of Nursing Workforce	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce. September 2022 progress update - Action remains on track for December 2022.	On track
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health	Mandy Jones, Deputy Executive Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design	On track

		Board's business planning cycle.			and nurse re-deployment across the Health Board. September 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme.	
	22121	Implement Allocate Safecare system to all clinical areas and associated training requirements.	Mrs Alison Griffiths, Director of Nursing Workforce	30/09/2022	Ensure that Health Board has increased visibility of the Nursing workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level. September 2022 progress update - Nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated completion end of November 2022.	Delay
	22122	Refresh and update the Nursing Recruitment and Retention strategy	Mrs Alison Griffiths, Director of	30/06/2022	This will allow an integrated medium term plan to be developed and implemented to ensure nurse recruitment and	Delay

			Nursing Workforce		retention better identifies and resolves nurse staffing challenges. September 2022 progress update - Pending the launch of the people strategy. Requires Board decision regarding investment in the oversees nurse recruitment programme and nurse recruitment team, anticipated completion by December 2022.	
	23095	Develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio. September 2022 progress update - Business case developed and submitted, awaiting approval.	On track
	24185	Corporate recruitment of Health Care Support workers to close the vacancy gaps and provide a stable and resilient workforce ahead of winter pressures.	Mrs Alison Griffiths, Director of Nursing Workforce	31/12/2022	Provide a stable and resilient workforce ahead of winter pressures, and associated increased activity and patient acuity. 3 phased approach will be taken phase 1 will recruit from	On track

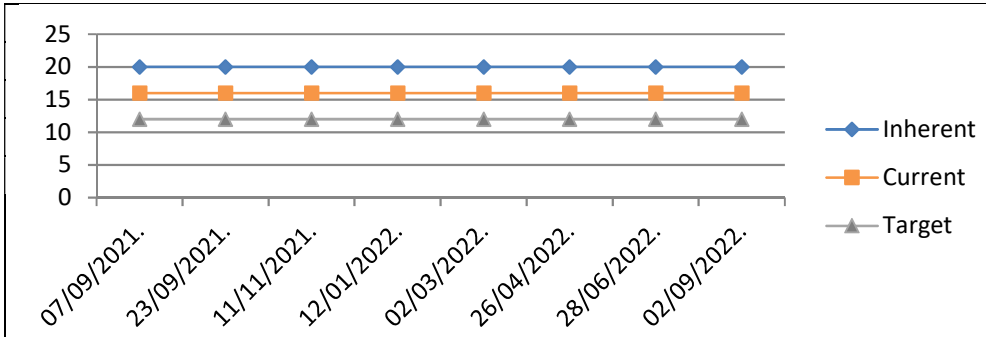
					the existing bank of staff, phase 2 will recruit from an identified number of individuals that have recently applied for a post within the Health Board, and phase 3 will involve a well-publicised recruitment campaign targeted at the public, this is provisionally booked for mid November 2022 with checks and offers being made on the day.	

CRR21-15	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 September 2022
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 October 2023

There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.

This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.

This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. All Wales and North Wales Safeguarding Procedures approved and in place. 2. BCUHB local work programmes in place and aligned to the national strategies which are regularly reported to Welsh Government. 3. Risk Management has been embedded into the processes of the reporting framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums agendas. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 6. The BCUHB Children's Division are managing the recruitment process for the replacement of the named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 8. Welsh Government interim monies has been utilised to increase physical capacity out of hours. 9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation. 10. Fully engaged and supporting the single unified Safeguarding Review lead by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding reviews and Homicide reviews. 11. Monies secured and implemented for the role of Independent Domestic Violence advocate in YG and YGC and WMH. 12. HB Leading on emergency department safeguarding action plans to support HIW findings and recommendations reporting to Safeguarding performance group and overarching HIW action plans.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government.

13. Undertaking bespoke supervision/peer support activities within high risk and low compliance areas/departments via Hospital Management Team's, reporting to the Safeguarding performance group. 14. Targeted intervention for key areas ie. the 3 Emergency Departments and a number of identified wards and areas within Mental Health and Learning Disabilities is in place, with escalation taking place accordingly.	

Gaps in Controls/mitigations
1. The increase in safeguarding activity, with enhanced complexity as a result of COVID, and the increase in victims recognised as a result of Domestic Abuse and Sexual Violence, refugees, modern day slavery/Human trafficking and county lines, has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place. 2. The inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated. 3. The lack of a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments relating to non-accidental injuries for children under the age of 2 years, with alternative platforms in place when they have limited digital patient records. 4. Lack of consistent approach by the 6 Local Authorities in North Wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible. 5. Named Doctor Safeguarding Children - Post appointed to awaiting start date, anticipated for the 1st October 2022. Currently working in conjunction with the Paediatric Team to ensure local arrangements are in place to support the Safeguarding agenda/portfolio. 6. Compliance rates of training does not provide assurance against the knowledge and application of the training into clinical practice. Measuring understanding and application of training materials using desktop reviews, audit and utilising a survey monkey is to be developed and monitored by implementation plan. Targeted activity for low compliance and high risk areas. 7. A number of senior post remain vacant following recruitment, risk assessment taken place on service delivery and identification of activities to ensure compliance and engagement.

8. Safeguarding Forums not consistently taking place, proactive engagement taking place with the Chairs to review membership and the agenda including the Cycle of Business to ensure full engagement and escalation.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls updated to reflect current risk position. 3. Post appointed to for the 'Named' Doctor for Safeguarding Children/Child at risk, with anticipated start date of the 1st October 2022. 4. Action ID 18113 – Action remains delayed with a Health Board Standard Operating Procedure to be developed to identify threshold and indicators to determine the referral into the process on a regional footprint, whilst awaiting the National agreement, this will provide a level of consistency and transparency. 5. Action ID 18120 – Action remains delayed with the activity suspended by the Welsh Government over the summer holidays due to re-convene on the 18th October 2022. 6. Identification of new action ID 24085 to review Safeguarding Terms of Reference and the Reporting Framework. 7. Identification of new action ID 24086 to monitor and review that Safeguarding Forums are convened in line with the Safeguarding Reporting Framework.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

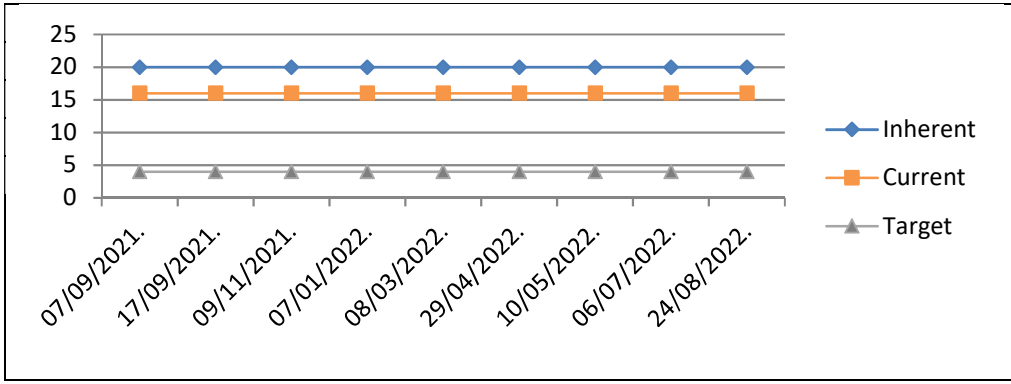
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve	18113	Implementation and monitoring of Workforce Safeguarding Responsibilities Standard	Michelle Denwood, Director of Safeguarding	20/12/2021	The process and the development of Key Performance Indicators' can be implemented across the	Delay

target risk score		Operating Procedure [Social Services and Well-being (Wales) Act 2014].	and Public Protection		Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings. In addition a Health Board SOP to be developed to identify threshold and indicators to determine the referral into the process on a regional footprint, whilst awaiting the National agreement, this will provide a level of consistency and transparency.	
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	The revised Procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks. August 2022 progress update - Activity has been suspended by the Welsh Government over the summer holidays due	Delay

					to re-convene on the 18th October 2022.	
	21216	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. August 2022 progress update - Working with Finance to identify anomalies which will influence the Business Case.	On track
	23507	Mental Health division to include the identification of resource to support a Safeguarding physical presence within the Mental Health Units.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	A single point of contact and physical presence will support the front line clinician to identify and to safeguard service users who may be at risk of harm. Will support the implementation of safeguarding practice and training. August 2022 progress update - Request raised for confirmation of additional resource in the Mental Health and Learning Disabilities	On track

					safeguarding forum, we await a formal response and included reference to this within the intended Safeguarding Business Case.	
	24085	Review Safeguarding Terms of Reference and the Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that reporting and governance is in line with the organisations revised structure ensuring operational and strategic safeguarding activity is aligned to the organisations performance and risk management activities ensuring compliance with safeguarding legislation relating specifically to the NHS.	On track
	24086	Monitor and review that Safeguarding Forums are convened in line with the Safeguarding Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that the Safeguarding agenda is embedded and key areas of risk escalated within the identified Health Economies and Mental Health and Learning Disabilities.	On track

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 24 August 2022
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 20 June 2023
There is a risk that insufficent Manual Handling training could lead to staff and patient injury, lost work time, Health and Safety Executive enforcement action (recent related Improvement Notices for Patient Falls, Patient Handling and Portering Load Handling risk assessments) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	1	4
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Health & Safety Strategy has been approved which includes Manual Handling. 2. Training plan is in place specifically in relation to Manual Handling, training compliance is monitored by the Mandatory Training Group. 3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment.	1. Regular oversight and review by the Occupational Health & Safety Team. 2. Reviewed at the Strategic Occupational Health and Safety Group.

5. A full review of the training was completed in August 2021 to ensure the training provided was in line with the All Wales Manual Handling training passport scheme. 6. Suite of fully functional training rooms secured. 7. Datix system is monitored daily by the Health and Safety team to review incidents and follow up on lessons learnt. 8. Multi-disciplinary team including Manual Handling representative set up and currently auditing compliance with patient handling risk assessments.	3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.

Gaps in Controls/mitigations
1. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing. 2. Low training compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance, however with the lack of trainers in place improvement in compliance rates is challenging. 3. Lack of integrated booking system with the ESR system and ESR is not easy to use. Manual bookings currently in place. 4. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains a gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme. 5. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented, but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 52%. 6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, action plan developed to comply with HSE improvement notice and Multi-Disciplinary Team set up to audit internal compliance. 7. Gap identified as a result of the Health and Safety Executive investigation into facilities staff compliance with training, with the potential for a prosecution for the Health Board. Training package is in place to ensure facilities staff are suitably trained.

Progress since last submission
1. Controls in place reviewed and updated to reflect current position. 2. Gaps in Controls reviewed and updated to reflect current position with new gap identified as a result of the Health and Safety Executive investigation into facilities staff compliance with training. 3. Action ID 17979 – Action remains delayed re-advertisement taken place and successfully appointed to the post of Manual Handling Manager with start date of the 1st September 2022.

4. Action ID 18859 – Action remains delayed, draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations.
5. Identification of new action ID 24050 for the Muscular-Skeletal Disorder Group to be re-instated to review trends in incidents and follow up improvement actions.
6. Identification of new action ID 24051 for an SBAR to be developed to request authorisation to increase staff numbers in training sessions.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Mrs Susan Morgan, Head of Health and Safety	30/11/2021	Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB. August 2022 progress update - Initial Manual Handling Manager appointment due to start on the 1st August withdrew from the post. Re-advertisement has taken place and successfully appointed to the post of Manual	Delay

					Handling Manager with start date of the 1st September. Interviews for band 6 advisors post taken place and successfully recruited to one post with start date to be confirmed. However, 2 advisor staff have since left the post. With current post vacancies for advisors at 4.6.	
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Mrs Susan Morgan, Head of Health and Safety	01/04/2023	Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training. The porters load handling risk assessments have been revised to include TILE. Supervisors have been re-trained on risk assessments and particularly load handling risk assessments. All porters to be given information, instruction and training on the risk	On track

					assessments. An audit programme has commenced for both patient falls and patient handling risk assessments.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mrs Clare Jones, Health & Safety Advisor	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff. August 2022 progress update - Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022. Ratification process will follow the completion of the policy review.	Delay
	23660	Consideration of alternative methods of Manual Handling training.	Mrs Susan Morgan, Head of Health and Safety	30/09/2022	Looking at alternative training delivery will improve capacity to increase compliance rates to support the prevention of staff and patient injury.	On track

					August 2022 progress update - This action will be picked up by the new Manual Handling Manager who will be in post from the 1st September 2022 following successful recruitment. Trials took place in August from an external source to provide orientation and refresher training to supplement the internal team programme, positive feedback received following the trial, multi quote raised by procurement for continuation through September 2022. Anticipated delay to the action due date due to the action to be allocated to the new Manual Handling Manager when commenced in post.	
	24050	Muscular-skeletal disorder group to be re-instated to review trends in incidents and follow up improvement actions.	Mrs Susan Morgan, Head of Health and Safety	31/12/2022	Identify hot spot areas and to target those areas for intervention.	On track
	24051	SBAR to be developed to request authorisation to	Mrs Susan Morgan, Head of	31/10/2022	Increase the number of available seats and therefore	On track

		increase staff numbers in training sessions.	Health and Safety		increase the numbers of staff trained.	

<table>
<tr><td rowspan="4">CRR21-17</td><td>Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 08 September 2022</td></tr>
<tr><td rowspan="2">Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.</td><td>Date of Committee Review: 06 September 2022</td></tr>
<tr><td>Target Risk Date: 31 March 2023</td></tr>
<tr><td colspan="3">There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to Child and Adolcent Mental Health Services (CAMHS) to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:
• Current operational hours of CAMHS is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• crisis presentations to the Emergency Departments with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
• awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.</td></tr>
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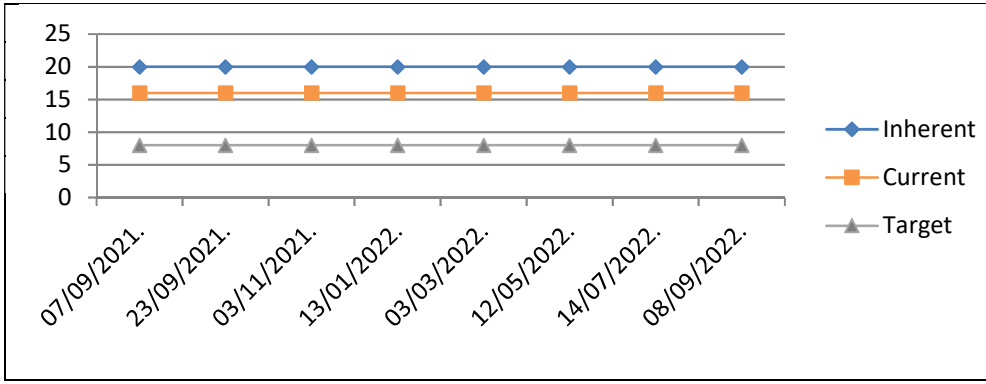


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Area Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Area Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 9. Safeguarding discharge Standard Operating Procedure for young people in place. 10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS, which includes incident notifications.	1. A scoping exercise or report of Child and Adolescent Mental Health Services (CAMHS) Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB approach. 3. Risk also regularly discussed at the Area - Quality and Safety Group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with Welsh Government, joined with Mental Health Division on a quarterly basis.

11. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff. Currently working with recruitment agencies and established multi-disciplinary team is already in place. 2. Lack of suitable Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all health economy areas and Local Authority partners. 3. Lack of agreed consistency, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission
1. Controls in place reviewed to reflect current risk position. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. The new NICE guidance NG225 was published on the 07/09/2022. 4. Action ID 17956 - Anticipated delay to the action due date due to staff availability both in terms of Health Board and Local Authority colleagues. 5. Action ID 17964 – Anticipated delay to the action due date, plans being developed to deliver training of youth Mental Health First Aid, this will be delivered within each Integrated Health Community, further work required to develop a rolling programme of training which will extend beyond the action due date. 6. Action ID 23091 – Anticipated delay to the action due date, recruitment remains ongoing, anticipated delay in recruiting to substantive post, use of locums remains ongoing during this period.

Links to	
Strategic Priorities	**Principal Risks**
Improved USC (unscheduled care) pathways Integration and improvement of Mental Health Services	BAF21-01 BAF21-08

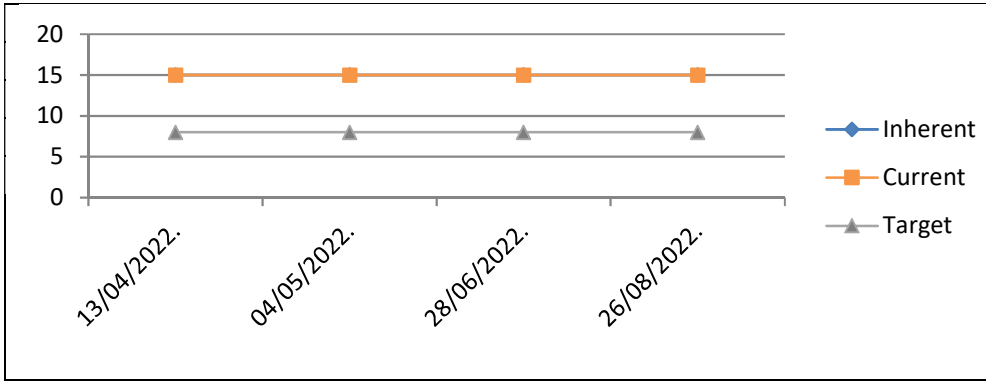
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways. August 2022 progress update - Anticipated delay to the action due date due to staff availability both in terms of Health Board and Local Authority colleagues. Timelines and pathways to be developed to identify roles and responsibilities of various internal and external agencies in relation to the recommendations resulting from the NICE guidance.	Delay
	17963	Task and Finish Group to review SCH03 Policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	31/12/2022	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On track

					August progress update - NICE guidance NG225 was published on the 07/09/2022, Task and Finish group can now be progressed.	
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ Emergency Department staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/10/2022	Create awareness and develop skill in assessment and improve staff morale. August 2022 progress update - Plans being developed to deliver training of youth Mental Health First Aid, this will be delivered within each Integrated Health Community, further work required to develop a rolling programme of training which will extend beyond the action due date. Training requirements are highlighted in the new NICE guidance and recommendation in relation to supervision for staff.	Delay
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital. August 2022 - Summer break has delayed the action	On track

		address needs across agencies.			development, meeting arranged for September 2022.	
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing	31/10/2022	Provide further assurance following a review by an external body and the implementations of any recommendations to support the development of high quality and safe care. August 2022 progress update - Implementation of recommendations remain ongoing.	On track
	23091	Progress with recruitment to bespoke campaign for Child psychiatry.	Mrs Louise Bell, Assistant Area Director	31/10/2022	Implementation will help to deliver a safe and sustainable service within BCU. August 2022 progress update - Recruitment remains ongoing, anticipated delay in recruiting to substantive post, use of locums remains ongoing during this period.	Delay

CRR22-18	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2024

There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB.
This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies.
This could lead to an increase in healthcare associated infections, patient harm and loss of reputation to the organisation.



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workloads for all staff in the team e.g. ensuring experienced Infection Prevention nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. 5. Reviewing and prioritising attendance at meetings and on groups etc. 6. Employed senior manager via an agency to support the team.	1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. 2. Alert organism statistics. 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee. 4. Patient incident reviews.

7. Supporting and protecting existing team with measures including weekly team meetings and reviews.	5. Regular review of Datix Incidents which are alerted to the team when logged on the system for learning purposes and for rectification. 6. Outbreaks are monitored, managed and reported to Infection Prevention Sub Group. 7. Regular review of Infection Control and Prevention trajectory reported at Local Infection Prevention Groups. 8 Risk regularly reviewed at Infection Prevention Sub Group.

Gaps in Controls/mitigations
1. There is a national issue recruiting into Infection Prevention and Control roles, particularly at a senior level (7s and above). Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 2. Experienced Infection Prevention Agency nurses only want to work remotely. Staff members working remotely are required to review policies produce reports which in turn releases non-remote working staff to undertake clinical work. 3. The 2 vacant band 8bs have been advertised but there were no suitable applicants. Post re-advertised and currently cross covering within the service with Senior members of the Infection Prevention team (IP) providing support to other areas as well as their own. Recruited internally to senior 8a level supported by other senior Infection Prevention staff.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Action ID 20654 – Action delayed to the original action due date, with planning to involve the Infection Prevention champions in the infection prevention campaigns planned for October 2022. 4. Action ID 21696 – Action delayed with the appointment at lower grade and providing training to staff members is in place and remains ongoing. 5. Action ID 22927 – Action delayed as awaiting future course dates to be released by the University.

6. Action ID 21702 – Action closed as the development programme now in place.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-09

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	20654	Use Infection Prevention Champions to promote good practice.	Mr Dafydd Williams, Infection Prevention Nurse	30/09/2022	To help promote IP in their own departments whilst visibility of the IP team will be low August 2022 progress update - Re-started Infection Prevention training sessions 2 per month and established weekly forum to support IP champions with queries, new guidance etc. Anticipated delay to the original action due date, with planning to involve the Infection Prevention champions in the infection prevention campaigns planned for October 2022	Delay

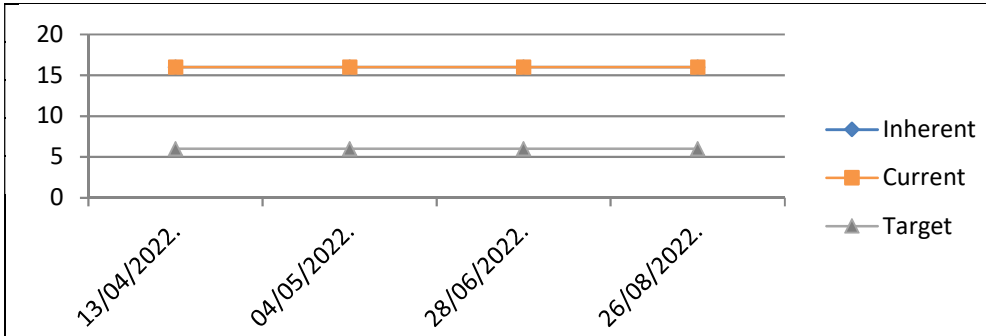
	20659	Business case for expanding current team	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	To outline case to the Executive that more staff are required and obtain approval for funding August 2022 progress update - Meeting to be set up with Finance to review current allocation due to not being aligned with current establishment.	On track
	21696	Recruit to current vacant Infection Prevention posts	Mrs Andrea Ledgerton, Specialist Matron IP	30/09/2022	Fill current vacant posts August 2022 progress update - Appointing at lower grade and providing training to staff members is in place and remains ongoing.	Delay
	21698	Work with Communications and Workforce to develop a Recruitment Campaign for Infection Prevention nurses	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To help attract IP staff to BCU	On track
	21702	Draw up a development programme and a succession plan to 'grow our own'.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/08/2022	Action Closed 26/08/2022 To develop own IP staff and support recruitment and retention Internal promotions and additional support from	Completed

					senior staff in place action ID 21696 is in line with this action. August 2022 progress update - Action closed as development programme now in place.	
	22927	Promote Infection Prevention Massive Open Online Course education programme	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/09/2022	To improve knowledge, practice and compliance with IP in wards and departments. August 2022 progress update - Promoting via Infection Prevention Sub group with significant interest, however awaiting future course dates to be released. Anticipated delay to the action due date awaiting future course dates to be released by the University.	Delay

CRR22-19	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 February 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 March 2024

There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including:
1. Sterile service departments air handling units require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade.
2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes and washer disinfectors at YGC and WM are at end of life. Also they rely on a paper track and trace system.
3. There is a lack of robust approved SOPs for decontamination.

This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Decontamination audits have been increased to twice yearly. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units. 3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention team. 3. Decontamination audits by Authorised engineers.

4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board. 5. Single use scopes are being used where possible removing the requirement for decontamination. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard. 7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment which has been completed. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.	4. Sterile services departments have audits carried out by notified bodies in accordance with the Medical Device Directives/Regulations. 5. Risk register on decontamination.

Gaps in Controls/mitigations
1. The Decontamination Advisor currently on a period of extended leave. Staff member currently acting up into the position to cover this period. Exploring with Agencies whether external appointments could be made. 2. Some Consultants do not want to use single use scopes – Looking at exploring alternative methods of decontamination for the re-usable scopes. 3. There are not many risks on Datix related to Decontamination and there is inconsistency in scoring e.g. one site has a risk related to track and trace in Sterile Services and Disinfection Units scoring 10, another scores it 4. There needs to be review of all risks relating to Decontamination and updates requested from de-contamination group members. Decontamination Group have met on the 25th August, with significant improvement in relation to the risk register entries, with work ongoing to further improve. 4. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans.

Progress since last submission
1. Control in place review to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Action ID 22146 – Action closed as completed with the approval of the revised Decontamination Group terms of reference. 4. Action ID 22931 – Action closed as completed with the report received by the Health Board on the 19th August. 5. Action ID 22148 – Action delayed, capital bid has been submitted however anticipated delay to the action due date.

6. Action ID 22149 – Action delayed, with the Shared services report received by the Health Board during August 2022, meetings to be established during September 2022.
7. Identification of new action ID 24069 to establish a stakeholder group to review the Shared Services report.
8. Identification of new action ID 24070 for the recruitment of an External Consultant to facilitate and progress the recommendations following the Shared Services report.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-02 BAF21-09

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	22146	Revise and approve the Decontamination group terms of reference	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/06/2022	Action Closed 04/07/2022 To ensure appropriate and robust membership of the group and a process of monitoring and continual improvement. August 2022 progress update - Action closed as completed with the approval of the Terms of reference.	Completed
	22147	Policies and Standard Operating Procedures	Ms Rebecca Gerrard, Director	31/12/2022	As part of good governance and so staff are aware of	On track

		written/revised and approved for Decontamination.	of Nursing Infection Prevention & Decontamination		their responsibilities and roles and how to decontaminate medical devices. The action will focus on policies and procedures due for review by the end of 2022.	
	22148	Purchase new washer disinfector for endoscopy unit at YG	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/08/2022	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated August 2022 progress update - Capital bid has been submitted however anticipated delay to the action due date.	Delay
	22149	Meet with key stakeholders re scope issues at Ysbyty Glan Clwyd and Wrexham Maelor	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/08/2022	To highlight key issues and establish a way forward August 2022 progress update - Shared services report received by the Health Board during August 2022, meetings to be established during September 2022.	Delay
	22152	Community Dental Services, Assets and Facilities group to reform	Peter Greensmith, Business Support	31/03/2023	To establish formal timeframe and funding for plans.	On track

		and form a plan for moving forwards.	Manager - Dental			
	22153	Estates to meet with sterile services managers	Mr Arwel Hughes, Head of Operational Estates	30/09/2022	To revise risk assessments and make plan for upgrading Sterile services departments August 2022 progress update - Action will take place following the publication of the Shared Services report to identify priority areas, anticipated by September 2022.	On track
	22931	NHS Wales Shared Services review of Sterile Services and Disinfection Units	Mr Arwel Hughes, Head of Operational Estates	31/07/2022	Action Closed 26/08/2022 To outline the specific risks and help BCU identify priorities. August 2022 progress update - Report received by the Health Board on the 19th August.	Completed
	23024	To seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To demonstrate the improvement and high standards achieved by Endoscopy at the Unit.	On track
	24069	Establish a stakeholder group to review the Shared Services report	Ms Rebecca Gerrard, Director of Nursing	31/10/2022	To make improvements to the decontamination facilities and infrastructure.	On track

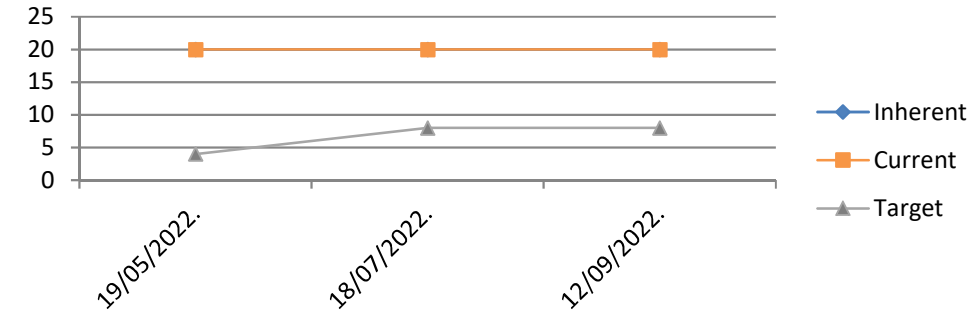
			Infection Prevention & Decontamination			
	24070	Recruitment of an External Consultant to facilitate and progress the recommendations following the Shared Services report.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	Develop a decontamination strategy and business cases and to ensure that the recommendations are fully implemented which will result in the improvement of the infrastructure and facilities for decontamination.	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 12 September 2022
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 31 December 2022

There is a risk that BCUHB staff cannot access their mandatory resuscitation training.

This is due to several factors including:
A lack of 'fit for purpose' training accommodation and equipment across the sites; Insufficient numbers of Resuscitation Officers/Trainers.

This could lead to failure to deliver effective patient care resulting in preventable harm or death from impaired or unsuccessful resuscitation. Additional risk of financial claims against BCUHB resulting from preventable harm/deaths.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances

1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. 2. Training plan in place governed by the UK core skills framework. 3. Resuscitation training is a mandatory training programme across the Health Board. 4. Delivery of the training has been re-designed to increase capacity, this has resulted in the reduction of clinical staff's time away from clinical duties. 5. Systems and processes are in place to manage attendance at training sessions. 6. Additional temporary training footprint sourced within the Central region. 7. Hospital Management Team engaging with Central site clinical areas to establish accurate data on the training needs within areas and to ensure attendance mandate is adhered to. 8. Assurance that all resuscitation attempts by the emergency response teams are led by staff who hold the current Advanced Life Support qualification for the respective teams. The assurance of this is being supported by the reinstatement of the daily test bleeps for the teams in Central, and with a log of the current advanced resuscitation qualification status recorded each day as team members respond to the test bleep. Where an 'expected team leader' does not hold the required qualification, then the team leadership role is deferred to another team member who does hold the required qualification.	1. The risk is reviewed monthly by the Resuscitation Services senior management team, and is presented to the Resuscitation committee on a quarterly basis. 2. Training figures and capacity are regularly reviewed on a quarterly basis at the Resuscitation Committee via site reports. 3. The risk has been presented to PSQ (Performance Safety & Quality), and Clinical Effectiveness groups.

Gaps in Controls/mitigations
1. Despite controls above, there remains a deficit of approximately 2000 training places per year for resuscitation training at UKCSTF Level 3 on the Central locality. 2. There is no designated training accommodation on the Central locality. This lack of accommodation is in breach of the national standards as set by the Resuscitation Council UK. Continued breach could result in loss of course centre license on the Central locality which would cease all level 3 training from the site. The identified potential accommodation requires approximately £136k (subject to contractors quotation) to make safe and fit for purpose and there is currently no identified funding source. Identification of this funding source has been asked for from Central Site Management with support from Estates / Planning / Finance teams. 3. With particular relevance to the Ockenden report is the Newborn Life Support (NLS) provision which is running on limited capacity both East and West, and is at 0% capacity in central with no NLS training at all due to the lack of availability of suitable training accommodation.

4. The Audio-Visual system required for these courses is failing on the East site. In May 2022 two of the systems failed during the delivery of an Advanced Trauma Life Support course, which required those rooms to run without these resources for the remainder of the course. This impeded the course delivery and will feature in the course report from the course director to the Royal college of Surgeons. The failure of the AV system will impact on every course run in the East venue and requires replacement.
5. There is currently no functional and reliable cardiac arrest audit within BCUHB. Therefore rates (other than raw switchboard data), outcome data, and improvement opportunities cannot be reliably established. Actions are in place to develop a functional audit of 2222 calls.

Progress since last submission

1. Controls in place reviewed and updated to reflect current risk position.
2. Gaps in controls reviewed and updated to reflect current risk position.
3. Proposal to extend the Target Risk Due date from the 30/09/2022 to the 31/12/2022 due to awaiting the formal quotation and funding source identification for the works to be completed.
3. Meeting held on the 02/08/2022 between Resuscitation team, COVID testing Unit, planning department and Deputy Executive Medical Director. Agreement to split the "Laing O'Rourke : Redevelopment Building" (currently occupied solely by the Covid Testing Unit (CTU)) for co-occupancy with CTU and Resuscitation Services has been reached and plans drawn up for quotation.
4. Planning department have sent the plans to the contractor for quotation after the meeting (2nd August 2022), and a completion timeline for the required estates works. Quotation anticipated from the contractor on the 30/09/2022. Once the quotation is received the site Hospital Management Team in Central are aware that they will then be tasked with identifying the funding source for the work.
5. Reporting to the Executive Medical Director on the progress of the risk response and training trajectory information continues.
6. Action ID 19313 – Action delayed as awaiting a formal quotation and timescale for the required estates work.
7. Action ID 23208 – Action delayed with agreement in principle made on the layout and occupancy of the CTU building as shared with Resuscitation Services.
8. Action ID 23754 – Action delayed as awaiting for Informatics to complete data collection entry actions, data collection plan to start by the end of September 2022.

Links to

Strategic Priorities	Principal Risks
COVID 19 response Primary and community care Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-04 BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	19313	Provision of permanent and fit for purpose training and office accommodation on the YGC site	Mrs Sarah Bellis-Holloway, Resuscitation Services Manager	30/09/2022	"While it will not mitigate the clinical absence of Resuscitation Officers from the acute site, or loss of other non-training activity; the identification of a suitable commercial venue in which we can provide all levels of resuscitation training, along with F&P funding approval will lower the score in relation to training from 20 to 4 in the short term (lease period). This will mitigate the risk until a permanent venue within the YGC footprint is developed." August 2022 progress update - Still awaiting a formal quotation and	Delay

					timescale for the required estates work. Quotation anticipated from the contractor on the 30/09/2022.	
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Mr Neil Rogers, Acute Care Director	30/06/2022	This action will enable a building to be secured for delivering training on the Centre Site thereby helping mitigate and manage this risk in the long-term. September 2022 progress update - Agreement in principle has been made on the layout and occupancy of the CTU building as shared with Resuscitation Services. The plans have been drawn up, and are awaiting a quotation from the contractor via the Planning dept. Once the quotation is received then the Central Hospital Management Team will have knowledge of the amount of funding they need to source.	Delay
	23754	Complete data collection design for 2222 electronic audit with Informatics support.	Mr Christopher Glyn Shirley,	15/08/2022	Reliable and robust data will enable the health board to provide accurate data on cardiac arrest rates, and	Delay

			Resuscitation Officer		report on outcomes. It will also enable analysis of opportunities to reduce patient harm, reduce cardiac arrests, and aim to help to prevent unplanned critical care admissions. August 2022 progress update - Awaiting for Informatics to complete data collection entry actions, data collection plan to start by the end of September 2022.	

Risk CRR22-23 - This risk is to be discussed during Deep Dive.

CRR22-23	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 02 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22 June 2022
	Risk: Inability to deliver safe, timely and effective care	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 09 January 2024

There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity to accommodate patients awaiting specialty beds as per RCEM covid 19 resetting Emergency Department care.

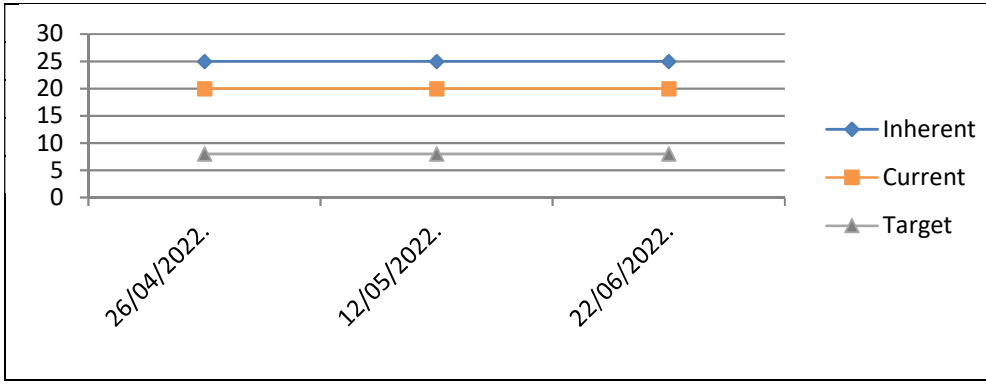
This could lead to:

• Delay/inability to triage new attendants within 15 minutes of arrival as per national key performance indicators in line with EDQDF/WAM, deterioration in health/condition and increase level of harm including increased length of stay, level of intervention required and potential increase in mortality, breach of social distancing measures, which would increase spread of infection and/or potential outbreak.

• Inability to bring patients into the department from ambulances, detrimental impact to the community in terms of redeployment/response of ambulances, inability to meet privacy and dignity needs of patients, breach of performance measures as set out and monitored by Welsh Government, and pressure on the workforce, i.e. increase in workload due absences, difficulty in recruitment and retention of staff.

• Negative feedback / patient experience that is reflected via HIW and CHC national reviews.

• On going risk of patients leaving without being seen further impacting on WAST Demand and patients deteriorating in the community after leaving without being seen.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Site escalation policy in place monitored through the Emergency Department Clinical Quality Group. 2. Emergency department escalation policy in place, monitored through the Emergency Department Clinical Quality Group. 3. Infection prevention policy in place, monitored through the Emergency Department Clinical Quality Group. 4. Welsh Government guidelines in place, monitored through the Emergency Department Clinical Quality Group. 5. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside Emergency Department, monitored through the Emergency Department Clinical Quality Group. 6. Matrons audit in place to identify areas i.e. welfare checks. 7. Unscheduled Care Improvement Group in place PAN BCUHB to improve patient flow throughout the organisation. 8. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients. 9. Secure screening process in place at point of entry to identify those at risk / suspected COVID and redirected to the Red ED accordingly. 10. Restricted access to the waiting room for relatives (Paediatrics/Elderly/Physically challenged etc.).	1. Risk is reviewed at Emergency Care meeting and escalated to site Quality and Safety and Health and safety meeting. 2. Triage waits Key Performance Indicator data reported each quarter through the site accountability meetings. 3. Report to Clinical Effectiveness Group. 4. Performance is monitored through harms, incidents, complaints and handovers. 5. Fortnightly reviews with WAST of any harm/delays that may of occurred due to overcrowding.

Gaps in Controls/mitigations
Insufficient Capacity/physical environment to mitigate overcrowding

Progress since last submission
1. Risk description updated to reflect current risk position. 2. Controls in place reviewed and updated to reflect current risk position. 3. Assurances reviewed and updated to reflect current risk position. 4. 01/06/2022 – Monkey pox screening update shared with all staff. 5. Action ID 19510 - Action closed as completed. 6. Action ID 21359 – Action closed as Symphony work now completed.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-14

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	19510	Review and update Emergency Department (ED) escalation plan.	Mrs Lindsey Bloor, Directorate General Manager	31/05/2022	Action Closed 12/05/2022 This will highlight the demands in the department at the time and ensure named individuals have allocated	Completed

					actions to assist in de-escalating of patients in ED to maintain patient safety.	
	19516	Review the action plan for Unscheduled care Improvement Group and identify action holders for updates.	Mrs Hazel Davies, Acute Site Director	30/09/2022	This will de-congest ED of the excessive volume of patients who reside in ED awaiting specialty beds. Statistically we are seeing reduction in admission of high risk patient group and improved ambulance waits. Next steps / actions: Evolve AEC/AMU/GP queue Enhanced Frailty model on site Develop an urgent care centre to replace existing UPCC.	On track
	20605	Increase establishment for additional Health Care Support Workers.	Mrs Rachel Bowen, Deputy Head of Nursing EC	22/07/2022	This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in Emergency Department.	On track

	21359	Implement Emergency Department risk status in place of SAPHTE Scoring.	Mr Nathan Rogers, Lead Manager – Emergency Care	31/05/2022	Action Closed This will ensure we are using the correct risk coding for the department in line with EDQDF. Symthony work now completed.	Complete
	21360	Increasing the footprint of ED to manage overcrowding to protect the minor injury stream (WMH).	Mrs Hazel Davies, Acute Site Director	01/12/2022	It will enable relocation of the minor stream of patients in ED to an alternative area which will reduce overcrowding within the department.	On track
	23001	Ongoing recruitment to approved business case.	Mrs Lindsey Bloor, Directorate General Manager	31/08/2022	This will support staffing in additional areas of ED once available.	On track
	23002	Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC).	Mrs Jackie Evans, AMU Matron	16/09/2022	This will reduce the number of patients in ED waiting room.	On track
	23312	Development of the Same Day Emergency Care working group to increase the direct access route for SDEC.	Karen Mottart, Consultant Anaesthetist/Medical Director	30/09/2022	This will reduce the number of those patients attending ED who are ambulatory.	On track

Appendix 2 – Newly Escalated Risks

CRR22-25	**Director Lead:** Executive Medical Director	**Date Opened:** 20 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of failure to provide full vascular services due to lack of available consultant workforce	**Date of Committee Review:** New Risk
		Target Risk Date: 31 October 2022
There is a risk that there will be delays in the delivery of emergency, urgent and routine care for vascular patients. This is caused by to lack of consultant workforce which has impacted on services recently and meant only emergency and urgent services can be provided for a short period of time. Business Continuity plans are not adequate to mitigate and patients may need to be transferred NHS England for the the provision of urgent and emergnecy services.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	5	4	20
	Current Risk Rating	5	4	20
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. There are business continuity meetings occurring (between 3 and 5 times weekly) with all relevant operational teams 2. Action plans and decision logs are being maintained and reported to Exec Team daily.	1. Regular review through the 3-5 times weekly vascular operational planning meetings (which feed directly to the Executive Medical

3. Consultant Workforce Rotas are monitored on a daily basis forecasting risks and mitigations put in place 4 records of cancelled procedures are being kept and the risk of patient harm due to those cancellation being monitored. 5. External communication to Community and Primary Care outlining management and referral of routine, urgent and emergent patients 6. Further contingencies are being planned for potential additional complications which may lead to diversion of services to NHSE, including the number of emergency and urgent patients 7 Daily Monitoring of gaps in rota. (Consultant rota as normal from 01/08/2022) from 01/08/2022 Agency Locum commencing to support 1 x long term sickness, restricted practice and dual operating. 8. Further contingency to be agreed with Executive Medical Director in relation to diversion of potential aortic emergency to another Organisation.	Director and be reviewed via Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
1. There is diminished resource across operational, governance, network and clinical teams in order to maintain any traction on day to day service running, planned improvements, action plans, and transformational change in addition to this work.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	23819	Develop local business continuity plans with Hub and Spoke Site Directorate Managers	Mrs Elaine Hodgson, Directorate General Manager	26/07/2022	Provide appropriate escalation and plans to mitigate risks Work is in progress, all three General Managers across each site are currently working on the business continuity plan. August 2022 progress update - Business Continuity Planning Session arranged with Clinical and operational teams for the 15th September 2022.	Delay
	23998	Identify critical vascular conditions that may present via the ED or GP/ community referrals. Identify co-dependencies such as Renal and Diabetic Foot Services time critical illnesses	Ms Jenny Farley, Vascular Network Director	31/08/2022	Will ensure patients are not at risk as there is a plan to either treat and stabilise before transfer to NHS England	Completed
	23999	Daily review of all overdue patients to ensure urgent patients are recognised and discussed with clinicians to ensure no	Ms Jenny Farley, Vascular Network Director	31/08/2022	Ongoing daily reviews to ensure no harm due to delay in treatment August 2022 progress update - this continues as part of the	Ongoing

		harm due to delay in treatment	Directorate Manager Surgery East, Centre and West. Elaine Hodgson Dafydd Pleming Keely Twigg		Vascular Operational Group Processes in place	
	24000	Chief Medical Officers Meetings with HB Executive Medical Director to discuss where support can be offered from in the event of inability to provide emergency and time critical care.	Dr Nick Lyons, Executive Medical Director	31/08/2022	Agreement with Liverpool (LiVES) Vascular services to support MDT decision making to ensure patients are prioritised Work in progress with Stoke Hospital to receive Urgent and Emergency Patients if required. August 2022 progress update - Discussions on going with Stoke.	Delay
	24001	Identifying all vascular patients on the waiting lists and prioritising in the event of all day-case and outpatient services need to be transferred out to England	Directorate Manager Surgery East, Centre and West.	31/08/2022	3 x weekly meetings Directorates on each site report any urgent or time critical patients that require escalation for clinical intervention	Ongoing

	24071	Identify clinical workforce establishment and vacancies	Ms Jenny Farley, Vascular Network Director	31/08/2022	Will enable appreciation of workforce required to deliver vascular services	Completed

CRR22-26	**Director Lead:** Executive Medical Director	**Date Opened:** 29 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of significant patient harm as a consequence of sustainability of the acute vascular service	**Date of Committee Review:** New Risk
		Target Risk Date: 31 December 2022
This is a risk that the acute vascular service could not be sustained Potentially caused by a reduction in the consultant workforce (sickness/vacancies) and the need for dual operating which requires two consultants to be available on call 24/7.This could impact on the safety of care for time critical patients.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	5	20
	Target Risk Score	4	2	8
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1.Reintroduction of dual consultant operating (for aortic patients only) 2.Implementation of a focussed recruitment plan 3. Enhanced MDT oversight by a specialist centre. 4.Implementation of the vascular improvement plan (following Royal College of Surgeons review) 5.Contingency planning should the staffing levels fall below acceptable levels (maximising non consultant roles to support patient care and the use of agency)	1. Additional support during the AAA operation to limit risk of complications 2. Reduces the reliance agency locums and doctors without a consultant level qualification 3. Ensures that expert skills are agreeing on the most effective

6.Ongoing risk assessment of the waiting list in line with clinical priority 7. Work in progress to out-source time critical patients including renal.	procedures for patients and timely decision making, and record keeping 4. Evidences the RCS recommendations are being actioned 5. Ensures Operational Team are fully aware of the patients to prioritise for emergency or time critical transfers to other hospitals and which patient conditions can be managed safely by other vascular/renal/diabetic teams internally. 6. Ensures that patients are prioritised on their clinical need and the most urgent patients waiting time deadlines are adhered to for timely treatment 7. Prevents delays to time critical treatments.

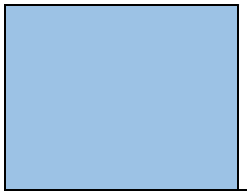
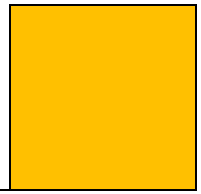
Gaps in Controls/mitigations
1. High sickness and annual leave reduces the ability for dual operating and potentially short notice 2. Poor reputation of service makes recruiting to consultant posts challenging, plus geography of the Health Board 3. Delays in patient decision making when insufficient MDT members attend the MDT 4. 100 + actions, plus actions from the Vascular Quality Panel review, insufficient workforce to support the delivery of the actions in a timely manner 5. May happen at such short notice that immediate transfer of emergency and urgent patient is required with limited notice for NHS England providers 6. Waiting List size significant post Covid, with little capacity to manage anything other than emergency and time critical urgent patients

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	24003	Commencement of dual operating.	Ms Jenny Farley, Vascular Network Director	11/07/2022	Reduces the risk of harm to patients Dual operating commenced 11th July 2022.	Completed
	24004	Additional funding requested to ensure effective medical and therapy workforce model. Recruitment campaign ongoing within current establishments	Ms Jenny Farley, Vascular Network Director	31/12/2022	All consultant vacancies recruited to (with the exception of the CD post interviews August 2022) Ensures consistently safe patient care across all three sites. Reduces the reliance on agency workforce	On track
	24005	Invite extended to Stoke as well as Liverpool to attend and contribute to the MDT	Ms Jenny Farley, Vascular	25/07/2022	Action closed 25/07/2022 Support decision making in the absence of sufficient vascular	Completed

			Network Director		surgeons and support prioritisation of patients for intervention	
	24006	Vascular Improvement Plan lead in post and Vascular Network Director in post for wider transformation	Ms Jenny Farley, Vascular Network Director	31/12/2022	Supports the co-ordination of actions needed to deliver against the recommendations. Ensures regular updating of the improvement plan Longer term transformation of the services for stability	On track
	24007	Business Continuity planning in place	Directorate Managers Elaine Hodgson, Dafydd Pleming,	31/09/2022	Ensures all risks are identified and mitigated to support patient safety, enables immediate response to crisis Away Day agreed for the 16th September to complete business continuity plan.	On track
	24008	Risk Assessment of Waiting lists	Directorate Managers Elaine Hodgson, Dafydd Pleming,	31/08/2022	Identifies the upcoming risks/ issues as well as patient demand and capacity to manage time critical patient care	Completed
	24009	Working with NHSE to support the potential transfer of time critical patients to other service providers	Ms Jenny Farley, Vascular Network Director, Dr Andrew Foulkes Medical	30/09/2022	Ensures treatment of time critical patients Will help to develop a future service model to include service provision in England. Discussions are ensuing with Royal Stoke Hospital and Shrewsbury Hospital	On Track

			Director, Mrs Sally Baxter Associate Director of Strategy			

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 August 2022
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** New Risk
		Target Risk Date: 28 April 2023

There is a risk that following the RCS stage 2 review of 47 sets of case notes, Vascular medical workfroce documenation is non-compliant with regulatory standards for recording keeping.

This may be caused by the use of software infrastructure across the three sites which doesn't communicate with each other; the lack of digital health records, human factors and staff being used to working without sufficient resource. This could also be caused by lack of communication, human error and the lack of good processes and adequate resources.

This could impact on patient outcomes, patient safety, reputation of the service, poor patient experience and clinical staff fitness to practice.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Weekly case note audits in YGC are undertaken to monitor standards of record keeping actions are taken when poor documentation is identified 2. Medical consultant and trainee grade champions have been identified to support improvement in documentation 3. Refresher training on consent has been between March and May 2022 from HIW and the GMC. 4. Introduction of a pilot scheme for “CITO” electronic MDT proforma to be easily viewed by all relevant MDT members due to complete in October 2022. 5. MDT forms process of being filed by MDT co-ordinator in the notes on the same day put in place. 6. IMTP bids for additional administrative and MDT support have been created.	1. All actions relating to this risk are included on the RCS Vascular improvement plan reviewed monthly at the Vascular Steering Group which feeds into Quality, Safety, and Experience Committee, and then Board

Gaps in Controls/mitigations
1. The infrastructure supporting the vascular service is inadequate. Whilst this doesn't directly affect clinician’s documentation, it does prohibit clear and robust processes to support the efforts. Weekly audits identifying areas for improvement on a regular basis showing need for further input are undertaken. Until August 2022, the lack of permanent Clinical Leadership of vascular medical teams to drive and embed improved practice and ensure compliance and sustainability has been a risk 2. In sufficient MDT co-ordinators across all three sites

Progress since last submission
1. Notes audits continue with signs of some improvement and reported into the VSG meeting monthly 2. Advised by Executive Medical Director that a score of 12 was insufficient in light of the RCS stage 2 report - increased to 15.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-02

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	22282	Reference to RCS vascular improvement plan	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/12/2022	The actions aim to further identify issues, complete weekly audit for assurance of improvement, provide standardised documentation such as clerking and ward round documentation to prompt quality, involvement of regulatory bodies for training, 1:1 meetings with clinicians to review audits results and improvement requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues. There is a large number of actions assigned to improvement for documentation / consent processes which is kept up to date and reported on monthly. This is an ongoing activity. There are objective signs that the Consent process and note keeping standards have gone up.	On track

	24075	Involve regulatory bodies in training medical staffing in record keeping and consent	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/05/2022	Action closed 31/05/2022 This will ensure that all relevant staff area fully conversant with the need for accurate record keeping and the consequences of failure to do so	Completed
	24076	Pilot CITO as part of MDT	Ms Jenny Farley, Vascular Network Director	31/10/2022	To ensure legible documentation. Enhancing security and patient data storage	On track
	24077	Appoint a Clinical Director to lead the service	Mr Balasundaram Ramesh, Consultant Orthopaedic and Trauma Surgeon	31/08/2022	Action closed 26/08/2022 Will provide strong leadership, delivery of all key recommendations within the vascular improvement plan.	Completed
	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Ms Jenny Farley, Vascular Network Director	31/10/2022	Will ensure holistic approach to patient care, will improve communication	On track
	24079	Administrative and governance workforce analysis undertaken, identify gaps to support governance processes	Ms Jenny Farley, Vascular Network Director	31/10/2022	Identify the investment required to support effective documentation governance infrastructure	On track

	24080	Case note filing training to be given to Ward Teams	Ms Jenny Farley, Vascular Network Director	30/11/2022	Will ensure correct filing processes for all patient records reducing the risks associated with poor documentation	On track

Appendix 3 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	20
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR21-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-20	There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents.	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR21-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16
CRR21-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	Executive Medical Director	Quality, Safety and Experience	20
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		

Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Risk Key Field Guidance / Definitions of Assurance Levels V2

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">All Wales Thromboprophylaxis Policy</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Quality, Safety Experience Committee (QSE)</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">01/11/2022</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">The QSE Committee is asked to approve the All Wales Thromboprophylaxis Policy for implementation within BCUHB.

This Policy is based on National Institute for Health and Care Excellence (NICE) Clinical Guideline (NG) 89 providing clear guidance regarding National Standards. The guideline forms the foundation for thromboprophylaxis risk assessment tools for use in all Welsh Hospitals.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to: approve the Policy.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Gill Harris - Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Christine Welburn – BCUHB Thromboprophylaxis Nurse</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☐</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">To improve physical, emotional and mental health and well-being for all.</td></tr>
</table>

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with NICE Guidance – NG89.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The All Wales VTE Thrombosis Policy was written in conjunction with VTE Leads across Wales. It was ratified by the group and signed 20/01/2020. All stake holders within that group consulted prior to completion. No All Wales EQIA completed, local BCU EQIA therefore required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Policy does not relate to a Strategic decision as it is the implementation of an All Wales Policy and adherence to NICE Guidance, therefore an SEIA is not required.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	No specific Strategic/Corporate Risks identified, however failure to implement specific guidance on the management on VTE poses a risk to patient safety.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no financial implications as a result of implementing this Policy***.***
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Policy has a specific “Education” section and there is a requirement for training. An all Wales E learning package is in development (anticipated at the end of October) to support understanding of this Policy.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This document was subject to National Consultation via the All Wales Group. Minor amendments to the document following the completion of a local EQIA, i.e specific signposting of clinicians for the treament of patients under 16 that was omitted in the All Wales Policy.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Amherthnasol Not applicable.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Amherthnasol Not applicable

Reason for submission of report to confidential board (where relevant)	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Once approved, the document will be uploaded to the BCUHB Intranet page and notification will be included within the Corporate Bulletin.	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	All Wales VTE Thromboprophylaxis Policy
Date form completed:	*03/02/2022*

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

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.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	**All Wales VTE Thromboprophylaxis Policy**
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy covers assessing and reducing the risk of Venous Thromboembolism (VTE) in people aged 16 and over in Welsh Hospitals. It aims to help healthcare professionals identify people most at risk and describes treatments and interventions that can be used to reduce the risk of developing a VTE as per NICE Guidance 89(NG 89) Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis (DVT) or pulmonary Embolism(PE).
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	All Wales Hospital Acquired Thrombosis (HAT) steering group
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	NICE Guidance 89(NG 89) Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis (DVT) or pulmonary embolism (PE) 21/03/2018
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Policy has been written at an All Wales level to be implemented BCU wide through dissemination through the medical Director to all specialities and disciplines within BCU .

Part A Form 1: Preparation

Please answer all questions

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The success of this policy relies on the engagement of all consultants and Advanced Nurse Practitioners who will be included as part of medical Education. It will also rely on internal communication
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Approximately 55% of venous thromboembolism (VTE) cases occur during or within 90 days of admission to hospital; these Hospital Acquired Thrombosis (HAT) cases account for an estimated 25,000 preventable deaths each year (Thrombosis UK, 2020a). UP to 60% of all VTE's are hospital acquired, accounting for 10% of all hospital deaths and is the number one cause of Preventable hospital mortality(Thrombosis.org/Thrombosis – statistics.php)Therefore this Policy gives clear guidance regarding National standards and forms the foundation for VTE Thromboprophylaxis. This allows the prescriber to assess an individual's risk of VTE and risk of bleeding to decide if VTE Thromboprophylaxis is appropriate.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** **Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.**		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age	√			√	This policy will reduce avoidable harm to all patients being admitted to hospital over the age of 16 years, through VTE risk assessments and subsequent prescribing according to risk factors as per All Wales VTE policy There is no current Nice Guidance regarding under 16 years of age. Each case is discussed with Paediatrician and Consultant Haematologist on an individual basis. VTE affects all ages and there are a number of risk factors which may indirectly relate to age – such as hip / knee replacement surgery that are more common in older people. Staff assessing risk factors should be sensitive to the needs of patients in respect of age, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	A potential negative impact has been identified for children as there is no National Guidance for them. To mitigate this the policy will explicitly sign post staff to consult a Paediatrician and Consultant Haematologist.
Disability	√		√		Certain disabilities and health conditions increase the risk of individuals developing VTE. The risk assessment /policy will	

Please answer all questions

					ensure these patients are individually assessed as to their risk of developing a VTE and therapeutically managed accordingly. Patients with sensory impairment will not be impacted: -Patients who are deaf will receive written information/leaflet as per policy -Patients who have cognitive impairment will also receive written information for carers/family as per policy Staff assessing risk factors should be sensitive to the needs of patients in respect of disability, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	
Gender Reassignment	√		√		Each patient admitted to hospital will be risk assessed as per policy to establish their individualised risk factors in developing VTE. People undergoing gender reassignment treatments either through hormone treatment and or surgery may pose a risk factor or VTE. (Thrombosis UK | The Thrombosis Charity wishes to increase awareness of thrombosis among the public and health professionals and to raise research funds to improve patient care. Helping people who suffer from VTE, DVT, PE and clots.) Stonewall [1] estimate 1% of the population might identify as trans, including people who identify as non-binary.	

[1] [1] Student Frequently Asked Questions (FAQs) | Stonewall

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					Staff assessing risk factors should be sensitive to the needs of patients who are transgender, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	
Pregnancy and maternity	√		√		The policy advises that all midwives/obstetricians should assess all patients for their risk of VTE. Pregnant patients admitted under maternity will be assessed under Green Top Guidelines no 37a 2015 and follow their policy alongside the All Wales VTE Policy. Patients who are pregnant who are admitted for medical or surgical reasons will be assessed for their risk of VTE following the All Wales VTE policy guidance. Pregnancy and post-partum (6 weeks) is a risk factor for VTE. The policy includes providing patients with an information leaflet. This is available in a bi-lingual format. Staff assessing risk factors should be sensitive to the needs of patients who are who are pregnant, given birth or experienced a miscarriage or termination, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	
Race	√		√		This guidance is not anticipated to negatively effect individuals, because of their race.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					There is insufficient evidence to indicate VTE is more predominant in a particular race. Staff assessing risk factors should be sensitive to the needs of different ethnicity/race groups, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	
Religion, belief and non-belief	√		√		Each patient admitted to hospital will be risked assessed as to their individualised risk factors in developing VTE as per All Wales Policy. The treatment options are able to cater for religions and beliefs where certain medicinal restrictions are in place. The policy notes that some patients may have concerns with ingredients of heparins due to animal origin. Further information is available within the policy to help guide health staff with these conversations.	
Sex	√				Each patient admitted to hospital will be risk assessed to their individual risk factors regardless of sex as per All Wales Policy. A number of risk factors may impact men and women differently (for example women on HRT or certain contraceptives), therefore there is an impact on sex but it is not assessed to be either positive or negative, as the treatment remains the same for all sex's.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Sexual orientation		√			Each patient admitted to hospital will be risk assessed to their individual risk factors regardless of sexual orientation as per All Wales Policy. Staff assessing risk factors will be sensitive to the needs of patients in regards to sexual orientation. Staff assessing risk factors should be sensitive to the needs of patients with regard to sexual orientation, as per professional codes of conduct and other relevant BCUHB Policies such as WP8 – Equality, Diversity and Human Rights Policy.	.
Marriage and civil Partnership (Marital status)		√			Each patient admitted to hospital will be risk assessed to their individual risk factors regardless of marital status, as per All Wales Policy. The assessment is that there is no impact on this characteristic.	
Socio Economic Disadvantage	√		√		Risk factors of VTE may relate to conditions, which have higher prevalence in groups which experience socio economic disadvantages. Socioeconomic Status and Risk of VTE | PracticeUpdate	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
√		√		Article 14 prohibition of discrimination	The individualised risk assessment as recommended by All Wales policy removes any likelihood of discrimination, as the clinical management plan is tailored to each patient.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	√		√		Patient information will be available bilingually.	
Treating the Welsh language no less favourably than the English language		√			As per above.	

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	The All Wales VTE Thrombosis Policy was written in conjunction with VTE leads across Wales. It was ratified by the group and signed 20/01/2020. All stake holders within that group consulted prior to completion. No All Wales EQIA completed Local BCU EQIA therefore required
Have any themes emerged? Describe them here.	*This policy is ratified at an All Wales Level and other hospital across Wales have already implemented policy.*
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*All Wales EQIA not completed at time of ratification therefore BCU EQIA completed for implementation of document – minor administrative amendments made to the policy to reflect the EQIA.*

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	All Wales VTE Thromboprophylaxis Policy

2. Brief Aims and Objectives: (Copy from Form 1)	*This policy covers assessing and reducing the risk of Venous Thromboembolism (VTE) in people aged 16 and over in Welsh Hospitals. It aims to help healthcare professionals identify people most at risk and describes treatments and interventions that can be used to reduce the risk of developing a VTE as per NICE Guidance 89(NG 89) Venous thromboembolism in over 16s: Reducing the risk of hospital acquired deep vein thrombosis (DVT) or pulmonary embolism (PE).*

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and**	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

reduced or mitigated any obstacles, you should be able to answer 'No' to this question.		
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes x	No	
	As approved across Wales full impact assessment completed to implement policy across BCU.		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x	
	Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No	
	How is it being monitored?	VTE audit monthly to ensure VTE policy is followed	
	Who is responsible?	Clinician responsible throughout hospital admission.	
	What information is being used?	Data received monthly from RCA completion of potential Hospital acquired Thrombosis, Datix and mortality review.	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	When will the EqIA be reviewed?	*3 years locally unless policy is reviewed at an All Wales level prior*

7. Where will your policy or proposal be forwarded for approval?	*CEG/QSE as per Policy on Policies.*

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Lisa Pemberton	VTE Lead/ Thromboprophylaxis Nurse-East
	Christine Welburn	VTE Thromboprophylaxis Nurse-Central
	Rhianwen Griffiths	VTE lead/Thromboprophylaxis nurse-West
Senior sign off prior to committee approval:	*Name of senior sign off prior to committee approval*	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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 **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No negative impact identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No negative impact identified		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	No negative impact identified		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	All Wales document with wide consultation across Wales No negative impact noted		

Version V0.4 **Reference number - TBC**

All Wales Thromboprophylaxis Policy

Author & Title	All Wales Hospital Acquired Thrombosis Group (HAT) Christine Welburn – BCUHB Thromboprophylaxis Nurse				
Responsible Dept / director:	Gill Harris - Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services				
Approved by:	BCUHB Hospital Acquired Thrombosis Group – May 2020 Clinical Policies & Procedures Group – July 2022 Clinical Effectiveness Group – Chair's Action – August 2022				
Date approved:					
Date activated (live):					
Documents to be read alongside this document:	Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (NG 89)				
Date of next review:					
Date EqIA completed:	February 2022				
First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Employees/workers 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.

All Wales Thromboprophylaxis Policy

This policy is based on National Institute for Health and Care Excellence (NICE) Clinical Guideline (NG) 89 providing clear guidance regarding National Standards. The guideline forms the foundation for thromboprophylaxis risk assessment tools for use in all Welsh Hospitals.

Contents

1. Overview

This policy covers assessing and reducing the risk of Venous Thromboembolism (VTE) in people aged 16 and over in Welsh hospitals. There is no national guidance for those under 16 years (i.e NICE). Clinicians should consult with Pediatrician and Consultant Haematologists on an individual basis.

This policy aims to help healthcare professionals identify people most at risk and describes treatments and interventions that can be used to reduce the risk of VTE utilising NICE Guidance 89 (NG89) – Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

Who is it this policy for?

- Healthcare professionals

Who does this policy cover?

- All patients aged 16 years and over admitted into hospital are at risk of VTE. This includes patients discharged from hospital, including from Accident & Emergency and trauma clinics with lower limb devices, such as plaster casts or braces and pregnant women admitted to hospital or a midwife-led unit including up to 6 weeks after giving birth, and patients at high risk of VTE attending hospital for day case procedures including cancer treatment and surgery.

2. Background

Up to 60% of all VTEs are hospital-acquired, accounting for 10% of all hospital deaths and is the number one cause of preventable hospital mortality (thrombosisuk.org/thrombosis-statistics.php). Many deaths are preventable if patients are offered a VTE risk assessment on admission to hospital and when required, appropriate thromboprophylaxis. The House of Commons Select Committee Report on the Prevention of Venous Thromboembolism in hospitalised patients first addressed the situation in February 2005. In May 2012, the Welsh Assembly Government Health and Social Care committee held a one-day enquiry into in to Venous Thrombo-embolism Prevention in Welsh hospitals. The All Wales Thrombosis Group manages the implementation of the NICE NG89 clinical guidance, the Welsh Government (WG) recommendations and audit of Hospital Acquired Thrombosis (HAT) through a means of continuous Root Cause Analysis (RCA). The group reports directly to the Welsh Government.

Five recommendations were made following the one-day enquiry in May 2012:

Recommendation 1: Compliance with relevant NICE guidance.

Recommendation 2: Clinicians are mandated to carry out VTE risk assessment for all hospitalised patients and prescribe thromboprophylaxis as appropriate.

Recommendation 3: Health Boards will develop a standardised method of demonstrating their HAT rate.

Recommendation 4: An RCA will be undertaken for all patients who develop a VTE during their hospital stay or within 90 days following discharge to establish if the event is hospital acquired.

Recommendation 5: Welsh Government and health boards work together to raise awareness amongst patients and clinicians of the risks of developing HAT.

NICE NG89 (updated August 2019) was released in 2018 providing clear guidance regarding National Standards. The guideline forms the foundation for thromboprophylaxis risk assessment tools for all patient groups.

3. Policy Statements

All patients aged 16 years and over admitted to Welsh hospitals must be fully assessed for their risk of VTE. The risk assessment should not only consider the individuals risk of VTE but also their risk of bleeding and any other conditions which may affect the appropriateness of administering thromboprophylaxis.

- All patients admitted to Welsh hospitals will have their risk of developing a VTE assessed on admission:
    - Using a tool published by a national UK body, professional network or peer reviewed journal as a reference and / or as a clinical document. For example; Department of Health VTE Risk Assessment Tool
    - Referring to the appropriate treatment intervention as per NICE NG89 and prescribe pharmacological or mechanical prophylaxis as appropriate in accordance with local formulary.
    - Documenting treatment choice on the VTE prophylaxis section found within the All Wales In-Patient Medication Administration Record.

- Where thromboprophylaxis, chemical or mechanical, is **not** required or is contraindicated this **MUST** be clearly documented on the VTE prophylaxis section found within the medication chart and documented in the patient's case notes.

- Reassess medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition

changes. See recommendations 1.1.8 Re Assessment of Risk of VTE and bleeding (NICE NG89)

- The clinical notes of all patients who develop a VTE during their current inpatient admission (length of stay to be greater than 24 hours of being admitted) or having had a hospital inpatient admission (length of stay to be greater than 24 hours) in the health board within the previous 90 days following discharge will be reviewed to establish whether:
  - A thromboprophylaxis risk assessment has been completed on admission as per health board policy.
  - Appropriate treatment has been offered.

  Where the answer to either of these questions is 'No' a RCA will be undertaken to establish if the HAT was potentially preventable.

- The number of suspected HAT cases related to a hospital stay are collated by the Health Board monthly and RCA's and associated actions are reported to Welsh Government on a quarterly basis.

4. Principles

Consultants and relevant clinicians within their teams, supported by nursing and pharmacy employees/workers, are responsible for the uptake of thromboprophylaxis risk assessment for all patients on admission and for re-assessment during the hospital stay.

All patients receiving thromboprophylaxis will be given a full explanation of the need for treatment, as per NICE NG89, supported by an appropriate patient information leaflet, such as Lowering Your Risk of Blood Clots (Thrombosis UK 2019) or EIDO: Reducing your risk of developing a blood clot (DP01), or a locally developed patient information leaflet professionally or peer reviewed. Patients who have cognitive or visual impairment will also receive written information for their carers/family where required.

5. Scope of Policy

This policy applies to all patients 16 years and over admitted to hospital.

6. Policy Review

The Health Board Hospital Acquired Thrombosis (HAT) Committee are responsible for facilitating, reviewing and ratifying this policy, clinical guidelines and risk assessments 3 yearly or earlier if required.

7. Duties and Responsibilities

Overarching Managerial Responsibility

Clinical Directors / Heads of Nursing / Heads of Midwifery / Heads of Pharmacy are responsible for ensuring that this policy and associated clinical guidance, procedures and risk assessments are available for the relevant employees/workers within their clinical area.

Admitting Doctor / Clinician

It is the responsibility of the clinician:

- To assess each patient as soon as possible within 14 hours after admission to hospital or by the time of the first consultant review using the risk assessment appropriate to the specialty as a reference or as a clinical document and prescribe appropriate treatment on the All Wales In-Patient Medication Administration Record.
- To balance the person's individual risk of VTE against their risk of bleeding when deciding whether to offer pharmacological thromboprophylaxis to medical, surgical and trauma patients.
- If using pharmacological VTE prophylaxis for medical patients, start it as soon as possible and within 14 hours of admission, unless otherwise stated in the population-specific recommendations (see NG89 sections 1.4 to 1.9).
- If using pharmacological VTE prophylaxis for surgical and trauma patients, start it as soon as possible and within 14 hours of admission, unless otherwise stated in the population-specific recommendations (see NG89 sections 1.10 to 1.15).
- To **document and inform the patient** of any decision not to treat or any deviation from the guidelines in the patient case notes.
- To re-assess all hospitalised patients for their risk of VTE at the point of consultant review and/or if their clinical condition changes.
- To inform the patient why they are having thromboprophylaxis treatment.

Nurses

It is the responsibility of the qualified nurse to:

- Prompt the responsible clinician to ensure all patients are risk assessed as soon as possible after admission to hospital or by the time of the first consultant review and then re-assessed daily **OR** as their clinical condition changes.
- Ensure the prescribed thromboprophylaxis is administered as required and documented on the All Wales In- Patient Medication Administration Record.
- Support the clinician in informing the patient why they are having or not having thromboprophylaxis treatment.
- Supply each patient on admission or in pre-assessment clinic with a HAT patient information leaflet explaining need for risk assessment on admission, thromboprophylaxis during their hospital stay and VTE prevention advice on discharge from hospital.

Obstetrician / Midwife

It is the responsibility of the obstetrician / midwife to:

- Assess all women on admission to hospital or a midwife-led unit if they are pregnant or gave birth, had a miscarriage or had a termination of pregnancy in the past 6 weeks, to identify their risk of VTE and bleeding. A tool published by a national UK body, professional network or peer-reviewed journal should be used. The Royal College of Obstetricians and Gynaecologists Green-top Guideline No 37a – RCOG (2015), developed the most commonly used risk assessment tool.
- Reassess risk of VTE and bleeding, and assess the need for thromboprophylaxis for all women:
    - within 6 hours of giving birth, having a miscarriage or having a termination of pregnancy **or**
    - if their clinical condition changes **and** they:
        - are pregnant **or**
        - have given birth, had a miscarriage or had a termination of pregnancy within the past 6 weeks
- Inform the patient why they are having or not having thromboprophylaxis treatment.
- Ensure the prescribed thromboprophylaxis is administered as required and documented on the All Wales In- Patient Medication Administration Record.
- Supply each patient on admission or in ante-natal clinic with a HAT patient information leaflet explaining the need for a risk assessment on admission, thromboprophylaxis during their hospital stay and VTE prevention advice on discharge from hospital.

Pharmacists

It is the responsibility of the pharmacist to:

- Check that patients have appropriate thromboprophylaxis prescribed when reviewing the All Wales In-Patient Medication Administration Record. To support nurses and midwives in prompting the clinical teams to complete VTE risk assessments.
- Support the clinician in informing the patient why they are having or not thromboprophylaxis treatment.

8. Education

- Ensure all clinicians responsible for undertaking VTE prophylaxis risk assessment or re-assessment has the necessary competence to undertake their duties safely.
- Ensure all employees/workers caring for patients undertaking mechanical or chemical VTE prophylaxis treatment has the necessary competences to undertake their duties safely.

9. Audit

- VTE cases associated with a hospital admission, known as HAT, are collated via radiology and Informatics and reported to WG each month by appointed members of clinicians from each health board on the HAT reporting template. These cases are validated by a process of RCA to determine if they are potentially preventable HATs and reported quarterly to WG to establish the number of potentially preventable HAT's in each health board.

- The rate of patients receiving a VTE risk assessment on admission to hospital can be collected from the 'Hospital Thermometer' monthly audit, specifically from the VTE prophylaxis section within the All Wales In-Patient Medication Administration Record, or similar locally agreed method of audit or audit tool.

10. Tools and Documents

- Each Health Board is responsible for the creation of VTE Risk assessment tools and documents associated and complying with this policy.

Considerations for Individual Health Boards

7-day pharmacological thromboprophylaxis in medical patients:
The most recent NICE guidance (NG89) recommended that all medical patients receive at least 7 days of pharmacological thromboprophylaxis.

Some health boards and trusts in the UK have recommended against the use of routine extended (i.e. beyond discharge) pharmacological thromboprophylaxis in medical patients. Reasons for this decision include concerns around cost vs benefit ratio, validity of the key studies in modern practice, safety of home Low Molecular Weight Heparin (LMWH) administration.

These concerns are in line with the British Society of Hematology's recent rebuttal to the NICE
guidance.

Extended thromboprophylaxis in medical patients is currently not recommended within the American College of Chest Physicians (ACCP 2012) guidelines.

Pharmacological thromboprophylaxis should be regularly reviewed. On discharge, post admission with an acute medical illness, if the patients risk of VTE outweighs the risk of bleeding, NICE recommends considering continuing pharmacological thromboprophylaxis for a minimum of 7 days. If this is deemed necessary, it must be ensured that people who are discharged with pharmacological VTE prophylaxis

are able to use it correctly, or have arrangements made for someone to be available who will be able to help them.

Prescribing mechanical thromboprophylaxis: When prescribing mechanical thromboprophylaxis only one device is to be prescribed and fitted at a time – there is no evidence to support the use of more than one mechanical device at the same time.

Prescribing unlicensed medications: At the time of publication (NG89 - March 2018), Low Molecular Weight Heparin (LMWH), Fondaparinux, Apixaban, Dabigatran or Rivaroxaban did not have a UK marketing authorisation for use in patients 18 years and younger for use as thromboprophylaxis medication.

Aspirin does not have a UK marketing authorisation for use as thromboprophylaxis medication. However, it is NICE NG89 approved for use as thromboprophylaxis in patients who have had a total hip replacement or total knee replacement. Within this patient group, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Religious, social and cultural beliefs: Be aware that heparins are of animal origin and this may be of concern to some patients. Discuss the alternatives with patients who have concerns about using animal products, after discussing their suitability, advantages and disadvantages with the person. See Religion or belief: a practical guide for the NHS.

11. NICE NG89 Treatment Intervention links:

Hyperlinks correct at time of access (September 2022). Whilst every effort is taken to maintain links, users of this policy are advised to check that they are accessing the most up to date information in line with best clinical practice.

Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (NG 89)

1.1 Risk assessment

1.2 Giving information and planning for discharge

1.3 All patients

1.4 Interventions for people with acute coronary syndromes or acute stroke or for acutely ill patients

1.5 Interventions for people with renal impairment

1.6 Interventions for people with cancer

1.7 Interventions for people having palliative care

1.8 Interventions for people admitted to critical care

1.9 Interventions for people with psychiatric illness

1.10 Interventions when using anaesthesia

1.11 Interventions for people having orthopaedic surgery

1.12 Interventions for people having elective spinal surgery or cranial surgery or people with spinal injury

1.13 Interventions for people with major trauma

1.14 Interventions for people having abdominal, thoracic or head and neck surgery

1.15 Interventions for people having cardiac or vascular surgery

1.16 Interventions for pregnant women and women who gave birth or had a miscarriage or termination of pregnancy in the past 6 weeks

12. Other Links

NHS Risk Assessment Tool

All Wales In-Patient Medication Administration Record

TUK - Lowering Your Risk of Blood Clots: Patient information leaflet

All Wales tissue viability Anti Embolism Stocking (AES) guidance

13. Links to NG 89 – Miscellaneous information

Terms used in this guideline (NG89)

Putting this guideline into practice

Context

More information

Recommendations for research

- 1 Risk assessment
- 2 Dose strategies for people who are obese
- 3 Direct oral anticoagulants for people with lower limb immobilisation
- 4 Aspirin prophylaxis for people with fragility fractures of the pelvis, hip or proximal femur
- 5 Duration of prophylaxis for elective total hip replacement surgery

Update information Recommendations that have been changed

14. Website Links

Thrombosis UK

e-VTE

Teitl adroddiad: ***Report title:***	IPC05 Outbreak Reporting and Control Policy, including Major Outbreaks			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	Outbreaks of infection can affect both primary and secondary care and may have serious consequences for service users and NHS organisations including; mortality, morbidity, distress, delays in treatment and impacts on service provision. Not all outbreaks are preventable, however it is possible to minimise the effect of outbreaks when they occur by taking prompt preventative actions and control measures. Many hospital outbreaks have minimal or no public health implications and are managed using BCUHB's outbreak reporting and control procedure. However, if an infectious disease outbreak within a hospital or other healthcare setting has any potentially serious public health implications, such as consequences for the wider community or it is identified as being food or water borne, 'The Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan')' will be utilised to guide ongoing management. This policy aims to minimise the effects of outbreaks by ensuring there are appropriate systems in place for the rapid, well-coordinated response whilst making efficient use of all healthcare resources in order to contain the outbreak. As outbreaks of infection may vary widely in extent and severity, this policy aims to clearly define the structure for the recognition, escalation and management in these situations.			
Argymhellion: ***Recommendations:***	The Committee is asked to receive and approve IPC05 Outbreak Reporting and Control Policy, including major outbreaks following a recent review.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Andrea Ledgerton, Advanced Lead Nurse Specialist, Infection Prevention			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Infection Prevention Sub Group (IPSG) Plan on a Page
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Code of Practice for the Prevention and Control of Healthcare Associated Infections (2014) Welsh Government 6 key mandatory performance indicators/organisms Health and Safety at Work Act 1974
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes Completed and approved by Local Equality Delivery Lead
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required. The Policy does not relate to a strategic decision. QSE are asked to approve an existing policy following review.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Risks to operational activity delivery and disruption associated with risks of outbreaks and ward closure. Risks to reputation of BCUHB associated with non-achievement of HCAI targets/objectives.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Resource implications are considered within the policy. Outbreaks of an infectious nature are difficult to predict and can lead to significant financial implications to control them. Charges for cleaning, laboratory specimens, drugs, laundry, equipment-hire and personnel can all lead to increased expenditure. The increased costs fall both on the Hospital directly involved in the patient care and those providing support services such as Laboratory, Radiology, Pharmacy, Estates and Facilities.

	Costs generated by outbreaks of infectious conditions will normally be funded from the baseline budgets of the areas concerned. Any overspends generated will be submitted as cost pressures at the end of the financial year. In exceptional circumstances, e.g. pandemic, additional resources/funding may be available from Welsh Government.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Education considerations are included within the 'training' section of the policy to support understanding. There are implications associated with the cohort/movement of workforce which are managed by the Hospital Management Teams with support from the Infection Prevention Team as appropriate.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Protocol reviewed collaboratively by the Senior Infection Prevention Nurse Team, Public Heath Wales Microbiologists, Emergency Planning and Resilience Lead. Consultation via IPSG 26/07/2022 and further consultation sought via CPPG on 16/08/2022 and PSQG Sept 2022
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Links in with BAF point 1.2 'Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety , resulting in a deterioration of care and harm to patients and service users'
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable.
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Following completion of the necessary consultation and approval processes, this policy will be uploaded onto the Health Boards intranet site and disseminated to all relevant clinical areas via the Infection Prevention Sub Group, Local Infection Preventions Groups, and publicised using the BCUHB Weekly Newsletter Circulation.	
List of Appendices: Appendix 1 – IPC05 Outbreak Report and Control Policy Appendix 2 – IPC05 Policy appendix 5 – BCU Outbreak Agenda (Site slide) Appendix 3 – IPC05 Policy appendix 5 – Outbreak Agenda (slide) Appendix 4 – IPC05 Policy appendix 8 – End of outbreak summary slide	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version Number 3.0

IPC05 OUTBREAK REPORTING AND CONTROL POLICY, INCLUDING MAJOR OUTBREAKS

Author & Title	Amanda Pagett Infection Prevention Specialist- Agency Andrea Ledgerton, Advanced Nurse Specialist Lead, Infection Prevention				
Responsible Dept/ director:	Infection Prevention Team Angela Wood Executive Director of Nursing & Midwifery				
Approved by:	Infection Prevention Sub Group- 26/07/2022, Clinical Policies and Procedures Group- 16/08/2022, For consideration by Patient Safety and Quality Group- Sept 2022, and for consideration by Quality Safety & Experience Group- Oct 2022				
Date approved:	***** 2022				
Date activated (live):					
Documents to be read alongside this document:	IPC13 Protocol for the Management of Norovirus (2022) The Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan') July 2022 National Infection Prevention & Control Manual (2022). Chapter 3 The Outbreak Management Plan (2021) Public Health Wales Infection Prevention and Control Measures for SARS-CoV-2 (COVID-19) in Health and Care Settings: Wales (May 2022)				
Date of next review:	****** 2025				
Date EqIA completed:	30/08/2022				
First operational:	March 2017				
Previously reviewed:	March 2020	Oct 2020			
Changes made yes/no:	No	Yes- reviewed in line with learning from the COVID-19 pandemic			

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.

Table of Contents

1.0 INTRODUCTION

Outbreaks of infection can affect both primary and secondary care and may have serious consequences for service users and NHS organisations including; mortality, morbidity, distress, delays in treatment and impacts on service provision. Not all outbreaks are preventable, however it is possible to minimise the effect of outbreaks when they occur by taking prompt preventative actions and control measures.

Many hospital outbreaks have minimal or no public health implications and are managed using BCUHB's outbreak reporting and control procedure. However, if an infectious disease outbreak within a hospital or other healthcare setting has any potentially serious public health implications, such as consequences for the wider community or it is identified as being food or water borne, 'The Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan')' will be utilised to guide ongoing management.

2.0 AIMS/OBJECTIVE

This policy aims to minimise the effects of outbreaks by ensuring there are appropriate systems in place for the rapid, well-coordinated response whilst making efficient use of all healthcare resources in order to contain the outbreak. As outbreaks of infection may vary widely in extent and severity, this policy aims to clearly define the structure for the recognition, escalation and management in these situations.

3.0 SCOPE

This policy applies to all Betsi Cadwaladr University Health Board employees and workers as defined by section 230 of the Employment Rights Act 1996. The scope includes, but is not limited to: agency; board members; consultants and contractors; locums; students; vendors and volunteers. Herein referred to as 'employees/workers'.

The policy sets the standard of practice expected to ensure the early detection and management of outbreaks of infection, whilst ensuring all steps are taken to limit the spread of infection, minimise the disruption of services, cessation of the outbreak and preventing recurrence where possible.

4.0 ROLES AND RESPONSIBILITIES

All employees/workers within the Health Board are responsible for implementing elements of this policy that are relevant to their role and place of work.

Line managers at all levels are responsible for ensuring their teams comply with this policy, ensuring they are provided with the facilities and resources needed to comply with it. As prompt recognition and investigation is essential, teams must be aware of how to notify the Infection Prevention Team if an outbreak is suspected (see Appendix 1 and 2).

Individual roles and responsibilities can be found within the 'Action Cards' within Appendix 7.

5.0 DEFINITION OF AN OUTBREAK

5.1 An outbreak of infection is defined as two or more individuals experiencing a similar illness that are linked in time and/or place, e.g. multiple patients with suspected or confirmed norovirus on the same ward. Where there are endemic rates of specific infections, an outbreak may also be considered where there is a greater than expected incidence of infection compared to the background rate. Where the background level of an organism/infection for the facility or organisation is normally zero, or a single case has serious potential public health consequences (e.g. hospital acquired *Legionella*, Diphtheria), one case can and should be declared as an outbreak and an Outbreak Control Group (OCG) formed.

5.2 The formal declaration of a 'major' outbreak will normally be considered if an outbreak is characterised by one or more of the following:

- A significant immediate and/or continuing communicable disease health hazard;
- One or more cases of serious communicable disease;
- Large numbers of cases or numbers greater than expected of infections for which there is a wider public health implication;
- Involvement of more than one Local Authority where a joint response needs coordination;
- Where an outbreak crosses the border and affects people living in one or more of the other UK countries.

See section 12 for further information.

5.3 In the case of viral gastroenteritis, symptoms among employees/workers as well as patients is suggestive of an outbreak, as is the sudden onset of symptoms, including projectile vomiting. In this situation, the IPC13 Protocol for the Management of a Norovirus should be used in conjunction with this document.

6.0 RECOGNITION OF AN OUTBREAK OR INCIDENT

The rapid recognition of an outbreak is one of the most important objectives of routine infection surveillance. Outbreaks may be identified by the Infection Prevention Team and Microbiology Laboratory via Laboratory Information Management System (LIMS) or IC Net (electronic infection surveillance system); or by nursing and medical staff, volunteers or students working in the clinical area, particularly if the onset is rapid and affects a significant number of patients/employees/workers.

Health Board placed Healthcare Epidemiologists and epidemiological data can be utilised to support confirmation of diagnosis/outbreak, construct a working case definition, include descriptive, e.g. context from community rates (depending on the

pathogen and assist with communication of concepts (e.g. typing, genomics). Epi-tools, time-lines and other available resources can be utilised to support ongoing epidemiological monitoring.

7.0 DECLARATION OF AN OUTBREAK

Upon notification, a suspected outbreak of infection is initially investigated by the Infection Prevention Team (IPT). The investigation includes determining the epidemiological case definition, the number of individuals affected, symptoms, likely source and mode of spread. Information gathered allows an assessment of the severity of the problem and initiation of immediate control measures.

Based on the initial investigations, the IPT will agree the severity of the outbreak. This will depend on the number of individuals affected, the identity of the causative organism and the speed of onset. The outbreak will be classified as level 1, 2 or 3 (see section 9) and an appropriate Outbreak Control Group (OCG) formed (see Appendix 3) and Outbreak Control Group Meeting held. A proposed OCG Meeting Terms of Reference, OCG membership list and agenda template slide can be found within Appendix 4 and 5.

If it is found that no outbreak exists, departmental employees/workers will be reassured and care taken to ensure that they are not discouraged from further reporting in the future. This will be documented by the IPT to the Site/Area Management Team.

8.0 PURPOSE OF THE OUTBREAK CONTROL GROUP MEETINGS

The Purpose of the Outbreak Control Group Meetings is:

- To discuss the likely epidemiology using available data, extent of the outbreak and up to date overview of the current situation (total new cases within the last 24 hours, total patients/employees/workers affected on site, total number of contacts where applicable, total number of patients/contacts requiring additional clinical support (e.g. critical care input, CPAP).
- Identify any immediate actions to reduce the risk of further spread and agree control measures such as isolation, increased/altered environmental cleaning schedules, bay/ward/department closure, avoidance of non-clinical patient movement between wards or settings, where relevant assessment of staff and patient vaccination status and restriction of visitors and employee/worker movement.
- Consider operational impact/mitigating measures and scrutiny and assurance of key mitigations.
- Ensure patients are being kept informed and managed to optimise patient flow, safe healthcare provision and timely reopening of clinical areas closed.
- Review infection prevention related audit data.
- Review ward/departmental staff levels.
- Identify and address, where possible issues relating to estates and facilities e.g. ventilation.
- Agree mitigation, escalation and communication including media approach.

- Agree reporting arrangements, including BCUHB Executives and Welsh Government.
- Agree any additional testing required for patients and employees/workers, including organism typing/genome sequencing.
- Ensure personal protective equipment (PPE) in use is appropriate and readily available.
- Identify Infection Prevention Champions to support infection prevention control measures, audit and education.
- Agree the necessary strategy of communications required.

9.0 LEVELS OF OUTBREAK

LEVEL 1 (single ward/department level)
An outbreak of two or more healthcare associated infections (HCAI) cases (including indeterminate) in a single ward/department with or without single isolated HCAI infections in other wards on the same site (this would include single patients transferred from an outbreak ward who test positive shortly following transfer with no further transmission). This will impact on operational capacity. e.g. multiple cases of suspected infective diarrhoea in one ward.

LEVEL 2 (multiple wards)
An outbreak of two or more HCAI cases (including indeterminate) occurring in more than one ward/department within one hospital, or involving wards/departments in another site that routinely receives patients from the source hospital. This will impact on the Health Boards operational capacity at one acute site (DGH) and corresponding area (i.e. West/Central/East).

LEVEL 3 (BCUHB-wide)
An outbreak in more than one acute site when either:

- there is evidence of transmission of cases between acute hospitals that have resulted in more than one LEVEL 2 outbreak being declared.
- There are independent transmissions at times of high community transmission resulting in LEVEL 2 outbreaks being declared affecting multiple sites across BCUHB. This presents a significant risk to a large number of patients, employees/workers or visitors, and/or requires significant control measures such as the closure of large numbers of wards or facilities and services, and/or threatens Health Board ability to meet its emergency or elective commitments.

Once satisfied that ongoing transmission of infection has ceased (taking into account the HCAI incubation period) it is the responsibility of the OCG Chair to ensure the affected ward/department(s) confirms completion of the ward opening/stepdown checklist and infection prevention practice assurance gained prior to discontinuation of attendance at the OCG.

See section 13 for further information.

10.0 CONTROL MEASURES

The IPT will advise on the control measures required to minimise the effects of the outbreak, which may include:

- Patient placement (isolation/cohorting).
- Management of affected patients and contacts, e.g. condition/requiring additional support, vaccination status.
- Minimisation of patient movements between wards.
- Hand hygiene.
- Personal Protective Equipment (PPE) requirements for employees/workers, patients and visitors.
- Closure of bays, wards or departments.
- Management of exposed employees/workers, e.g. movement, exclusion, vaccination status assessment.
- Additional microbiology testing requirements.
- Employee/worker/visitor restrictions.
- Management of the environment (e.g. enhanced ventilation) and enhanced cleaning of the environment and patient shared equipment.
- Management of waste and linen.
- Communication of key information to employees/workers.

11.0 REPORTING/NOTIFICATION/COMMUNICATION

All employees/workers should be vigilant and report any suspicions of an outbreak of infection to the IPT immediately (see Appendix 1). The IPT will ensure any external notification requirements, e.g., for Welsh Government, are completed as appropriate. Communication of information between the OCG and the Executive Director of Nursing and Midwifery will take place through the Director of Nursing Infection Prevention and Decontamination (or on-call Executive member in their absence).

Where possible, outbreaks will be reported as an incident by the IPT on Datix within 24 hours. Completed post infection reviews (PIRs) will be linked to the Datix incident and added to the system by Ward/Department Managers, and incident closed by Ward/Department Manager once declared over. Any incidents that fall within the definition of a 'serious incident' will also be reported by the IPT to Welsh Government in line with 'Notification of No Surprise/Sensitive Issue' arrangements (form SI2) within 24 hours.

The Heath Board's Press Officer will be informed. No information concerning the outbreak will be released to the Press or Public by any other means. The OCG/Executive Team should approve any press release prior to issue.

12.0 MANAGEMENT OF AN OUTBREAK WITH MAJOR PUBLIC HEALTH IMPLICATIONS

Should the IPT judge the outbreak to be of sufficient extent or severity, they will notify the relevant Director of Public Protection (DPP), Consultant in Communicable Disease Control (CCDC)/Consultant in Health Protection (CHP) at Public Health

Wales for the provision of specialist advice and support on communicable disease control issues. In outbreaks that have major community/public health implications, 'The Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan')' will be utilised to guide ongoing management. The DPP or CCDC/CHP will work closely with the Health Board and participate in the Outbreak Control Group Meeting as appropriate.
In the event of a serious outbreak that occurs outside of the Health Board setting that has the potential to impact its services, the DPP or CCDC/CHP may request that the Health Board initiates and convenes an OCG to ensure any potential healthcare resources and control measures are in place.

13.0 ACTIONS TO BE TAKEN AT THE END OF THE OUTBREAK OF INFECTION

It is the responsibility of the Chair to hold a final meeting of the OCG to formally close the outbreak and meet the following objectives:

- To use epidemiological data to confirm the end of the outbreak.
- To confirm completion of the ward-opening/stepdown checklist, where appropriate, prior to re-opening.
- To summarise the areas affected, number of patients/employees/workers involved, likely causative agent and produce a final outbreak summary slide/report (see template within Appendix 8).
- To review the experience of all participants involved in the management of the outbreak.
- To identify particular difficulties that were encountered.
- To recommend, if necessary, structural and procedural improvements that would reduce the chance of recurrence of an outbreak.
- To communicate that the outbreak is closed to all those who were involved throughout the outbreak.
- To inform others inside and outside of the organisation of any lessons to be learned from the outbreak.

14.0 RESOURCES

Outbreaks of an infectious nature are difficult to predict and can lead to significant expenditure to control them. Charges for cleaning, laboratory specimens, drugs, laundry, equipment-hire and personnel can all lead to increased expenditure. The increased costs fall both on the Hospital directly involved in the patient care and those providing support services such as Laboratory, Radiology, Pharmacy, Estates and Facilities.

Costs generated by outbreaks of infectious conditions will normally be funded from the baseline budgets of the areas concerned. Any overspends generated will be submitted as cost pressures at the end of the financial year.

In exceptional circumstances, e.g. pandemic, additional resources/funding may be available from Welsh Government.

15.0 EQUALITY INCLUDING WELSH LANGUAGE

Equality assessment has identified no inequality or disadvantage to implementing this policy. The policy is promoted equally to all and all the protected characteristics. The Health Board has a duty to protect life (article 2) and the policy supports that by preventing/mitigating harm.
Although there is a potential for negative psychological impact associated with patient isolation, bay/ward closure, visiting restrictions etc., this is recognised and clinical teams will be supported to ensure any potential negative impacts are minimised where possible. The policy is not currently available in the Welsh language but will be facilitated on request.

16.0 WELL-BEING OF FUTURE GENERATIONS

This policy supports 'a healthier Wales' and has been developed in line with the well-being goals in accordance with the 'Well-being of Future Generations (Wales) Act (2015)' whilst ensuring consideration has been given to collaborative working and integrated approaches.

17.0 ENVIRONMENTAL IMPACT

The Health Board has limited number of single room accommodation to care for patients who are at risk of acquiring or transmitting infection. The Health Board has a designated 'Isolation Policy' and 'Side Room Risk Assessment Tool' to support the effective prioritisation and allocation of side room accommodation across all sites. Furthermore, the clinical need for patients occupying side rooms is reviewed daily by the Ward, Bed Management and Clinical Site Management Teams, with IP Nurse representation at Bed Meetings during outbreaks.

18.0 TRAINING

All employees/workers must undergo online e-learning Level 1 infection prevention and control training, with clinical employee/workers also required to undertake on-line Level 2 infection prevention and control training. Where additional training on this policy is required, microteaching sessions will be delivered.

19.0 IMPLEMENTATION

Following completion of the necessary consultation and approval processes, this policy will be uploaded onto the Health Boards intranet site and disseminated to all relevant clinical areas via the Infection Prevention Sub Group, Local Infection Preventions Groups, and publicised using the BCUHB Weekly Newsletter Circulation.

20.0 MONITORING OF COMPLIANCE/AUDIT

Compliance with this policy will be monitored during the Outbreak Control Group Meetings as real-time learning is identified and addressed/shared as appropriate; and as part of the actions to be taken at the end of the outbreak.

All clinical areas within BCUHB will be subject to annual audit, utilising the Infection Prevention Society Quality Improvement Tools, which have been adapted for use. In outbreak situations within clinical or non-clinical areas as appropriate, additional audits of practice will be completed by ward teams, IPC Champions and the IPT (as directed by the IPT), for example, COVID-19 audits, *Clostridium difficile* snapshot audits, daily hand hygiene audits.

21.0 CONSULTATION

This policy has been developed in conjunction with senior members of the Infection Prevention Team, Public Health Wales Microbiologists, and BCUHB Emergency Preparedness Resilience and Response Lead. Further consultation and approval will be sought via the Infection Prevention Sub Group, Clinical Policies and Procedures Group, Patient Safety and Quality Group and the Quality Safety and Experience Group in line with OBS1 Management of Policies & Procedures and other Written Control Documents.

22.0 REVIEW

This policy will be reviewed every three years in line with the Health Boards OBS1 Management of Policies & Procedures and other Written Control Documents, or following the receipt of updated national guidance whichever is sooner.

23.0 REFERENCES

The Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan') June (2020)
National Infection Prevention & Control Manual (2022) Chapter 3
The Outbreak Management Plan (2021) Public Health Wales
Infection Prevention and Control Measures for SARS-CoV-2 (COVID-19) in Health and Care Settings: Wales. Public Health Wales (May 2022)

APPENDICES
APPENDIX 1 Infection Prevention Team contact details

West

Infection Prevention Team: 01248 384060, Bleep 059/081/661

Consultant Microbiologist: 01248 384367

The BCUHB IPT provide an oncall service at weekends and bank holidays between 09:00 until 17:00 and can be contacted via the hospital switchboard.

After 17.00 until 09.00hrs week-days, weekends and bank holidays contact the on-call Medical Microbiologist via switchboard.

Central

Infection Prevention Team: 01745 448255, Ext 7391/7392, Bleep 6843/4562,

Consultant Microbiologist: 01745 583910 Ext 2935

The BCUHB IPT provide an oncall service at weekends and bank holidays between 09:00 until 17:00 and can be contacted via the hospital switchboard.

After 17.00 until 09.00hrs week-days, weekends and bank holidays contact the on-call Medical Microbiologist via switchboard.

East

Infection Prevention Team: 01978 727277, Bleep 5203

Consultant Microbiologist: 01978 291100, Ext 5257

The BCUHB IPT provide an oncall service at weekends and bank holidays between 09:00 until 17:00 and can be contacted via the hospital switchboard.

After 17.00 until 09.00hrs week-days, weekends and bank holidays contact the on-call Medical Microbiologist via switchboard.

Consultant for Communicable Disease Control (CCDC)/Health Protection Team: 0300 00 300 32

APPENDIX 2 Actions to be taken by Ward/Department staff in the event of a suspected outbreak of infection

Contact the Infection Prevention Team (IPT) if:

- An unusual infection is confirmed e.g. *Legionella*, Diphtheria, Ebola.
- A number of patients and/or employees/workers display symptoms of infection.
- An unusually high number of 'common' infections (MRSA, *Clostridium difficile)* are confirmed.

Inform the Senior Nurse/Clinical Site Manager.

↓

Ensure infection prevention measures are in place (e.g., Personal Protective Equipment (PPE), hand hygiene, additional environmental cleaning) as directed by the IPT.
Prepare detailed information on affected cases, as directed by the IPT.
Follow any further instructions from the IPT.

↓

Check adequate supplies of consumables are available at ward/department level (e.g. PPE, paper towels, alcohol hand gel).
Construct a list of any items needed and place an order for.
Await the outcome of the outbreak control or incident meeting if one is deemed necessary.

↓

Follow the advice and guidance of the IPT, ensuring any new cases are promptly reported to the IPT, until the outbreak is declared over.
Notify the IPT of any difficulty in implementing IP recommendations.

↓

IPT to consult with Site/Executive Lead as required to confirm the level of outbreak and agree the criteria for declaration of closure of the outbreak.

APPENDIX 3 Summary of responsibilities, management and communication in the event of an outbreak of infection (levels 1, 2 and 3)

LEVEL 1 (Single Ward/Department Level)

Outbreak Control Group meeting must include as a minimum:-

- Hospital Management Team Representative, Director of Nursing (Chair), Medical Director (Deputy Chair),
- Specialist Matron or Senior Nurse from Infection Prevention.
- Ward/Department Sister/Manager/Deputy, Matron and Head of Nursing
- Ward/Department Consultants responsible for the care of the affected patients.
- Any other co-opted members deemed necessary (e.g. Facilities Team, Occupational Health Team).

IPT advice regarding bed/bay/ward/department closure, restriction of patient movement, control measures and criteria for closure of the outbreak (and via email and bed meeting).

LEVEL 2 (Multiple Wards)

Outbreak Control Group meeting must include as a minimum:-

- As LEVEL 1
- Public Health Wales Consultant Microbiologist/ Infection Control Doctor.
- Facilities Team member.
- Any other co-opted members deemed necessary (e.g. CCDC/CHP, Communications Team, Health and Safety Team, Workforce, Epidemiologist).

IPT advice regarding bed/bay/ward/department closure, restriction of patient movement, control measures, and criteria for closure of the outbreak (and via email and bed meeting). Action plan development and implementation.

LEVEL 3 (BCUHB wide)

Outbreak Control Group meeting must include as a minimum:

- As LEVEL 2
- Executive Director of Nursing (Chair), Director of Nursing Infection Prevention and Decontamination (Deputy Chair)
- Emergency Preparedness, Resilience and Response Lead
- Representative from Tactical Control Centre
- Hospital Director or Acute Site Director
- Epidemiologist
- Communication manager
- Workforce manager
- Any other co-opted members deemed necessary (e.g. Director of Public Protection (DPP), CCDC/CPH, Health Protection Team, Pharmacy Lead, Union Representation, Risk Manager, Representative from Welsh Ambulance Service (WAST), Microbiology Laboratory Manager, Workforce, Procurement, PHW representatives, Environmental Health Officer, Regulators, e.g. Health and Safety Executive, Healthcare Inspectorate Wales, Food Standards Agency).

The IPT/Microbiologist/Advanced Lead Nurse Specialist, Infection Prevention will determine if a LEVEL 3 outbreak exists in collaboration with the site teams and the Executive Director of Nursing and Midwifery. Consideration is given to the following:

- Number of individuals affected.
- Pathogenicity of the organism involved.
- Potential for spread within the hospital and community.
- Impact upon the organisation and patients.
- Whether a Level 3 BCU-wide meeting is required to oversee/control the situation.
- Whether business continuity plans need to be implemented.
- Whether there is the need for a communications helpline/strategy.
- Whether advice should be sought from external agencies.
- Seek assurance from the Site OCG meetings, focusing on the control measures and required actions and resources
- Ensure that interim and final reports are completed and sent to Welsh Government including Datix and Serious Incident where applicable.
- Responsibility of Site/Area Management Team(s).

APPENDIX 4 Terms of Reference: Key Information- Outbreak Control Group (OCG)

Terms of Reference.

For all outbreaks: Level 1, 2 & 3

- To agree a case definition (what constitutes a genuine case).
- To discuss the likely epidemiology, extent of the outbreak and up to date overview of the current situation (total new cases within the last 24 hours, total patients/employees/workers affected on site, total number of contacts where applicable, total number of patients/contacts requiring additional clinical support (e.g. critical care input, CPAP).
- Identify any immediate actions to reduce the risk of further spread and agree control measures such as isolation, increased/altered environmental cleaning schedules, bay/ward/department closure, minimisation of non-clinical patient movements and restriction of employee/worker movement.
- To provide clear instructions and/or information for ward/department employees/workers and others, including contracted workers.
- Consider operational impact/mitigating measures and scrutiny and assurance of key mitigations.
- Ensure patients are managed to optimise patient flow, safe healthcare provision and timely reopening of closed clinical areas.
- Review infection prevention audit data.
- Review ward/departmental staff levels.
- Identify and address, where possible issues relating to estates and facilities.
- To clarify the resource implications and how they will be met, e.g. additional supplies and employees/workers (particularly nurses, doctors, laboratory and IPT workers).
- Agree mitigation, escalation and communication with employees/workers, patients, relatives and visitors, including media approach. This includes nominating responsibility for making statements to the news media throughout the duration of the outbreak and may need to be agreed with partner agencies including Public Health Wales.
- Agree reporting arrangements, including BCUHB Executives and Welsh Government.
- Agree any additional testing required for patients and employees/workers.
- Identify IPC Champions to support IPC measures, audit and education.
- To meet frequently to review progress on outbreak investigation and control.
- To define the end of the outbreak and evaluate the lessons learned. For a Level 1 outbreak this may be in the form of an email to confirm actions agreed.
- Minutes of the meeting/slide sets will be circulated within one day unless the next meeting is due to be held the same day. The date, time and place of subsequent meetings will be stated at the end of each meeting.
- For a Level 3 outbreaks, each member of the OCG should be issued with an Action Card outlining their responsibilities and duties, as a checklist of tasks to be undertaken (see Appendix 7).

APPENDIX 5 Draft Agenda for Level 1 and 2 Outbreak Control Group Meetings

1	Welcome/Apologies
2	AAA (Alert, Analytical, Assurance) Reporting • Overall Summary • Epidemiological data • Situation Report • Individual Ward/Department/Site Updates (include situation, assurance mechanisms, key findings, actions)
3	Infection Prevention update Issues Of Significance (IOS)
4	Control Measures • Patient placement and management, including affected patients and contacts • Practice compliance (PPE, hand hygiene) • Closure of bays, wards or departments • Management of exposed employees/workers (movement, exclusion, vaccination status) • Additional microbiological testing requirements • Employee/visitor restrictions • Management of the environment (e.g. ventilation, waste, linen) and enhanced cleaning • Consideration of patient vaccination and other mitigations to reduce risks to vulnerable patients
5	Facilities update
6	Workforce
7	Operational Activity/Admission Compliance
8	Communications
9	Actions/Action log
10	Any other business
11	Date of next meeting

The following slide describes the agenda for virtual/TEAMS meetings:

Outbreak Agenda (Slide) v1.pptx

Appendix 5 Draft Agenda for BCU-Wide Level 3 Outbreak Control Group Meeting

The BCU-wide Level 3 Outbreak Control Group meeting will seek assurance from the Site OCG meetings, focusing on the control measures and required actions and resources.

Outbreak Type:

Date Time

Location

Name of chair:

1.	Welcome/Apologies
2.	Background
3.	Individual site summary updates (maximum 1-2 slides- see embedded template): • epidemiology • include situation, assurance mechanisms, key findings, actions • operational activity impact/admission compliance  BCU Outbreak Agenda (Site Slide).pp
4	Infection Prevention update Issues of Significance (IOS) Control Measures • Patient placement and management, including affected patients and contacts • Practice compliance (PPE, hand hygiene) • Closure of bays, wards or departments • Management of exposed employees/workers (movement, exclusion, vaccination status) • Additional microbiological testing requirements • Employee/visitor restrictions • Management of the environment (e.g. ventilation, waste, linen) and enhanced cleaning • Consideration of patient vaccination and other mitigations to reduce risks to vulnerable patients
5	Implications of control measures, available resources
6	Chair to distribute Action Cards to key members if a Level 3 outbreak is agreed (See Appendix 7)
7	Facilities update
8	Workforce
9	External reporting
10	Communication Strategy
11	Actions/Action log
12	Any other business
13	Date of next meeting

APPENDIX 5 Aide memoire of matters to be considered

Investigating the source of the outbreak

- Epidemiological studies/review of core data by local intelligence (IP and Nursing).
- Specimens:
  - identify specimens and investigations required
  - collection and transport arrangements
  - liaison with laboratory.
- Consider if additional screening of patients and staff is required (also consider deliberate release, CBRN, SARS, smallpox and activate appropriate plans).

Control measures

- Patient placement; isolation or cohort care.
- Management of exposed patients/contacts (condition/requiring additional support, vaccination status).
- Movement of unaffected, unexposed patients to other departments/facilities.
- Infection prevention procedures for the clinical care of patients (e.g. hand hygiene, PPE)
  - provide written instructions for clinical staff.
- Infection prevention procedures for the protection of staff (e.g. hand hygiene, enhanced PPE).
- Additional testing required - staff and patients.
- Minimisation of non-clinical patient movements.

Consider

- If immunisation is available/indicated.
- Use of prophylactic medication.
- Specific drug therapy for affected patients.
- Use of infection control posters to alert staff and visitors entering and leaving the affected area.
- Use of signs to re-route staff pathways and minimise thoroughfare.
- Additional healthcare and support staff to manage increased workload.
- Special cleaning/disinfection/disposal procedures:
  - Additional domestic staff.
  - Additional collections of clinical waste.
- Additional Supplies:
  - Availability of alcohol-based hand rub.
  - PPE.
  - Protective clothing.
  - Disposable equipment.
  - Medications.
  - Linen, etc.
  - Supply of additional cleaning products and waste bags, etc.
- Restrictions on:
  - Visiting.
  - Transfers.
  - New admissions.
  - Non-essential staff.
- Closure of facilities:
  - Catering if food poisoning suspected.
  - Clinical departments as recommended.
  - Ventilation systems, etc.

- Management arrangements for the support of clinical staff and Infection Prevention staff during the outbreak.
- Monitoring arrangements and responsibility for monitoring specimen results.
- Daily review of epidemiology.
- Documentation records of the outbreak.

Communications

- With patients and their relatives:
  - Lead responsibility is usually clinical care staff.
  - Consistency of information.
  - Consider use of a written information leaflet.
  - Support for clinical staff.
  - Production of posters and information.

- With staff:
  - Lead responsibility usually managers, supported by the Occupational Health Team.
  - Consider anxiety over risks to self and family members.
  - Concerns regarding increased workload.
  - Advice on personal protection.
  - Ensure clear communication to all staff groups.

- With switchboard:
  - Ensure they are informed of the outbreak provide clear instructions on actions to be taken.

- With the media:
  - Agree text for press statements.
  - Press Officer or CCDC /CPH to deal with enquiries, as agreed by Chair.
  - Issue of regular bulletins.

- Liaison with other agencies:
  - Public Health Wales (PHW) Health Protection Team.
  - Welsh Ambulance Service Trust (WAST).
  - Environmental Health (EH).
  - Health and Safety Executive
  - Food Standards Agency (FSA)
  - Local Authority.
  - General Practitioners (GPs).
  - Public Health Wales (PHW) Communicable Disease Surveillance Centre (CDSC).

Key support services that may also need to be alerted are:

- Bank/Agency Staff Manager.
- Catering Department.
- Supplies/Sterile Supplies/Pharmacy.
- Facilities Management.
- Mortuary.
- Estates Department.
- Any other department or discipline specified by the Chair.

APPENDIX 6 List of Attendees at the Outbreak Control Group Meeting

Date:

Location of Outbreak;

Name (Print)	Signature	Representing/Dept	Ext/Bleep

APPENDIX 7 Action Card 1: Consultant Microbiologist/Infection Control Doctor (ICD) or deputy

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Provide expert advice on management of the outbreak.
- Attend OCG meetings.
- Provide continuing expert advice to clinical staff on management of the outbreak and treatment of patients affected.
- In collaboration with the lead Infection Prevention Nurse, recommend appropriate isolation of patients, particularly if single rooms/are not available. This will include advice on the use of cohort bays or isolation wards.
- Advise the OCG on the need to escalate the Business Continuity Plans, the Major Incident Plan or disease specific control plans.

	Action	**Completed By/Date & Time**
1	Verify Outbreak	
2	If not already aware, Inform the Infection Prevention Nurses, Consultant Medical Microbiologists, and the Laboratory.	
3	Contribute to determining the appropriate response to the outbreak: i. Local management by the Infection Prevention Team ii. Call a standby stage for further assessment iii. Declare a Major outbreak, notify the DPP or CCDC/CPH, activate the plan.	
4	On calling a standby or activating the plan, inform the Director of Nursing Infection Prevention and Decontamination/On-call Executive.	
5	Discuss with the Infection Prevention Nurses and clinical staff the need for specific control measures and treatment prior to the Outbreak Control Group (OCG) meeting.	

APPENDIX 7 Action Card 2: For the Executive Lead Nurse or Deputy

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Convene and lead a Level 3 BCU-wide OCG meeting and agree secretarial support.
- Activate Silver or Gold incident management arrangements where Business Continuity and/or Major Incident plans have been activated.
- Consider operational impact/mitigating measures, and scrutiny/assurance of key mitigations.

	Action	**Completed By /Date & Time**
1	Notify Chief Executive and continue to act as a link between the Level 3 Outbreak Control Group (OCG) and Chief Executive.	
2	Approve or seek approval for extra funding and resources if required.	
3	Ensure other Senior Managers are notified as appropriate.	
4	Ensure that the Site/Area Manager(s) of the main area(s) affected, has Outbreak Control Group(s), convenes meetings and provides secretarial support to team meetings.	
5	Ensure clear lines of communication are established within the Health Board and with external agencies.	
6	Nominate a manager to coordinate activity of all non-clinical directorate staff.	
7	Ensure Action Cards are distributed to all OCG members.	
8	Delegate and record specific areas of responsibility to named individuals.	
9	Review, challenge and support control measures to ensure they are effectively implemented	
10	Agree the strategy for communication with the Media, including information to be released.	
11	Ensure escalation to the business continuity plans, the Major Incident Plan or disease specific control plans if appropriate.	
12	Ensure the outbreak is documented for national reporting, and that this information, including the final outbreak report is sent to the Welsh Government and to the Regional Epidemiologist, PHW.	

13	At the end of the outbreak, ensure a final meeting of the OCG is held in order to formally close the outbreak and meet the following objectives: i. Receive an overall summary of the outbreak ii. Review the experience of all participants involved in the management of the outbreak iii. Identify particular difficulties that were encountered iv. Revise the Outbreak Reporting and Control Policy on the basis of lessons learned v. Recommend, if necessary, structural and procedural improvements that would reduce the chance of recurrence of an outbreak communicate that the outbreak is closed to all those who were involved throughout the outbreak.	

APPENDIX 7 Action Card 3: For the CCDC/CPH (or deputy)

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Act as link between the Outbreak Control Group (OCG) and other parts of Public Health Wales, as appropriate.
- Provide expert advice on the control of the outbreak.
- Provide epidemiological advice.
- Provide public information and media handling if required.
- Provide overall responsibility for the control of communicable disease.
- Lead and co-ordinate outbreak control, working closely with the Health Board and Consultant Microbiologist/ICD in outbreaks that have major public health implications.

	Action	**Completed By /Date & Time**
1	Inform Welsh Government, Local Authorities, CCDC/CPHs in neighbouring districts, if appropriate.	
2	Advise on the access of additional surge-capacity support from Public Health Wales medical and nursing staff, if required.	

APPENDIX 7 Action Card 4: For the Lead Infection Prevention Nurse (IPN) on each site.

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Provide support to Hospital Management Teams and Ward/Departmental staff to ensure prompt resolution of the outbreak.
- Liaise with key individuals, as allocated by the OCG Chair.
- Produce written infection prevention advice for dissemination to affected areas.
- Review the outbreak at least daily, in collaboration with the Consultant Microbiologist/ICD, Advanced Nurse Specialist/Lead Nurse Infection Prevention and Control/ Director of Nursing- Infection Prevention and Decontamination.
- Attend meetings of the OCG, and report on current situation, control measures and any challenges with implementation. Contribute to outbreak reports, including the final report.

	Action	**Completed By/Date & Time**
1	Liaise with Consultant Microbiologist /ICD and Advanced Nurse Specialist/Lead Nurse Infection Prevention and Control/ Director of Nursing- Infection Prevention and Decontamination and ensure they are fully briefed on the scale of the outbreak and actions being taken.	
2	Commence outbreak documentation.	
3	Provide initial briefing to direct and advise IPN teams as per their Action Card.	
4	Review workload and postpone planned infection prevention activities, if required, in order to respond immediately to the outbreak.	
5	Assess the requirements for isolation of patients, particularly if single rooms/ are not available.	
6	Consider the options of cohort bays/isolation wards and advise the OCG accordingly.	
7	Assess the level of information that can be gathered prior to the OCG Meeting (Initial assessment, further assessment, and additional information if time allows - see Action Card 5).	

8	Co-ordinate and direct IPNs to visit affected areas and collect the required information immediately.	
9	Collate initial information on the extent of the outbreak, incorporating information provided by IPNs visiting affected areas.	
10	Report findings and advise the OCG Meeting.	
11	Report outcome of OCG Meeting to IPNs, and continuing actions required.	
12	Direct IPNs to; - ensure OCG actions are implemented - visit affected areas as allocated - complete individual outbreak documentation - disseminate written infection prevention advice - appropriate incident reporting occurs, e.g. Datix, Welsh Government	
13	Collate information on facilities and additional supplies required in affected areas, and liaise with key staff to ensure these are provided.	

APPENDIX 7 Action Card 5: For the Infection Prevention Nurses assisting the Lead Infection Prevention Nurse (IPN)

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Provide support to Ward/Departmental staff.
- Visit affected areas daily, as directed by the Lead IPN, ensuring completion of outbreak documentation.
- Report to the Lead IPN, clearly identifying additional requirements for each affected area.

	Action	**Completed By /Date & Time**
1	Undertake an initial visit to affected areas as directed by the Lead IPN. No advice on movement of patients must be given until after the Lead IPN has collated the information from the initial visits.	
2	Report back to Lead IPN promptly with initial documented information.	
3	Return to the area, complete information gathering. Implement actions as directed by the Lead IPN.	
4	Complete the patient location sheet.	
5	Complete the Outbreak Assessment Form.	
6	Return to the area, complete information gathering. Implement actions as directed by the Lead IPN.	
7	In collaboration with the Nurse-in-charge, assess the adequacy of supplies and facilities, including: i. Availability and siting of alcohol-based hand rub ii. Liquid soap and paper towels iii. Protective clothing iv. Disposable equipment v. Linen Cleaning products vi. Waste bags vii. Signage	

APPENDIX 7 Action Card 6: For Site/Area Managers

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Liaise with and collaborate with the Lead IPN to ensure prompt resolution of the outbreak.
- Restrict patient/staff movement as advised by IPN.
- Ensure recommended control measures are implemented and oversee compliance.
- Ensure prompt notification to IPN of any new cases.
- Ensure any staff affected by the outbreak condition are excluded from work for the prescribed time period.
- Convene an Outbreak Control Group (OCG).

	Action	**Completed By /Date & Time**
1	Convene Outbreak Control Group (OCG) if not already done so, as directed by the Lead Executive or Infection Prevention Team (IPT), ensuring secretarial support.	
2	Ensure notes from the meeting are distributed within 1 day of the meeting.	
3	Attend OCG meetings as required. If unable to attend, ensure a Senior Management Team attendance.	
4	On notification of an outbreak, liaise with Matron and Ward/Department managers to ensure staffing and resources are adequate.	
5	Implement all actions as agreed in the OCG meeting.	
6	Ensure all staff are kept informed of actions required to manage the outbreak including designation of a Lead/Matron to co-ordinate deep cleaning and opening of areas as agreed in the OCG meeting.	
7	Ensure post infection reviews (PIRs), where appropriate are assigned to Datix incidents and the Datix incident closed once the outbreak is declared over.	

APPENDIX 7 Action Card 7: For Medical Lead in affected area(s)

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Liaise with the Consultant Medical Microbiologist, Clinical Pharmacist, and other key individuals as allocated by the Outbreak Control Group Chair.
- Visit the affected areas at least daily.
- Provide support and guidance to other medical staff.
- Ensure review of patients affected by the outbreak daily, in collaboration with other medical staff in the area, and ensure information on cases is collated via wards/Matrons for OCG.
- Ensure any medical staff affected by the outbreak condition are excluded from work for the prescribed time-period.
- Ensure that in accordance with the law, a certificate is forwarded for notification of any cases of food poisoning or other Notifiable Disease.

	Action	**Completed By /Date & Time**
1	Review medical staffing levels in affected areas, and escalate medical staffing problems via divisional management structure.	
2	Ensure medical representation and feedback at the OCG and pan-BCU OCG meetings.	
3	Report outcome of OCG Meetings to medical staff within area, and relay continuing actions required.	
4	Keep clear written records of actions taken.	
5	Act as a role model for the IP measures required and ensure all medical staff are also compliant	

APPENDIX 7 Action Card 8: For Manager/Nurse in Charge of affected area(s)

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Liaise with and collaborate with the IPNs to ensure prompt resolution of the outbreak.
- Restrict patient/staff movement as advised by IPN.
- Ensure recommended control measures are implemented and oversee compliance.
- Ensure prompt notification to IPN of any new cases.
- Ensure any staff affected by the outbreak condition are excluded from work for the prescribed time period.

	Action	**Completed By /Date & Time**
1	Inform the IPN of the outbreak/incident and provide them with details of the affected patients, staff and visitors. Information should include: - name, hospital number, date of birth, - date of admission - diagnosis, antibiotic therapy - extent of symptoms Additional information required may include: - use of aperients - food history, including enteral and sip feeds - recent travel - other as determined by the IPN	
2	Complete the outbreak assessment form for each of the affected patients, staff and visitors.	
3	Out-of-hours contact the on-call microbiologist, via Switchboard, providing them with details of the affected patients, staff and visitors	
4	Inform the Matron and bleep holder of the outbreak/incident.	
5	Assess the availability of isolation nursing facilities, ensuring all patients currently in isolation have up-to-date isolation scores.	
6	In collaboration with the IPN, assess the adequacy of supplies and facilities, including: I. Availability and siting of alcohol-based hand rub II. Liquid soap and paper towels III. Personal protective equipment IV. Disposable equipment V. Linen VI. Cleaning products	

	VII. Waste bags	
7	Maintain clear written records of resources needed and actions taken.	
8	Notify the IPN of additional requirements for the area.	
9	Attend OCGs as requested	

APPENDIX 7 Action Card 9: For Matron/Bleep Holder

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Liaise with and collaborate with the Lead IPN to ensure prompt resolution of the outbreak.
- Visit the affected areas and review the outbreak at least daily to ensure control measures are in place.
- Provide support and guidance to ward/departmental staff.
- Ensure recommended control measures are implemented and oversee compliance.
- Liaise with ward/departmental staff and the Assistant Director of Nursing, to ensure staffing levels are adequate to control the outbreak.
- Attend the Outbreak Control Group Meetings and report on current situation, control measures and any difficulties with implementation.
- When the reopening/deep cleaning process commences provide co-ordination to enable the process runs smoothly.

	Action	**Completed Date & Time**
Keep clear written records of actions agreed, when implemented and resource implications.		
1	Visit affected area and liaise with Nurse-In-Charge and IPN.	
2	Cancel planned activities, if required, in order to respond immediately to the outbreak.	
3	Support the Nurse-In-Charge in the gathering of information prior to the Outbreak Control Group (OCG) Meeting.	
4	Review staffing levels in affected areas.	
5	Ensure the Site Co-ordinator is updated.	
6	Oversee outbreak documentation completion as advised by the IPN.	
7	Liaise with key individuals, as allocated by the OCG Chair.	
8	Report outcome of OCG Meeting to Nurse-In-Charge of wards/departments, and relay continuing actions required.	
9	Ensure post infection reviews (PIRs), where appropriate are assigned to Datix incidents and the Datix incident closed once the outbreak is declared over.	
10	Liaise with the Lead IPN to collate information on facilities and additional supplies required in affected areas.	

APPENDIX 7 Action Card 10: For Occupational Health Service

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Attend the Outbreak Control Group (OCG) meeting, and advise on the occupational health measures required.
- Provide advice and support for staff, with regard to their own health, and support managers in managing any staff health issues.

	Action	**Completed By /Date & Time**
1	Identify any specific Occupational Health measures that require implementation.	
2	Ensure colleagues within the Occupational Health department are informed of the outbreak.	
3	Prepare any written information on staff health issues that may be required.	
4	Collaborate with Health and Safety colleagues to ensure that Occupational Health advice is provided to managers on the need for RIDDOR reporting, in line with the following statement: 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) form F2508A must be completed and returned the HSE within 10 days if the disease is listed as reportable, in Schedule 3 Part 1 of the regulations'.	
5	Carry out any additional actions as agreed at the OCG meeting.	
6	Keep clear written records of actions agreed, when implemented and resource implications.	

APPENDIX 7 Action Card 11: For Area Teams

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Act as link between the Outbreak Control Group (OCG) community and primary care services. This link will include undertaking appropriate communications and advise on relevant out of hospital responses.
- Assess the implications of the outbreak for the community. This will include impact upon all community services including hospitals, care and residential homes, staffing resources.
- Inform Director of Public Health, Chief Executive Officer and Chair of OCG of identified implications of the outbreak.
- Attend or ensure a deputy attends relevant OCG meetings.
- Provide support and guidance to OCG and to community and primary care staff.
- Liaise with community prescribing pharmacist, and other key staff, including relevant staff local authority.
- Keep clear written records of actions agreed, when implemented and resource implications.

APPENDIX 7 Action Card 12: Communications Department

Level 3 Outbreak (may also be used at Level 2 Outbreak)

Role:

- Ensure attendance at OCG meetings as deemed appropriate by OCG Chair.
- Establish initial and ongoing lines of communication and the development of early statements for the public, staff and stakeholders, including:
  - i. targeting of key audience
  - ii. messaging and type of delivery
  - iii. production and distribution of material to appropriate sites (posters and patient visitor information).
  - iv. the need for communications helpline provision.

APPENDIX 8 Outbreak summary slide template (final report)

The example summary slide/final report template (see below) must be completed by the OCG Chair at the end of the outbreak; describing the wards/departments/ hospitals involved, total number of patients/employees/workers affected, likely causative agent (if known), outbreak start and end date, any identified lessons learned and ongoing recommendations actions to reduce the risk of reoccurrence of an outbreak.

End of outbreak summary slide v2.ppt

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

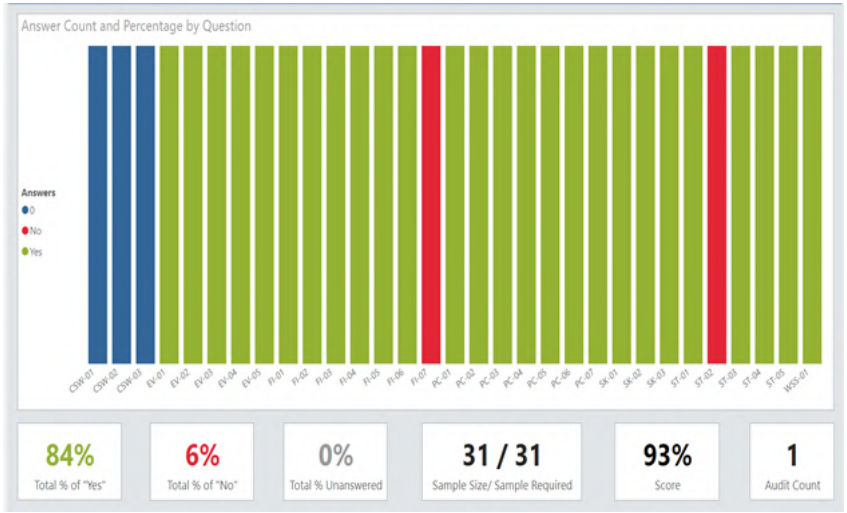
Latest report:

Insert date

Insert Area

Situation:

- *** patients affected in total*
- *** employees/workers affected*
- *affecting ** wards*
- *** ward/bay closures*
- *Full operational activity continues*



Assurance mechanism:

- *Testing of symptomatic patients*
- *Daily staff testing*
- *Enhanced cleans*
- *Daily PPE audit completed*
- *All bay doors/side rooms are kept closed.*

***C4C** (insert date)*
Nursing: 96.97%
Estates: 85.29%
Domestics: 98.97%

Key findings:

- **Recovered patients not being transferred out of the ward (7 pts by tomorrow)**
- **Hand Hygiene 100% - consistent.**
- **Ward footfall low**
- **Staff FFP3 wearing 100%, including medics.**
- **No issues currently with PPE stock**

Actions:

- **Board round each day to push discharges home**
- **Escalation to site team to plan transfers of recovered patients.**

*Insert Ward/Department/Organism/date Outbreak Agenda

- AAA (Alert, Analytical, Assurance) Reporting
- Epidemiology Curve
- Situation Report
  - Overall Summary
  - Individual Ward/Department/Site Updates (include situation, assurance mechanisms, key findings, actions)
  - Infection Prevention update IOS
- Control Measures
  - Patient placement and management, including affected patients and contacts
  - Practice compliance (PPE, hand hygiene)
  - Closure of bays, wards or departments
  - Management of exposed employees/workers (movement, exclusion, vaccination status)
  - Additional microbiological testing requirements
  - Employee/visitor restrictions
  - Management of the environment (e.g. ventilation, waste, linen) and enhanced cleaning
  - Consideration of patient vaccination and other mitigations to reduce risks to vulnerable patients
- Facilities update
- Workforce
- Operational Activity/Admission Compliance/ Lost bed days due to bed closures
- Communications
- Actions/Action log
- Any other Business

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Latest report:

Insert date

Outbreak Closure Summary Insert Area/Level of Outbreak

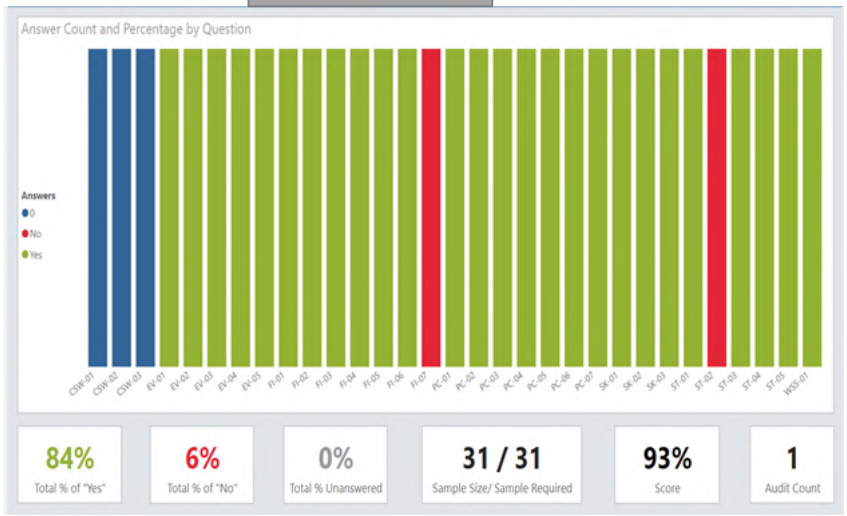
Situation:

- *Outbreak declared ** and ended *** (insert dates)*
- *** total patients affected*
- *** total employees/workers affected*
- *** total wards affected*
- *** ward/bay closures*
- *** bed days lost due to bed closures*
- *Elective activity un/affected*

Control Measures:

- *Testing of symptomatic patients*
- *Daily staff testing*
- *Enhanced cleaning of the environment*
- *Daily PPE audit completed*
- *All bay doors/side rooms are kept closed.*

Epidemiology



Summary:

- *Insert type of outbreak (e.g. respiratory, GI)*
- *Cause/suspected cause*
- *Resource implications*

Key findings:

Areas of good practice

- *Hand Hygiene 100% - consistent.*
- *Ward footfall low*
- *Staff FFP3 wearing 100%, including medics.*
- *No issues currently with PPE stock*

Areas of improvement

- *Patients not tested in accordance with national guidance*
- *Delay in the transfer of positive patients to single room/cohort area*

Actions/Recommendations:

Immediate actions:

- *Patient testing requirements reiterated at Site OCG. Testing reiterated in Weekly Newsletter and circulated BCU-wide.*
- *IPT attendance at site bed meeting.*

Ongoing actions:

- *To develop Testing SOP (IPT by (insert date))*
- *Circulate the Single room matrix/Risk assessment to all Clinical Teams (HMTs by (insert date)*

Templed adroddiadau'r Bwrdd/Pwyllgor
Board/Committee report template

Teitl adroddiad: ***Report title:***	**Mental Health and Learning Disabilities (MH&LD) Divisional Improvement Plan – Briefing Paper**
Adrodd i: ***Report to:***	BCUHB Corporate QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update to the QSE on progress made to date in the development and delivery of the MH&LD Divisional Improvement Plan. It seeks to provide assurance regarding the mechanisms that have been put in place to ensure there is increased grip and oversight on delivery of the plan across the Division, as well as providing assurance regarding elements of the plan that have been delivered as part of Phase 1. Since the previous QSE, progress has been made in two key areas. Firstly, the Programme Governance Framework aligned to assuring delivery and ownership of the plan. Secondly, progress against some of the Phase 1 deliverables, with alignment to the Targeted Intervention Outcomes included. QSE will be aware that during 2019-2022, the Division underwent a number of inspections, and these all identified some critical areas where improvement was required in the way that services were being delivered across the Division and across a number of domains. The plan is underpinned by detailed analysis and triangulation of these multiple sources of information. The six pillars – "work streams" - of the plan reflect the thematic elements of the analysis/triangulation, creating a structured and co-ordinated programme of work. This paper seeks to provide assurance to QSE that actions are being progressed and that sustainable delivery is happening. An integral part of delivering the plan will be embedding learning amongst across the Division to ensure sustainable improvement happens. The Divisional Improvement plan represents the portfolio of work streams that are being undertaken across the Division and includes Service developments, Operational improvement, and Service Transformation. These work streams include initiatives to enhance people, organisational development, culture-based improvements, and safety, in addition, going forward there will be a strengthened focus on improving outcomes.
Argymhellion: ***Recommendations:***	QSE are asked to note the progress made in the delivery of the Divisional Improvement Plan since the last meeting. QSE are also asked to note that some further small amendments reflecting the feedback from the ET are required and that the plan will be updated further following the QSE meeting.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of MHLD
Awdur yr Adroddiad: ***Report Author:***	Carole Evanson, MH&LD Divisional Director of Operations

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒		I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

This Improvement Plan is stronger in comparison to previous submissions. It will require continual management, oversight and review. The Plan has been constructed in collaboration with involvement of key stakeholders from "Ward to Board" and is owned by the Division. Evidence based approaches to improvement and programme management have been adopted throughout. However, the Division are in the initial stages of implementation and on that basis have scored assurance as 'Partial.' It is anticipated that there will be considerable progress in delivery of the plan and that assurance will move to an acceptable level by Quarter 3.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The strategic implications of the Divisional Improvement Plan and alignment of work streams relate to the following: ➢ Priorities within "A Healthier Wales: long term plan for health and social care" ➢ Together for Mental Health North Wales Strategy ➢ North Wales Learning Disabilities Strategy ➢ Alignment with the BCUHB Integrated Medium Long-term Plan ➢ Supports delivery against Targeted Intervention requirements ➢ Aligned with the Divisional Clinical Strategy/Clinical Effectiveness ➢ Supports integration agenda and aligns with BCUHB Operating Model ➢ Linkages with delivery of the Digital Strategy ➢ Covid-19 response and recovery ➢ Strengthen our wellbeing focus ➢ Recovering access to timely planned care pathways ➢ Improved unscheduled care pathways ➢ Integration and targeted improvement of mental health services ➢ BCU Estates Strategy ➢ People Stronger Together Strategy ➢ Mental Health Measure Standards

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The MH&LD Divisional Improvement Plan is the opportunity to include and align all key projects, streamline the process of governance, identify interdependencies, and enhance efficiencies within the total process of programme and project delivery. The plan addresses the improvements identified as being required by HIW.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *N* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments* Impact Assessments will be completed once the proposals have been approved.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* Impact Assessments will be completed once the proposals have been approved.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The financial implication of the plan is being progressed.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Division has had business cases approved for recruiting project management capacity to support implementation of the Improvement Plan, and are currenlty in place. This has been extended for a further 3 months. Substantive roles aligned to service improvement and development priorities are being recruited to, with 60% of the staff being in post by the end of October 2022.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been reviewed internally by senior leadership in consultation with the BCUHB Transformation and Improvement team, Clinical and operational leads and project managers across the Division. The Plan will be included within consultation workshops for the Together for Mental Health Strategy takiing place November 2022.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Rheswm dros gyflwyno adroddiad i fwrdd	Amherthnasol

cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf: Gweithredu argymhellion
Next Steps:

- To note the report provided
- BCU Corporate QSE Committee to review progress in December 2022 on actions achieved to date and outcomes delivered

Rhestr o Atodiadau:

Dim

List of Appendices:

MH&LD Divisional Improvement Plan

Appendix 1 – Navigation

Appendix 2 – Timescales

Appendix 3 – House

Appendix 4 – DIP Driver Diagram

Appendix 5 – Tier 1 Work stream

Appendix 6 – Tier 2 Sub Themes

Appendix 7 – Tier 3 Task Level detail

Appendix 8 – Key Performance Indicators

Appendix 9 – Example Power BI Dashboard

Appendix 10 – Example Plan on a page

Appendix 11 – Phases

MENTAL HEALTH & LEARNING DISABILITIES DIVISIONAL IMPROVEMENT PLAN

The Divisional Improvement plan represents the portfolio of work streams that are being undertaken across the Division and includes Service developments, Operational improvement, and Service Transformation. These work streams include initiatives to enhance people, organisational development, culture-based improvements, and safety.

Timescales - development, colloboration and implementation of the Improvement plan

House - visually showing the foundations of improvement

Tier 1 - Workstreams identified following a triangulation and thematic analysis exercise.

Teir 2 - Sub Themes developed aligned to improvements, including links to specific internal and external reports, inspections and incidents.

Tier 3 - Task Level Detial to inlcude Immediate assurance actions, Improvement actions and Assurance actions

Key Performance Indicators - high level indication showing how the Division will evidence improvement

Power BI Dashboard - data capture for evidence of improvement

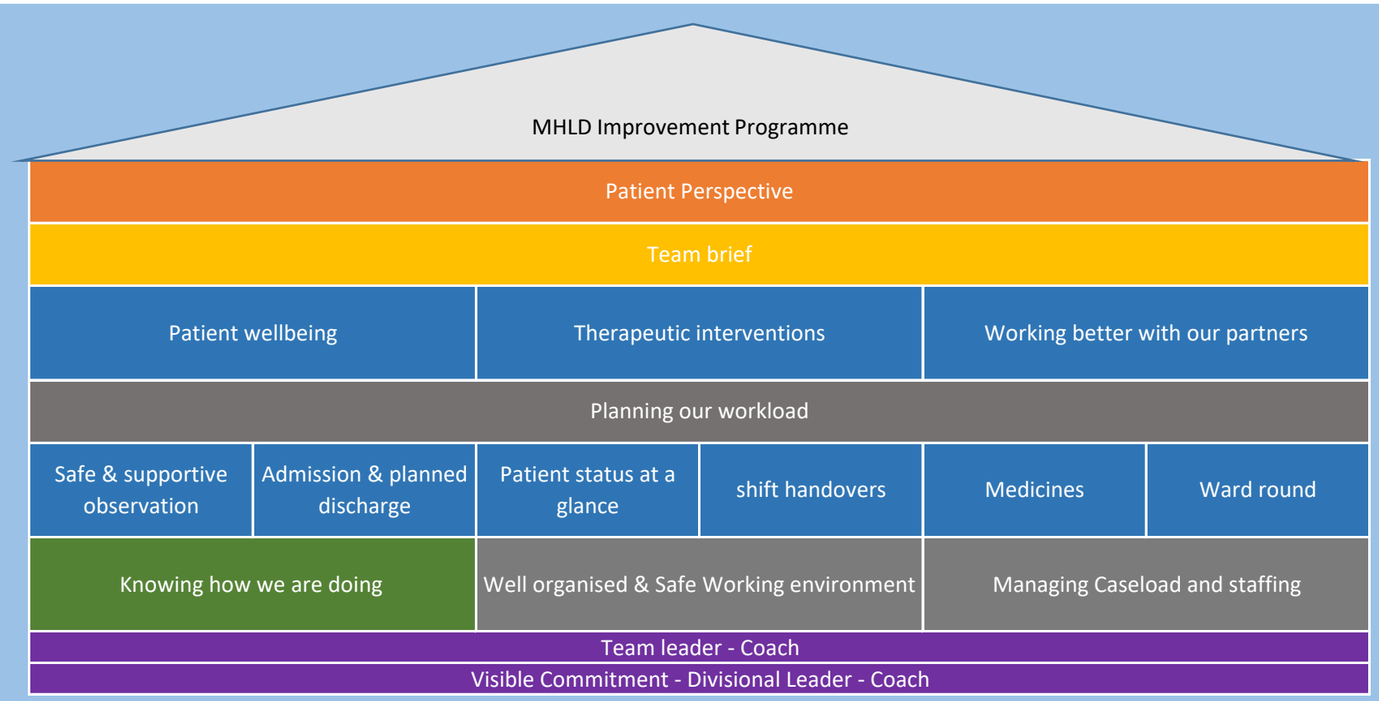
HSE NOC Action Plan - update aligned to HSE NOC, including progress made

Plan on a Page examples incorporating Aims, Objectives, Benefits and Outcome of each Workstream

Phases

Timescales for designing and agreeing the MHLD Improvement Plan

		Completion by:	Status as of 20 June 22:
Tier 1:	Triangulation of the reports, action plans, intelligence, and existing improvement work	30-Jun-22	Complete
	Creation of a MHLD improvement plan based upon above triangulation, populated to workstream level	30-Jun-22	Complete
Tier 2:	Population of workstreams to key sub-theme level	30-Jul-22	In progress
	Allocation of workstream leads	30-Jul-22	In progress
Tier 3:	Population of project themes with task level detail, measures, and timescales	30-Aug-22	In progress



Key:

- S1: Fundamentals of Care
- S2: Leadership, empowerment, culture & OD
- S3: Safe & Effective Care
- S4: Individual & Timely Care
- S5: Environment & Resource
- S6: Audit, outcomes & assurance

House

Strategic Aim	Targetted Intervention Outcomes	Divisional Improvement Plan Drivers	Measures
Improvement in Quality, Safety and Capacity/Wellbeing with improved Patient Experience, Access and Return on Investment.	M/O1: Organisational development	Target Operating Model implementation Clear governance framework, positive culture a	Increased mandatory training compliance Increased staff recruitment
	M/O2: Enhanced Staff Engagement	Full implementation of staff wellbeing initiatives Improved staff engagement and career development	Increased PADR compliance Increased no. of coaching / therapeutic sessions
	M/O3: Leadership Capacity	Strengthened sustainability & stability of Increased leadership visibility	Reduction in number of senior role vacancies Reduction in number of interim roles
	M/O4: Transformation	Enhanced crisis pathway development Strengthened support for patients with dementia	Reduced number of A&E crisis presentations Decreased number of DTOCs
	M/O5: Strategic Partnership	Together for Mental Health Strategy-Plan development Self Harm & Suicide Prevention Strategy-Plan development	Reduction in the number of safeguarding incidents Reduced suicides per capita
	M/O6: Service User Experience	A physical environment that enhances patient experience Compassionate and visible leadership at all lev	Increased number of compliments Reduced number of complaints
	M/O7: Good Governance	Strengthed risk management across the Ensuring the Privacy, Respect and Dignity of ev	Improved ward accreditation status Reduction in Mixed Cohorting risk reporting
	M/O8: Mental Health Measure	Timely access to early support Timely access to early advice	Improved referral to assessment Improved referral to treatment
	M/O9: Access to Therapies	Improved Access to Psychological Reduced waiting times for appropriate	Increased number of iCAN Hub access Increased number of calls to Call Line
	M/O10: External Reviews	Learning from concerns, incidents and Enhanced risk identification and resolution	Reduction in Falls Reduced number of risk of ligature incidents

Tier 1: MHLD Improvement Plan **Workstreams**

Rationale: These workstreams were identified following a triangulation and thematic analysis exercise. They draw upon the categories within Healthcare Standards, in keeping with standards used by HIW, as well as interface constructively with the existing pan-BCU improvement programmes.

Workstream 1:	**Fundamentals of Care**
	Areas that are fundamental to the delivery of safe care and an excellent patient experience
Workstream 2:	**Leadership, Empowerment, Culture and OD**
	Compassionate leadership, team working
Workstream 3:	**Safe Care & Effective Care**
	Quality and evidence based person centered care
Workstream 4:	**Individual & Timely Care**
	Right care, right time and right place
Workstream 5:	**Environment, Resource & Workforce**
	Includes staffing capacity and safe spaces
Workstream 6:	**Clinical Strategy, Audit, Outcomes & Assurance**
	Good governance, Clinical Strategy, Model of Care and Operating Model development

Tier 2: MHLD Improvement Plan **workstream sub-themes**

			HSE NOC	YGC Plan	Crisis Care recommend.	Ockenden	HASCAS	Community Suicide, HB	Psych. Therap. Review	HIW Inspections - Heddfan, Hergest, Coed Celyn, Mesen	Primary Care Dischardge MH review	Ablett Inpatient Suspected Suicide	Hergest Suspected Inpatient Suicide, DO	Ty Llywelyn unexpected Death	Holden	HSE Notice: Falls	Psychiatric Liaison review	OD review Mike Shaw	Targetted Intervention	IMTP
S1: Fundamentals of Care		**Named Lead: HoN**																		
1.1	Comprehensive understanding of roles & responsibilities	Head of Workforce	1	1		1											1			
1.2	Improve record keeping in line with BCUHB policy/procedure and national guidance	Quality and Safety Lead	1	1			1			1				1			1			
1.3	Review Inpatient/ward based care processes	Clinical Operational Manager	1	1	1									1	1				1	1
1.4	Improve the delivery of care to patients with Dementia	Dementia Consultant			1	1													1	
1.5	Improve the delivery of crisis care, including psychiatric liaison	Head of Governance		1	1	1											1		1	
S2: Leadership, Empowerment, Culture and OD		**Named Lead: Head of Workforce**																		
2.1	Strengthen sustainability & stability of leadership roles	Head of Workforce		1		1			1	1									1	
2.2	Increasing leadership visibility	Director of Operations		1		1				1					1					
2.3	Develop an open and honest culture where staff feel empowered	Wellness, Work and Us Lead	1	1					1	1					1			1	1	
2.4	Strengthen cohesive, multi disciplinary team working	Clinical Director, Central	1	1		1			1									1		
2.5	Strengthen communication & engagement with staff and partners	Communications officer		1		1			1	1									1	
S3: Safe & Effective Care		**Named Lead: HoN**																		
3.1	Improve & strengthen the management of risk across the Division	Head of Governance (FM)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3.2	Reducing the risk of ligature incidents	Head of Governance (GK)	1							1			1	1						
3.3	Ensure all observations are at the appropriate level to ensure they are safe and therapeutic	Head of Governance (GK)	1									1	1	1						
3.4	Reduction of incidents in relation to falls, medication errors and the deteriorating patient	Quality and Safety Lead	1			1				1				1	1		1	1		
3.5	Improving the recognition of safeguarding adults at risk and ensuring the appropriate pathway is followed	Safeguarding Lead	1			1									1					
S4: Individual & Timely Care		**Named Lead: Ops Lead**																		
4.1	Right care at the right time in the right place	Head of Nursing	1	1	1				1	1		1					1		1	
4.2	Review of current service processes	Head of Nursing	1	1	1							1					1		1	1
4.3	Individualised Care planning to promote independance	Head of Nursing			1										1				1	
4.4	Admission, Discharge and management of leave	Head of Nursing	1	1	1					1		1							1	
4.5	Listening and learning from patient & carers/family feedback	Quality and Safety Lead			1	1													1	1
4.6	Patient, carer and family information	Quality and Safety Lead			1				1	1									1	
S5: Environment and resource including workforce capacity and capability		**Named Lead: Planning Lead**																		
5.1	Roles capability - skills, knowledge & practice	Head of Workforce		1						1				1					1	
5.2	Managing daily caseload and staffing incl. rostering	Head of Planning and Performance		1						1									1	
5.3	Well organised and safe working environment incl dignity ie privacy	Assistant Director of Nursing	1	1	1	1				1							1			1
S6: Audit, Outcomes and Assurance		**Named Lead: Governance Lead**																		
6.1	Governance, risk and course correction (learning)	Head of Governance	1	1		1	1					1		1			1		1	
6.2	Knowing how I am doing - continuous audit cycle plan	Head of Governance		1						1				1						
6.3	Clinical policies and standard operating procedures	Quality and Safety Lead	1	1		1	1	1	1	1			1	1	1	1	1	1		
6.4	Strategy development	Medical Director																		

Tier 3: MHLD Improvement Plan **task level detail**

S1: Fundamentals of Care (Strategic Lead - HoN / HoG)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Head of Nursing**
1.1	All staff have a comprehensive understanding of their roles & responsibilities	Problem: actions demonstrate that staff can be unclear as to their role, responsibility and accountability resulting in a lack of decision making and suboptimal risk formulation, risk management and	Actions	Outcome	Supervision levels. Baseline from previous full years Supervision records. Percentage of staff that report that their manager takes a positive interest in their Health and Wellbeing - MHLD Div Performance Report	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
1.1.1	Ensure all staff have an understanding of their roles and responsibilities	At all levels of the organisation, staff are not fully aware of their role in the management of risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements **Improvement actions:** • CAEJ referenced job descriptions in place for each role with the creation of a MH&LD Divisional Job Description Library • Develop team objective templates that can be populated by each team to enable staff to ensure they understand their roles and responsibilities • Establish reflective practice groups to enable staff to meet and reflect on activity and discuss next step priorities • Develop an induction pack and process for each staff group so all new staff undergo consistent standardised induction, including requirements of their role • Improve consistency of individual / group Supervision sessions with line manager including monthly team meetings • Expedite the review all of Div. policy and procedures to ensure reviewed on time, full consultation occurs and updated when lessons learnt (refer to section 6) **Assurance actions:** • Annual audit of management evidence procedures to include PADR documentation • Managers will provide written confirmation to ensure that the PADR process & supervision take place according to Div. policy (refer to workforce Plan on a Page) • Sampling of notes and care plans and unannounced visits	All staff will have a clear understanding of their roles and responsibilities	% compliance for all complete Level 1 competencies of Core Skills & Training Framework - Quarterly NHS Framework report PADR compliance and supervision measured and reported monthly (via ESR) : quality checking of PADR/supervision Link to KPI PADR compliance		Phase 1	Aug-22	Jan-23	Head of Workforce
1.1.2	Improve the quality of supervision & PADR	Staff are not comfortable in speaking up and challenging decisions. This can impact on clinical safety, efficiency and clinical outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements • Review and strengthen the connection of team objectives to PADR **Improvement actions:** • Training plan to be implemented to embed policy for supervision & PADR completion • Develop consistent PADR management guidance to support managers • Review available PADR training for supervisors and revise accordingly to increase attendance. Explore new model of Group PADR. • Increase PADR compliance to 85% across all areas, monitor and review in MH&LD Finance and Performance meeting **Assurance actions:** • Review success of current PADR process and obtain staff feedback to revise	All staff feel confident to speak up when clinically appropriate to do so	Percentage improvement in completion of PADR and Supervision. PADR/supervision audited quarterly against agreed standards e.g. BCUHB values, roles and responsibility. Percentage count of who has had a PADR/medical appraisal in previous 12 months - NHS Performance Framework		Phase 1	Jun-22	Jan-23	Head of Workforce
1.1.3	Improve discharge through full implementation of discharge policy	Specific examples of incorrect discharge of patients from primary care mental health services due to incomplete risk assessment	**Immediate assurance actions:** • **DTOC workng group established, including weekly reporting.** • Review the MHLD Division governance structures, including how area mental health teams work together as one service, to ensure common understanding, and service delivery processes • Review all Datix entries relating to Primary Care Mental Health patients, as further evidence as to whether any patient harm was caused **Improvement actions:** • Refresh and improve the communication processes in the division to better support a two way flow of information, ideas, suggestions and decision making between the directors and the operational area mental health teams • Strenghen and support Listening Lead model • Agree and adopt common terminology for primary care and community mental health services across the MHLD division, Health Board and key stakeholders • Ensure a clear definition of roles and responsibilities across primary care and community mental health services, with consideration as to the need for consistent management structures and roles across the area mental health teams • Develop engagement processes and joint working across the MHLD division, ensuring a better understanding of decision making and accountabilities • Improve collaborative working between the MHLD division and clusters, with local area mental health teams sharing their current practice and suggestions • Review the Part 1 MHM model of care in North Wales, to include engagement with the three Area Divisions, clusters and other key stakeholders • Undertake an option appraisal of interim improvements to IT system support for the MHLD division, whilst awaiting the roll out of Welsh Community Care Information System (WCCIS). **Assurance actions:** • Annual report to Board to provide assurance of completion of actions and improvemnts • Sampling of notes and care plans and unannounced visits	All patients discharged have a comprehensive risk assessment and discharge plan completed and approved	Number of safety incidents relating to Discharge - Baseline over previous 12 months from ESR reporting target improvement to be set.		Phase 1	Aug-22	Mar-23	Head of Workforce

1.2	Improve record keeping in line with BCUHB policy/procedure and national guidance e.g. Mental Health Measure & Mental Health Act	Problem: Inaccurate, incomplete and missing documentation/records that impacts on continuity of patient care, decision making and patient	Actions	Outcomes	Supervision levels - Baseline from previous years Supervision records.	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
1.2.1	Implement MH&LD dissemination and improvement plan for record keeping and documentation	Clinical records are not consistently complete. Risks for patients result when clinical records are not complete, accurate, person-centred and updated.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements • Ensure all staff have access to the Health Records policy, proceudures and guidance and both are available in all staff areas **Improvement actions:** • BCUHB Record Keeping Policies and procedures will be shared, signed and to confirm these are understood by all staff and discussed at supervision (supervision document to be revisited and renewed) • Ensure record keeping is included within staff inductions • Record keeping training to be included in training plans, to be carried out by Health Records manager • Established audit cycle of records to ensure compliance and that staff continue to improve and maintain accurate records • Review a sample of Supervision records to ensure Managers have quality assured a sample of case notes with staff to rectify any anomalies during thier Supervision **Assurance actions:** • Annual service led deep dive review into the quality of clinical records / sampling of notes and care plans and	All clinical records are complete, with care plan and quality assured, by a manager	Documentation checks and validation. If baseline does not exist, establish a target completion % and measure Weekly. 95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision*this is to provide some t		Phase 1	Aug-22	Jan-23	Quality and Safety Lead

1.2.2	Ensure the design and implementation of a rolling records audit for MH&LD	Audits have not been consistent to pick up the quality and completeness of clinical records.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements **Improvement actions:** • See actions for 1.2.1 **Assurance actions:** • Develop an Audit plan to cover all areas of the division, and all professions, running on a continual, cyclical basis • Sampling of notes and care plans and unannounced visits	All clinical records are complete, with care plan and quality assured by a manager	Audit programme up and running by end of December, to cover all areas by January 2023		Phase 1	Aug-22	Oct-22	Quality and Safety Lead
1.2.3	Restructure and redesign its hard copy clinical records archiving and retrieval systems	Significant issues with care documentation have been identified, which included the following: a. Risks had been identified, but no care plan was in place to address the risk. b. Evaluation of section 17 leave not always documented. c. Issues with a lack of care plans for noncompliance of medication.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements - this will not need to be done as HR Group meeting underway • Alignment with Estates and Facilities management to assess **Improvement actions:** • Progress with Health Records subgroup aims, objectives and actions • Review current clinical record system including process from inception to archive • Identify areas to improve and redesign clinical records • Review current supplier arrangements (TATA, Oasis) to support the storing and archiving of records and procurement options as required **Assurance actions:** • Annual review / Sampling of notes and care plans and unannounced visits	All clinical records are complete, with care plan and quality assured by a manager	Monthly spot audits of record storage - results to inform improvements in record storage and retrieval - Baseline generated from previous audit outcomes.		Phase 1	Jun-23	Oct-22	Quality and Safety Lead

1.3	Review inpatient/ward based care processes e.g. ward rounds, shift handovers, Patient Status At a Glance * *not specific to any recommendation but good practice to review*	Problem: Understanding the current position and identification of any improvements required	Actions	Outcomes	Patient length of stay reduction - baseline from agreed 12 month records. Reduction in the no. of patients delayed discharge - Baseline from 12 month patient records.	RAG rating	Programme Phase	Start date	Complettion date	Clinical Operational Manager
1.3.1	Improve handovers and transfers of care to aid better communication between staff and external agencies	When the team meets for handover, inadequate time is allocated to discuss patients' needs, risks and management plans.	**Immediate assurance actions:** • Rapid review of root cause analysis (completed with 3rd parties) to understand the problem **Improvement actions:** • Review current 'safety huddle model' to communicate key safety information between healthcare professionals • Review / establish handover notes template to ensure that all patient concerns are clearly documented to aid a seamless handover • Review Putting Things Right (PTR) process for reviewing incidents and areas of concern that require improvements and ensure staff are up to date and compliant in those areas • Ensure the relevant operational procedures, protocols and processes are updated and that all staff have easy access to them (see section 6) • Strengthen staff and patient feedback to continually improve processes/actions completed (Caniad) • Establish a Team meeting Agenda to ensure ward processes are discussed to maintain awareness and continually improve **Assurance actions:** • Annual pathway audit / co-review with patients and carers • Sampling of notes and care plans and unannounced visits	All handover meetings will be completed with sufficient time to review holistic patient needs, risks and ensure a management plan is agreed.	Reduction in patient length of stay; reduction in no. of delayed discharges; handover review (see sub stream 1.2.3) - Baseline from previous 12 months patient records.		Phase 1	Aug-22	Dec-22	Clinical Operational Manager

1.4	Improve the delivery of care to patients with Dementia	Problem: Dementia: delivery of clinically led, safe and effective	Actions	Outcomes		RAG rating	Programme Phase	Start date	Complettion date	Dementia Consultant
1.4.1	Implement the review, redesign and development of a new 'end to end care pathway' for Older People and those with Dementia across the six counties of North Wales (including wellbeing and mental health)	Older People's mental health services have an incomplete skill set in relation to the care of patients with dementia and the support of their families	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Ensure that the patient area is underpinned by dementia-friendly design principles and safety assessed and free from hazardous materials to prevent any injuries e.g. falls • Obtain feedback from patients and their families and use the feedback to improve service provision **Improvement actions:** • Identify leads across the six counties to undertake review of services supported by Cons Nurse Dementia • Review internal Memory Service review by clinical nurse - Sep/Oct 22 • Review Memory Sevice review document by consultancy - Sep/Oct 22 • Review of dementia practices and their evidence base • Gap analysis of skills/knowledge/attitides required and 'current state analysis' to be completed • Gap analysis of skills required and current position to be completed • Implementation of pathway redesign project (just started 08.22) - 6 mnths • Ensure relevant staff are aware of and have easy access to the service dementia strategy and relevant guidance (align to North Wales Dementia Strategy) • Continue to raise dementia awareness and what can be done to manage the condition and to signpost to available support offers • Increase/enhance Memory service provision aligned to transformational programme, including options for remote assessments • Ensure relevant staff are aware of and have easy access to dementia strategy/policy/guidance (align to North Wales Dementia Strategy) • Current and forward looking workforce and service plans for the provision of appropriate levels of therapy and non-medical care for people with dementia • Ensure that the patient's needs are identified and clearly documented in an individualised care plan • Implement recommendations for transforming OPMH crisis support • Embedding of strong co-production, engagement and communication with patient groups through development of Division engagement model **Assurance actions:**	All patients will participate in high quality advice and support within mandatory timescales, in the right place, in the right way and at the right time.	Improved referral to assessment (average time) / reduced waiting list, improved patient experience, improve caseload : clinician ratio, improved contact : clinician ratio, improved clinical outcomes, reduced average cost per visit, reduced average annual		Phase 1 & Phase 2	Aug-22	Jul-23	Dementia Consultant

1.5	Improve the delivery of Crisis Care including psychiatric liaison	Problem:	Actions	Outcomes	Metrics developed following the Good Work - Dementia Learning & Development Framework - QSE Agenda	RAG rating	Programme Phase	Start date	Complettion date	Psychiatric Liaison Manager

1.5.1	Complete the review, redesign and development of a new 'end to end pathway' for psychiatric liaison services across the six counties of North Wales	Fragmented system of support without explicit North Wales Model of Care	**Immediate assurance actions:** • Rapid review of root cause analysis to inform immediate assurance actions **Improvement actions:** • Full implementation of the crisis support improvement programme (see plan on a page) • Full implementation of psychiatric liaison report (2022) recommendations **Assurance actions:** • Annual audit / spot checks with patients • Sampling of notes and care plans and unannounced visits	All patients will participate in high quality, responsive crisis care, within mandatory timescales, wherever they are based, according to best practice.	Improved referral to assessment (average time) / reduced waiting list, improved patient experience, improve caseload : clinician ratio, improved contact : clinician ratio, improved clinical outcomes, reduced average cost per visit, reduced average annual cost per patient - Baselines to be generated from any 12 month data. **TO BE AMENDED**		Phase 1 & Phase 2	Aug-22	Jul-23	Psychiatric Liaison Manager

S2: Leadership, Empowerment, Culture and OD (Stra		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Head of Workforce**
2.1	Strengthen sustainability & stability of leadership roles throughout division	Problem: lack of sustained stability within leadership roles across the Division resulting in staff dissatisfaction and variation in care strategy and delivery, which impacts on patient outcomes and experience	Actions	Outcomes	Starters/Leavers data - Baseline for previous 12 months. Percentage increase in positive Service User Experience feedback measured through service user feedback platforms; inclusive of Targeted Intervention Outcome 3 evidence submission	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
2.1.1.	Ensure that Senior Leadership roles are appointed to	There is insufficient strategic and improvement capacity to drive change in the Division.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Undertake a gap analysis to identify limitations in leadership capacity to drive change and improvements across the Division • Complete appointment of all interim roles • Recruit interim MH&LD Estates Lead for 12 months minimum **Improvement actions:** • Agree and implement Operating Model • Full review of all interim roles, progress with substansive posts as approrpriate • Establish relevant posts in line with budget and EC panel processes • Develop clear, relevant job descriptions and person specifications • Progress with Just R 12 month recruitment campaign (Go Live date September 22) aim to appoint 14 staff per month. • Complete recruitment to Service Improvement Team (8 posts) **Assurance actions:** • Annual establishment and staff survey engagement review	All senior roles will be appointed to in year 1.	No. of Senior Leadership Roles vacant - baseline number to be established to determine % complete		Phase 1 & Phase 2	Jul-22	Dec-23	Head of Workforce
2.1.2	Development and implementation of the Leadership & management developmental strategy	Staff feel they are not consistently communicated with compassionately by senior leadership.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities Improvement actions: • Progress with Wellness, Work and Us Year 2 Service Delivery Plan • Undertake a Training Needs Analysis • Development of career pathways • Development of an Apprenticeship framework • Action plans from BCU Staff Survey • You said, We did, We are going to do from MH&LD Reflect and Learn survey • Create a coaching programme for all senior leaders by utilising the newly appointed work based coach for the division? • Identify leadership training requirements • Commission leadership training for effective leadership and improved culture • Ensure clear documented team / Division goals and objectives that leaders can aspire to, with development of Manager Handbook • Establish a mentoring system to support the development of new leaders in post • Establish leadership forums to ensure leaders are aware of the desired culture and have the capability to inspire and drive organisational culture • Engagement with BCUHB wide clinical leadership and management scheme; • Implementation of workforce development plan **Band 6** and above clinical/operational and business support to have completed a Training Needs Analysis to determine level of awareness **Assurance actions:**	All staff feel confident to speak up when clinically appropriate to do so	Clinical Leaders Listening Time - Monthly reporting, baseline from previous 12 months, target to be agreed.		Phase 1	Jul-22	Jan-23	Head of Workforce
2.1.3	Complete the robust implementation of a consistent and high quality PADR process for all staff	Staff do not feel fully supported to develop into leadership roles within the Division.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Every member of staff to have an up-to-date PADR aligned with strategic objectives and BCUHB values. • Monitor improvement in PADR compliance so all staff have received their PADRs • Review Digital solutions for Div PADR (where paper based) as contingency due to delays in All Wales WCCS IT solution **Assurance actions:** • Annual audit / completeness and quality	All staff feel supported with their career development needs and aspirations	Percentage headcount who have had a PADR/medical appraisal in the previous 12 months - NHS Performance Framework (95% of all staff to have up to date PADRs - captured via ESR **this is to provide some tolerance within the system for PADRs not completed within the timeframe due to such things as long term sickness, unexpected absence etc.)*		Phase 1	Aug-22	Jan-23	Head of Workforce

2.2	Increasing leadership visibility, at all levels, with a purpose	Problem: Staff felt that leaders (local and divisional) were less visible impacting on staff feeling less valued (decision making, listened to)	Actions	Outcome	Increase in service user positive experience and satisfaction vie service user feedback; Overall staff Engagement - NHS Performance Framework monthly reporting,	RAG rating	Programme Phase	Start date	Complettion date	Director of Operations
2.2.1	Ensure there is Visible leadership with regular visits to site and clinical areas	Staff see Senior Leadership infrequently and want their issues to be seen and heard with additional support	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Meet with staff to understand the root cause of their concerns Share these findings with Operations Managers & DSLT and agree what realistically can be delivered so staff expectations can be managed • Develop plan for team development days, staff engagement sessions, service meeting participation • Include pen portraits into MH&LD Staff Briefing for all Directors and Senior Leads across the Divison **Assurance actions:** • Bi-annual audit of leadership visits	All leadership staff meet with clinical teams on a monthly basis	Percentage of staff that report that their line manager takes a positive interest in their health and well being - Divisional Performance Report Monthly- Baseline from previous 12 months. "You said, we did" feedback to staff provided on a monthly ba		Phase 1	Aug-22	Jan-23	Director of Operations

2.3	Develop an open and honest culture where staff feel empowered	Problem: not all staff feel confident to raise concerns, challenge decisions and make decisions autonomously within their scope of practice	Actions	Outcome	Increase staff satisfaction and positive feedback via Staff survey;	RAG rating	Programme Phase	Start date	Complettion date	Wellness, Work and Us Lead
2.3.1	Fully implement a positive culture of psychological safety - where staff feel safe to challenge decisions and raise concerns about standards of care	Staff feel uncomfortable in speaking up and challenging decisions. This can impact on clinical safety, efficiency and clinical outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Establishment of Freedom to speak up Guardians with whom staff can have safe conversations that can be fed up to management with no implications for staff • Root cause analysis to be completed (include 3rd parties) • Reaffirm Speak out safely platform - include in Staff Briefing and Div. Workforce meeting. • Introduce DSLT Pen Portraits in the Staff Briefing • Implementation of cultural change programme to promote positive communication and management behaviours. • Roll out Divisional Annual Learning Event to include launch of reviewed/new policies • Progress with training vidoe aligned to polices recently launched, to be used as part of staff induction **Assurance actions:**	All staff feel confident to speak up when clinically appropriate to do so	Supervision and PADRs; PADR compliance and supervision measured and reported monthly (via ESR) - Baseline generated from 12 months data. **Reduction in staff grievances.**		Phase 1	Jun-22	Mar-23	Wellness, Work and Us Lead
2.3.2	Successfully implement the practical use of 'decision making tools' to enhance clinical practice	Policy and procedures have not always been made as visually accessible and easy to read as possible. This can lead to incomplete implementation of policy and procedures with associated clinical risks.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to develop Decision Support Tools Implement the NCISH Ligature support tool across the Division • Strengthen the process for reviewing Division policy and procedures • Set a timetable to review and update each policy, prioritising relevant policies • Consult with relevant groups and governance channels • Sign off and implement revised policies by circulation across the Division including in Staff Briefing, reaffirm in Supervision and Agenda item in PTR **Assurance actions:** • Assign clinical lead to complete annual review, support and briefing sessions to clinicians • Sampling of notes and care plans and unannounced visits	All staff have read and follow mandatory policy, procedure and guidance	**Increased staff satisfaction and positive feedback via staff survey**, supervision and PADRs; PADR compliance and supervision measured and reported monthly (via ESR) : quality checking of PADR/supervision audited quarterly against agreed standards e.g. BCUHB values, role and responsibility, reflection. **Reduction in staff grievances.**		Phase 1	Aug-22	Mar-23	Wellness, Work and Us Lead

2.4	Strengthen cohesive, multi disciplinary team working	Problem: inconsistent involvement of MDT resulting in compromised decision-making and suboptimal service user care and treatment; poor service user experience	Actions	Outcome	Targeted intervention outcome 7 evidence submission re team attendance, membership, actions	RAG rating	Programme Phase	Start date	Complettion date	Clinical Director, Central
2.4.1	Successfully promote effective Multidisciplinary team working throughout the MH&LD Division	Staff do not always work in a multidisciplinary way as often as possible and this can lead to an incomplete assessment and risk factors.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of monthly MDT meetings to discuss complex cases; clarity and expectations set in relation to the role of physio, OT, dietetics, SALT and pharmacy in the assessment and care of older persons • Review of MDT TOR's to ensure appropriate membership and reporting • Implement reviewed MDT TOR's across the Division • To strenghen feedback route for Advocates to provide servcie user feedabck (MHM part 4) **Assurance actions:** • Bi-annual audit of case notes / inclusion of MDT input	All staff will complete mandatory training within mandatory timescales	**Service User experience reports** / Quarterly review of Tor's and meeting minutes to measure that meetings have taken place and include the appropriate attendees - Baseline created from previous meetings (Quality, Frequency etc.)		Phase 1	Sep-22	Mar-23	Clinical Director Central
2.4.2	Implement effective and productive team meetings through all services in the MH&LD Division	There are many meetings however more change needs to happen as a result so they are productive	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implement Divisional cycle of business to show clear reporting lines across all meeting Tiers across the Division from local to corporate level Ensure all staff groups are involved and participate in team meetings • Review team dynamics and areas for improvement during reflective practice sessions, Supervision and team PADRs. Guidance and development for effective meeting Chairs • Implementation of team sessions to identify common purpose, team objectives i.e. review TOR's • Implementation of workforce development plan to promote good working behaviours, improve communication and efficiency. • Progress with actions from Training and Development Group **Assurance actions:** • Annual staff survey, annual governance review	All staff will complete productive meetings training within 12 months	Number of meetings planned vs completed - Baseline established from present data or target agreed for number of meetings. Agenda developed and agreed.		Phase 1	Sep-22	Jan-23	Clinical Director Central

2.5	Strengthen communication & engagement with staff and partners (internal & external)	Problem: inconsistent communication & engagement with staff resulting in staff and partners not feeling listened to and included in decision-making	Actions	Outcome	Staff survey, service user feedback e.g. Caniad; inclusive of Targeted Intervention Outcome 2 evidence submission	RAG rating	Programme Phase	Start date	Complettion date	Communication officer
2.5.1	Ensure the successful implementation of a system of bespoke, meaningful and sustained staff engagement across the MH&LD Division	Staff do not feel listened and feel disconnected from strategic decision-making. This impacts on staff wellbeing and retention.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and renew Divisional communication and engagement strategy • Ensure methods of communication used are suitable for all staff groups, ie HCA with limited email access. • Implement initiatives including: ward to board; regular staff survey, regular leadership coffee meeting with services • Directors and Senior Managers to attend local areas/team meetings on rotational basis • Review the aims and objectives of the Listening Leads and Wellbeing Champions to ensure they effectively enable staff being listened to • Engage staff in the improvement of Betsi Net MH&LD pages **Assurance actions:** • Staff survey annual monitoring	All staff feel confident, listened to, supported and enabled within a positive, healthy and culture	Overall staff engagement - Mthly Divisional Performance Reporting- baseline from 12 months previous. Percentage of staff reporting their line manager takes an active interest in their health and wellbeing - Divisional Performance Report-baseline as before		Phase 1	Jun-22	Jan-23	Communication officer
2.5.2	Full implementation of a well-managed schedule of regular briefings to staff (debrief, lessons learned)	Staff feel out of the loop with strategic decisions and programmes of change underway.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Adopt a cascade system of regular briefings for all staff at all levels • Assure lessons learned have been embedded throughout the division through a programme of regular staff satisfaction audit • Continue with Staff Briefing Newsletter, 7 minute briefings, Safety bulletins as themes of leasons learnt arise **Assurance actions:** • Staff survey annual monitoring	All staff feel confident, listened to, supported and enabled within a positive, healthy and culture	Improved staff satisfaction against a July 2022 baseline		Phase 1	Aug-22	Feb-23	Communication officer
2.5.3	Enhance open collaboration, communication and learning with external partner agencies	Staff are not working in an integrated way with partner agencies and this can impact on the opportunity for shared learning when serious incidents occur.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a comprehensive stakeholder communication and engagement strategy • Map out existing and needed partners required to deliver T4MH, to ensure clear lines of communication to enable collaboration and engagement • Service User feedback to be used to inform change, with monhtly reporting to QSE • Review the current arrangements with the Joint Partnership Group meeting to ensure continued engagement with staff side representatives. **Assurance actions:** • Annual stakeholder survey	All clinicians will engage with partner agencies to ensure holistic, comprehensive and high quality care plans are in place and learning takes place	Quarterly audit of staff to identify knowledge of lessons learned- Develop baseline and target		Phase 1 & Phase 2	Aug-22	Dec-23	Communication officer

S3: Safe & effective care (Strategic Lead - HoN)		Problem	Action	Outcomes	Metrics and monitoring arrangements	RAG	Programme Phase	Start date	Completion date	Lead: Head of Nursing
3.1	Improve & strengthen the management of risk across the Division	Problem: Inconsistent adherence to risk management including assessment, formulation, application and documentation resulting in poor decision making and significant harm to patients e.g.	Actions	Outcome	Metrics and monitoring arrangements	RAG rating	Programme Phase	Start date	Completion date	Head of Governance (FM)
3.1.1	Ensure that the risk management policy and procedures are current, updated, reviewed, implemented and assured	Policy and procedures have not been systematically updated and audited fully to ensure full implementation from policy to practice.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Continue with current programme of clinical risk audits • Increase the number of staff attending WARRN training by 50% in year 1, etc. • Implement the Risk Assessment Guide whilst awaiting roll out of WARRN training • Continue with the programme of Risk Assessment training for HCA's to 50% compliance by year 1 • Ensure up to date and thereafter regular risk assessments are undertaken across the Division to identify and mitigate risks **Assurance actions:** • Annual review of policy and procedures by policy sub-group	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents		Phase 1 & Phase 2	May-22	Jul-23	Head of Governance (FM)
3.1.2	Consistent dissemination of a high quality induction pack for every new member of staff (which includes a copy of the 'risk management policy and procedures')	The Division is currently ensuring service continuity with a high proportion of interims. Interims have not historically been inducted consistently in current policy and procedures for managing risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Ensure risk management is included as part of induction process • Establish risk assessment training as part of training plans **Assurance actions:** • Annual review of policy and procedures by policy sub-group • Sampling of notes and care plans and unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents vs number of new starters		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.3	Ensure that high quality, comprehensive and inclusive risk management plans are completed by clinical services	Staff are not consistently producing high quality risk assessment and formulation which can lead to serious incidents due to incomplete mitigation.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Audit of every risk management plan and mitigation to ensure inclusion of information from the patient, family and carers. • Continue with Implementation of training plan for all registered staff across the division. • Continue to develope training plan for all unregistered staff across the Divison • Ensure managers monitor quality of Risk Management plan **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6)	All managers will ensure that high quality risk assessments are completed for every patient	95% of staff have completed risk management training; monthly measurement to be undertaken across all inpatient and community setting: 100% completed risk management plans to appropriate standard. Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.4	Ensure that all clinical documentation evidence clear communication and involvement of carers, families and professionals and that risk is reviewed	Poor quality clinical documentation has been noted in relation to significant harm events.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Clear and comprehensive documentation of risk assessment and management plans, inclusion in staff briefings, handovers. • Review handover proformas used across and agree a standard document to be used across the division. • Ambition to ensure all paper records are scanned onto an electronic system **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6) • Sampling of notes and care plans and unannounced visits	All managers will ensure that high quality clinical notes are completed and accessible for every patient	All staff using agreed handover proforma 100% of the time (sample of documentation across the division performed on a monthly basis). Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.5	Implement a clear process to ensure that every member of staff will read, review and sign off an understanding of the MH&LD Div. policy and procedures relating to risk	There is a lack of assurance for all staff having read, understood and agreed to follow current risk management policy.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Audit to ensure every member of staff has signed off on policy and procedures Assurance actions: • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plan sign-offs and review by managers (see section 6) • Sampling of notes and care plans and unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	All staff using agreed handover proforma 100% of the time (sample of documentation across the division performed on a monthly basis). Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Mar-23	Head of Governance (FM)
3.2	Reducing the risk of ligature incidents	Problem: ligature incidents resulting in significant learning opportunities for the organisation	Actions	Outcome	Reduction in ligature incidents and subsequent harm	RAG rating	Programme Phase	Start date	Completion date	Head of Governance (GK)
3.2.1	Implement a system of high quality risk assessment and formulation in relation to ligature	A review of recent ligature incidents has indicated that risk assessments were either not fully completed.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of a programme of ligature risk training for staff on risk policy • Introduce robust process for investigating ligature incidents **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6)	All managers will evidence that every member of staff has read, understood and is following the policy relating to managing risk relating to ligature.	All inpatients (100%) to have a risk assessment and risk management (to include environmental risks) plan in place; monthly sample measurement of inpatient documentation supplemented with a full annual clinical risk audit		Phase 1	Aug-22	Oct-22	Head of Governance (GK)
3.2.2	Ensure that comprehensive and uptodate envirnomental risk assessments are completed to identify, reduce and mitigate the risk of ligature incidents (*see also Environmental and resources work stream*)	Equipment has not been replaced to address safety risks identified.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to review and improve ligature safety of facilities and equipment within settings i.e. Estates review **Assurance actions:** • (see section 5 and section 6) • Annual anti-ligature risk assessment of estates • Routine anti-ligature risk assessment of estates • Sampling of risk assessmenets and unannounced visits	All MH&LD Estates will have an uptodate anti-ligature risk assessment and health and safety status	All inpatients to have a risk assessment and risk management (to include environmental risks) plan in place - Weekly review & Baseline developed from QSE records. monthly measurement of inpatient documentation supplemented with a full annual clinical risk audit		Phase 1	Jul-22	Dec-22	Head of Governance (GK)
3.2.3	Ensure that patient visibility is assessed and actions implemented in accordance with the Division's policy and procedures in all inpatien settings	A review of recent ligature incidents has indicated that issues have not been fully resolved relating to patient visibility.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to review and improve ligature safety of facilities and equipment within settings (see section 5) • Review and update of ligature policy and procedures • Ensure health and safety policies are in place and easily accessible by all staff **Assurance actions:** • Establish clear links between Div level risk management processes for Estates, Facilities and Clinical Services • Strengthen the Estates input to risk management	All managers will evidence that eachy member of their team has read, understood and is following the policy relating to managing risk relating to ligature.	Observation checks documented and checked - Baseline from current data. Reported weekly.		Phase 1	Aug-22	Dec-22	Head of Governance (GK)

3.2.4	Ensure that the current ligature policy and procedures are reviewed, up to date and disseminated to all staff	A review of recent ligature incidents has indicated that risk assessments were either not fully completed or mitigations were not fully implemented.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of ligature policy and procedures • Ensure health and safety policies are in place and easily accessible by all staff **Assurance actions:** • Quarterly monitoring of signed confirmation of having read risk policy and procedures / spot checks with managers to ensure monitoring is taking place	All managers will evidence that every member of staff has read, understood and is following the policy relating to managing risk relating to ligature.	95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision**this is to provide some tolerance within the system for the timeframe due to such things as long term sickness, unexpected absence etc.*		Phase 1	Aug-22	Oct-22	Head of Governance (GK)

3.3	Ensure all observations are at the appropriate level to ensure they are safe and therapeutic	Problem: Incident investigation learning has shown that the level of therapeutic engagement and observations have been inadequate and unaligned to	Actions	Outcome	Reduction in harm (via reduction in incidents relating to patient therapeutic observations); improved service user satisfaction and positive experience reported via service user experience feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance (GK)
3.3.1	Ensure that physiological and mental health assessment and observations are undertaken in all inpatient settings	The implementation of therapeutic observations has not always been completed to the optimum level of frequency, which can have implications for managing risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Briefing sessions, training programme and audit programme developed. **Assurance actions:** • Quarterly monitoring of signed confirmation of having read therapeutic observations policy and procedures / spot checks with managers to ensure monitoring is taking place	All managers will evidence that every member of staff has read, understood and is following the policy on therapeutic observations.	Percentage of mental health assessments undertaken (up to and including) 28 days from the receipt of referral for people aged under 18 years - Divisional Performance Reporting Baseline from 12 months previous. Weekly review via Quality Checks (Ward Manager/Matron) of observation charts and documentation: 100% of patients to have documented observations as per individual care plan.		Phase 1	Aug-22	Sep-22	Head of Governance (GK)

3.4	Reduction of incidents in relation to falls, medication errors and the deteriorating patient	Problem: Incidents have identified that patients experience avoidable falls, medication errors and failure to recognise physical health deterioration across the Division	Actions	Outcome	Reduction in falls rate i.e. per bed days, falls with harm (via Datix), reduction in medication error rate, reduction in incidents relating to deteriorating patients (physical health)	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
3.4.1	Ensure that risk assessments are completed to identify, reduce and mitigate the risk of Falls with active prevention measures assured	Themes and trends relating to falls, broken down by profession, are not reported currently in a way to embed the learning into the planned transformation work.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review / develop falls risk assessment process and document • Ensure all patients are risk assessed for falls • Project to review and reduce falls • Introduction of a sustained campaign of best practice examples in Falls reduction/ prevention across Elderly Mental Health Care in North Wales **Assurance actions:** • Annual audit / spot checks of risk assessments	All managers will evidence that every eligible patient has had a risk assesmsent completed (with falls included where clinically appropriate).	Falls resulting in harm or death/Number of inpatient falls - reported via QSE Agenda. Weekly sample of documentation to measure falls risk assessment compliance (aiming for 100%); and falls care plan/pathway in place (aiming for 100%) - Baseline generated		Phase 1 & Phase 2	Aug-22	Jul-23	Quality and Safety Lead
3.4.2	The service will ensure that medication and treatment plans are up to date, with clear review timescales included and with plans reviewed and updated (where appropriate)	Medication has been prescribed, without clearly stated and specific treatment goals, noted as set with the patient, taking into account any risks (including interactions), with a stated timescale for review and patient consent recorded.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review / develop medicines management policy and ensure it is easily accessible to staff • Develop template for medication review discussions with patients including consent and timetables reviews • Establish a process to review staff competencies every three years • Identify a link pharmacist to multi disciplinary teams **Assurance actions:** • Annual audit • Sampling of medical notes, treatment plans and unannounced visits	All medical patients will have clear, complete and accurate information relating to treatment, including medication and a time for review.	monthly inpatient medication review audit to identify any gaps in undertaking reviews with improvement plans and actions in place, Reduction in medicine incidents to be monitored weekly - Baseline generated from current data.		Phase 1	Aug-22	Dec-22	Quality and Safety Lead
3.4.3	Ensure that there is a rapid and effective response to the identification of an acutely ill (deteriorating) patients by clinical services	Deterioration in the condition of some patients has not been identified quickly enough in some cases, which can lead to avoidable harm.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of a programme of training for staff observations based on Div policy and procedures • Introduction of the All Wales systems in 'recognition of the deteriorating patient' across elderly mental health services in North Wales **Assurance actions:** • Annual audit / spot checks	All staff will complete mandatory training within mandatory timescales	% trained in NEWS and recognition of the deterioration for all registered staff; 95% of registered staff trained measured via training records, to be reviewed on a quarterly basis to pick up on new starters etc. Baseline to be established from existing records.		Phase 1	Aug-22	Mar-23	Quality and Safety Lead

3.5	Improving the recognition of safeguarding adults at risk and ensuring the appropriate pathway is followed	Problem: lack of recognition of safeguarding issues and appropriate intervention and referral	Actions	Outcome	Reduction in safeguarding incidents	RAG rating	Programme Phase	Start date	Completion date	Safeguarding Lead
3.5.1	Ensure all staff are fully trained to the appropriatel level of safeguarding training & awareness of policy	Staff have not always followed the internal safeguarding policy and procedures in full, which means that potential risks could have been averted.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of internal safeguarding policy and procedures • Monitor safeguarding training is completed as part of mandatory training requirements • Review the process for restraints, restrictions, seclusion to ensure they are compliant and appropriately applied **Assurance actions:** • Monthly monitoring of staff training compliance	All staff will complete mandatory training within mandatory timescales	Number of policy infractions - Baseline developed from existing data. (Training records; 95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision; safeguarding referrals rate**this is to provide some tolerance within the system for the timeframe due to such things as long term sickness, unexpected absence etc.)*		Phase 1	Aug-22	Oct-22	Safeguarding Lead
3.5.2	Ensure that advance planning is incorporated as part of full implementation of the Division's policy and procedures relating to the use of restrictive interventions	A lack of advance planning with patients has lead to an excessive number of incidents being managed with restrictive measures unnecessarily	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of policy and procedures • To reduce the use of restrictive interventions, patients who have been violent, aggressive or communicating distress are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions. • Progress programme of training (RESPECT, PICSS) impacted by Covid **Assurance actions:** • Quarterly audit of practice / annual review of policy and procedures • Sampling of notes and care plans and unannounced visits	All staff will complete mandatory training within mandatory timescales	95% Staff appropriate for Training in RPI - training records; RPI reported via Datix - reported at a local and divisional QSE level / Establish baseline and provide SMART measure in response		Phase 1	Aug-22	Sep-22	Safeguarding Lead

S4: Individual & Timely Care (Strategic Lead - HoO)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Ops Lead**
4.1	Right care at the right time in the right place	Problem: Patients are experiencing long waits for mental health input, and appropriate placement suitable for their needs.	Actions	Outcome	Reduced waiting times from referral to assessment and treatment-% improvement on baseline, Reduced waiting times for placements -% improvement on baseline ;no Datix for mixed cohorts (reporting via the Mental Health Measure i.e. Number of mixed cohorts - %improvement on baseline); increase in service user satisfaction (% improvement on baseline) and positive feedback	RAG rating	Programme Phase	Start date	Completion date	Head of Nursing

4.1.1	Ensure that there will be no mixed cohorting of mental health patients within North Wales	The environment does not promote privacy and dignity for the patient group. There are multi occupancy rooms and the bathrooms are shared between the patients on that ward. There were limited designated male and female facilities.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Terms of Reference of Project Group to be established **Improvement actions:** • Review of patient areas to introduce male and female designated facilities (co-produce solutions with patients) • Full implementation of 4 phase process (currently phase 2) • Assign Estates Lead from cohort to support process • Estates feasibility study (see section 5) • Development of a bed management strategy to manage the demand of in-patient beds **Assurance actions:** • Quarterly audit of mixed cohorting • Spot checks / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Reduction in Datix of any reported mixed cohorts / Continued to be monitored via exception reporting. Baseline to be developed and % improvement to be monitored.		Phase 1	Mar-22	Aug-22	Head of Nursing
4.1.2	Ensure patients are seen in accordance with Mental Health Measure timescales and as per national standards	Patients are not seen consistently from referral to assessment / treatment and greater progress is required.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a performance management strategy to address areas of underperformance **Assurance actions:** • Monthly performance monitoring	All patients will be seen within mandatory timescales	Improvement in waiting times from referral to assessment and treatment (% improvement on Baseline); reported into Finance & Performance / Improvement trajectory to meet KPI's to be reported e.g. psychological therapies		Phase 1	Sep-22	Mar-23	Head of Nursing
4.1.3	Ensure that every CHC placement plans is of a high quality, comprehensive and person-centred	CHC plans are not as comprehensive and person-centred as they could be. This can lead to sub-optimal outcomes and increased cost implications from unmet need.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review of placement plans **Assurance actions:** • Quarterly audit programme of placement plans by managers	All patients will participate in the development of a comprehensive, holistic outcomes-based care plan	Delayed transfers of care reported via F&P /divisional SLT-% improvement on baseline		Phase 1	Aug-22	Dec-22	Head of Nursing

4.2.	Review of current service processes to optimise patient journey	Problem: Gaps in core service processes- to be identified and addressed to meet population needs	Actions	Outcome	Inpatient and community establishment review; pathway development	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.2.1	Ensure that the whole system of support is mapped clearly from the service user's perspectice and produced into a clear directory of services that can improve access for all patients	There is no easily available directory of services that includes the full system of support in North Wales	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Completion of service mapping project including iCan • Development of patient journey through services and ways to improve streamlined transfer • Development of Service Directory available online Progress with Do Well Workshops to review T4MH Strategy **Assurance actions:** • Review of implementation of recomendations and review of current system with service users	All staff and patients will have clear information on the range of support available to enable their wellbeing and mental health needs	* to be determined following analysis		Phase 1	Aug-22	Dec-22	Head of Nursing

4.3	Improve Individualised Care planning to promote independence	Problem: Not all care plans are completed and reviewed collaboratively, to the required standard, resulting in variation in care and service delivery and patient experience across the	Actions	Outcome	Mental Health Measure ; Improvement in service user satisfaction and positive feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.3.1	Ensure that every client participates in the development of high quality, individualised & comprehensive care planning	All care plans do not show sufficient evidence of an individualised and holistic outcomes based approach.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Improvement plan implemented based on root cause analysis findings **Assurance actions:** • Quarterly audit of care plans to ensure promotion of independence • Spot checks of care plans / unannounced visits	All patients will participate in the development of a comprehensive, holistic outcomes-based care plan	% of care plans are completed and reviewed to the required standard: monthly sample measurement supplemented by annual audit. Baseline rom existing data.		Phase 1	Aug-22	Jan 2023	Head of Nursing

4.4	Ensure Admission, Discharge and Patient Leave processes are fully documented and communicated, and follow BCUHB Polices/Procedures	Problem: Documentation is not always clear in a patients admission, discharge and leave status resulting in incidents relating to communication and informing	Actions	Outcome	Reduction in patient safety incidents relating to admission, discharge and leave; Increased service user satisfaction and positive experience via Service User Experience Feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.4.1	Ensure that Admission processes are well planned, fully documented and comprehensive	The admission policy has been inconsistently implemented resulting in physical health conditions not being identified, user defined goals not being completed and patient preferences re: confidentiality / information sharing not being recorded.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of admission process - how? • Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission **Assurance actions:** • Quarterly audit of admission paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Monthly review to be undertaken across all inpatient and community setting as part of Quality Check: 100% completed admission criteria to appropriate standard. Baseline to be generated. % improvement on baseline.		Phase 1	Aug-22	Oct-22	Head of Nursing
4.4.2	Ensure that Discharge processes are implemented consistently with patient safety, recovery and proactive follow ups are completed every time	The a discharge policy has been inconsistently implemented resulting in patient treatment goals not being reviewed, post-discharge plan not being completed and mandatory follow ups not being completed within timescales.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of discharge process **Assurance actions:** • Quarterly audit of discharge paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Number of incidents relating to admission, discharge and leave (see 1.1.3) % improvement on baseline. 100% completed discharge planning measured against required standard - % improvement on baseline; Patients followed up within 72 hrs post discharge from psychiatric setting *95% level to provide tolerance for any issues that arise e.g., service user contact .		Phase 1	Aug-22	Nov-22	Head of Nursing
4.4.3	Ensure that the current policy and procedures relating to the 'management of patient leave' are understood, fully implemented and assured	Patients have been granted leave with inadequate patient leave planning and tracking resulting in serious incidents due to lack of management, record keeping and coordination.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of patient leave process **Assurance actions:** • Quarterly audit of leave paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	monthly measurement to be undertaken across all inpatient and community setting: 100% completed leave risk assessment and decision making documented to appropriate standard		Phase 1	Aug-22	Dec-22	Head of Nursing

4.5	Listening and learning from patient & carers/family feedback	Problem: lack of dedicated time to listen and understand the patient experience to make service improvements	Actions	Outcome	Increased service user satisfaction and positive experience via Service User Experience Feedback; inclusive of Targeted Intervention Outcome 2	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead

4.5.1	Every clinical service will ensure that Patient & carer experience/feedback is proactively sought, systematically reviewed and utilised to drive service improvements	Service user feedback is not systematically used to drive service improvement.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current feedback with parents and carers re: specific service experience • Include service user representation within Div Imp Plan project review process **Improvement actions:** • Review current service user engagement mechanisms • Develop a Divisional model and plan for service user engagement (online/open days) including FT Engagement Facilitator role. Build in evaluation of engagement approach from staff, patient, carer and partner perspectives • Increase number of Service user on interview panels **Assurance actions:** • Bi-annual audit presented to Patient Carer Experience meeting (PCE)	All services will understand the value of including patient and carer experience information to inform team meetings and planning on a monthly basis	Service User/Carer Experience Feedback Monthly report and development of % improvements in response 'you said we did' ; reported into patient experience group. Baseline established from existing data.		Phase 1	Jun-22	Dec-22	Quality and Safety Lead
4.5.2	Every clinical services will ensure that patients & carers/families are involved in the planning of high quality patient care and clinical records	Holistic care planning is not systematically mainstreamed across clinical practice, in part impacted by staffing level challenges, however, a holistic and comprehensive assessment with carers / families is required to assure a complete risk assessment and plan have been completed.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current feedback with parents and carers re: specific service experience • Include service user representation within Div Imp Plan project review process **Improvement actions:** • Review quality of clinical records • Review staffing levels and develop plan to optimise capacity • Develop policy, procedures for co-production / parent / carer involvement **Assurance actions:** • Annual co-produced review of service user engagement and operationalisaion of recommendations into service delivery and improved outcomes	All care plans will show evidence of carer, familiy, participation / invitation to be involved (where clinically appropriate)	Monthly report of Service User/Carer Experience Feedback and development of improvements in response 'you said we did' ; reported into patient experience group		Phase 1	Aug-22	Feb-22	Quality and Safety Lead

4.6	Provide patient information (for patients & about patients) in multi-formats	Problem: current patient information is not always user friendly or in multi formats e.g. different languages, accessible to [illegible]	Actions	Outcome	Service user experience feedback; accessible healthcare audit	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
4.6.1	Every service will ensure that information for patients, carers and family is clear, accessible and up to date	Information for patients has not been reviewed and updated regularly - patients tell us the information is unclear and needs to be presented in different languages to be accessible.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current service user information **Improvement actions:** • Develop a plan for service user information • Develop easy read documentation for patients • Each inpatient unit to create an patient information pack (bilingual) • Assess the need to have patient douc mentation and information in other languages **Assurance actions:** • Bi-annual audit of info with Caniad	All information for patients, carers and familiy, will be reviewed and updated, on an annual basis	Target number of languages vs Actual number - Baseline established from current availability. Monthly report of Service User/Carer Experience Feedback and development of improvements in response; improvements actioned if identified via Accessible Healthcare Audit		Phase 1	Aug-22	Dec-22	Quality and Safety Lead
4.6.2	Every service will ensure that information about patients, carers and family is clear, accessible and up to date	Information about patients has not always been shared with patients in a way to inform how a patient can engage with the service and or other methods of support to meet their needs	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current service user information **Improvement actions:** • Develop a plan for service user information • Develop patient journey document to share with patients for both inpatients and community service users • Develop family and carers information sheet, to include liaison wiht families and carers to ensure approrpoaite for thier needs **Assurance actions:** • Bi-annual audit of info with Caniad	All patients will be shared information about support, services avaialble, in a format that is accessible to meet their linguistic, cultural and cognitive requirements	Annual documentation audit with improvement plan identified if necessary; this will include information from other document checks as per previous tasks e.g. risk assessments, admission criteria		Phase 1	Aug-22	Mar-23	Quality and Safety Lead

S5: Environment, Resource & Workforce (Strategic L		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Planning Lead**
5.1	Understanding Roles, capability - skills, knowledge & practice	Problem: not all staff are the right staff in the right roles at the right time impacting on staff well being, management and leadership, and variation and suboptimal patient care and experience	Actions	Outcome	E-roster analysis; reduction in bank/agency & overtime usage; reduction in workforce concerns; improved training compliance; PADR compliance and sickness absence; Baseline developed for each and improvement plan developed.	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
5.1.1	Every manager will ensure that clear opportuntiies are provided to staff to enhance their skills, knowledge and clinical practice as part of a robust PADR process	Staff require opportunities to develop their skills to meet service gaps and in order to progress towards career development opportunities.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Training Needs Assessment progressed • Implementation of workforce plan, aligned to career development opportunities **Assurance actions:** • Annual review and audit • Spot checks of PADRs / unannounced visits	All staff will have a high quality PADR within mandatory timescales	95% of all staff to have up to date PADRs - captured via ESR **this is to provide some tolerance within the system for PADRs not completed within the timeframe due to such things as long term sickness, unexpected absence etc. / E-Rostering; staff reported issues via Datix. Baseline created from existing data.*		Phase 1	Aug-22	Dec-22	Head of Workforce
5.1.2	Every manager will ensure that sufficient time is available for supervision & reflection	Staff have communicated that they do not get enough time for reflective practice due to the pressures of working culture	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of workforce plan (see workforce workstream), aligned to reflective practise **Assurance actions:** • Annual review and audit	All staff will have a supervision session within mandatory time frames	95% staff to have monthly supervision		Phase 1	Aug-22	Dec-22	Head of Workforce

5.2	Managing Daily caseload and staffing incl. rostering	Problem: Staff are not always as diligent in the management of safety and risk	Actions	Outcome	E-roster analysis to establish current situation; Cost of bank; Cost of Overtime, Cost of Agency - Reported via QSE Agenda (Baseline established from existing data). % reduction in bank/agency & overtime usage; % reduction in workforce concerns; improved training compliance; increased PADR compliance and reduction sickness [illegible]	RAG rating	Programme Phase	Start date	Complettion date	Head of Planning and Performance
5.2.1	Every manager will ensure that clear standards for 'Forward planning' are in place, monitored, managed and actioned	Staff have not been forward planning to ensure that sufficient capacity is assured for service delivery.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Briefing to managers **Improvement actions:** • Demand and capacity review completed • Case load analysis aligned to national baseline recommendations • Implementation of workforce plan (see workforce workstream) • Review of Estates and Facilities requirements to meet workforce requirements **Assurance actions:** • Monthly monitoring by SLT	All managers will create, monitor and manage clear demand and capacity projections based on safe staffing levels	E-roster analysis to establish current levels. Cost of bank/agency & overtime usage reported in QSE Agenda; caseload monitoring Baselines created from existing guidelines or data		Phase 1	Jun-22	Apr-23	Head of Planning and Performance

5.2.2	Every manager overseeing recruitment actions will prioritise and complete actions in a timely manner	A high number of vacancies is impacting on service capacity and access times for services.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Re-affirm E roster KPI's with managers • Progress with Just R 12 month recruitment campaign • Review of current Agency spend/usage **Improvement actions:** • Develop recruitment strategy • Briefing sessions for manager aligned to capacity planning/management • Recruit to permanent positions / fill interim posts • Implementation of workforce plan including monitor / review of metrics to show return on investment of Just R • Review of Estates and Facilities requirements to enable new posts **Assurance actions:** • Monthly monitoring by SLT	All services will ensure recruitment to safe levels of establishment are achieved and maintained	Number of Responses vs Interviewed, Number of Interviewed vs Successful, Conversion rate - % improvement from baseline from existing data		Phase 1	Aug-22	Apr-23	Head of Planning and Performance

5.3	Well organised and safe working environment incl dignity i.e. privacy	Problem: Inadequate environmental estates leading to a poor experience and impacts on patient safety and safe working conditions for staff	Actions	Outcome	Use of existing organisational audits to provide divisional data/measures: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits	RAG rating	Programme Phase	Start date	Complettion date	Assistant Director of Nursing
5.3.1	Every clinical environment will be managed in a way to ensure 'privacy and dignity' is at the heart of clinical delivery at all times	The Division's Estate is not designed to be fit for purpose resulting inconvenient adaptations to service delivery required to ensure Privacy and Dignity are assured.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of any risk / exception reports **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities • Development of Estates strategy collaboratviely developed with Estates, Health and Safety and Operational colleagues **Assurance actions:** • Annual audit and review • Spot checks / unannounced visits with patient representatives	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Use of organisational audit programmes to provide data at a divisional level: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits, ensuring that improvement plans are developed if appropriate. Baselines developed for each measure with % improvements agreed.		Phase 1	Jun-22	Dec-22	Assistant Director of Nursing
5.3.2	Ensure that each clinical setting is well organised and fit for purpose to optimise patient experience, safety and quality outcomes	There have been delays in getting identified changes to Estates and Facilities completed. Business cases have been submitted without sufficient Capital available to enable a speedy resolution. New ways at looking at old problems are required to create safe and clinically effective environments that enable patient outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current allocated Capital for MH&LD Estates requirements • Review of available capital spend from last 3 years • Review requirements to recruit a ML&HD Estates person to be visible and available re: MH&LD clinical requirements **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities • Development of Estates strategy **Assurance actions:** • Annual audit and review • Spot checks / unannounced visits with patient representatives	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Use of organisational audit programmes to provide data at a divisional level: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits, ensuring that improvement plans are developed if appropriate. Baselines developed for each measure with % improvements agreed.		Phase 1	Aug-22	Mar-23	Assistant Director of Nursing
5.3.3	Ensure that 'environmental risk assessments' are completed, managed, safety requirements approved and implemented in a timely manner	There have been delays in getting identified changes to Estates and Facilities completed. Business cases have been submitted without sufficient Capital available to enable a speedy resolution. New ways at looking at old problems are required to create safe and clinically effective environments that enable patient outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current allocated Capital for MH&LD Estates requirements • Review requirements to recruit a ML&HD Estates person to be visible and available re: MH&LD clinical requirements **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Guttering assessment (in relation to ligature) to be included in plan • Strengthen local Estates meeting with clear governance to ensure actions progressed • Strengthen local and Divisional Health and Safety meeting with clear govenrance to esnure actions progressed **Assurance actions:** • Annual audit and review	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	All areas hosted by the division to have Environmental risk assessments undertaken; monitored by H&S divisional meeting aligned with corporate H&S meeting		Phase 1	Aug-22	Dec-22	Assistant Director of Nursing
5.3.4	Ensure that estates are designed and adapted to be safe and in particular reduce the risk of violence & aggression in the workplace	Buildings are not designed in a way to optimise safety for staff and patients.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities to promote dignity • Development of Estates strategy • Implementation of policy review and training programme • Design standards to be developed and agreed (a long term issue as there is no capital to deliver in the short-term) **Assurance actions:** • Annual audit and review	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Reduction in reported incidents in relation to V&A (patient on patient, patient on staff etc.) .Monitored via Datix and Physical Intervention and support service - reported into QSE		Phase 1	Aug-22	Dec-22	Assistant Director of Nursing

S6: Audit, Outcomes and Assurance (HoG / HoF)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Governance Lead**
6.1	Strengthening Governance, risk and course correction (learning)	Problem: ineffective governance processes at every level resulting in increased significant incidents, staff and service user concerns	Actions	Outcome	Reduction in patient safety Incidents, complaints and increase in compliments ; Inclusive of Targeted Intervention Outcome 7 submitted evidence	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance
6.1.1	Ensure that a clear governance framework is in place with explicit roles and responsibilities and clear reporting and escalation procedures	Staff have indicated a lack of clarity about roles and responsibilities within the process of governance.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Full development of the Divisional Cycle of Business (Targeted Intervention level 2 measure) (underway) **Improvement actions:** • Implementation and dissemination of Cycle of business • Staff training to acheive understanding of governance structures and processes • Audit of meeting TOR's across the Division **Assurance actions:** • Annual review	All meetings held across the Division will have an up to date TOR, with clear lines of reporting, escaltion and disemmination.	Inclusive of Targeted Intervention Outcome 7 submitted evidence / In place; currently being reviewed against operating model (which is awaiting to be agreed)		Phase 1	Aug-22	Dec-22	Head of Governance
6.1.2	Review and strengthen the process for managing allegations/incidents in line with Safeguarding and WOD processes	Reviews of incidents indicate that awareness of safeguarding policy and processes needs to be strengthened.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of safeguarding incidents and root cause analysis **Improvement actions:** • Development of safeguarding improvement plan (Triangulation of themes/trends) • Review and update its safeguarding training and ensure it is up to date and incorporates relevant legislation, safeguarding documentation, audits • Planned schedule of reflective learning sessions **Assurance actions:** • Annual audit	All staff are compliant with safeguarding mandatory training requirements	Reduction in Incidents reporting significant harm, complaints and an increase in compliments data: compliance with concerns KPI's e.g. 30 day response rate; monitored at local and divisional PTR feeding into QSE. Baseline available from existing reporting.		Phase 1 & Phase 2	Aug-22	Apr-23	Head of Governance

6.2	Knowing how I am doing - continuous audit cycle plan	Problem: incomplete data to support improvements leading to inefficient and unsafe processes	Actions	Outcome	Audit cycle in place and reviewed and monitored regularly	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance

6.2.1	Ensure a comprehensive measuremen and audit plan is developed, resourced, implemented and assured	Many metrics are recorded and reported while the data is not linked as well as it could be and some services are using paper records.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current Div. reporting and requirements **Improvement actions:** • Review feasibility of recruiting to a Div self-audit team • Project to strengthen the Div. performance dashboard including demand and capacity dashboard **Assurance actions:** • Annual audit	All clinicians will have access to the North Wales implementation of the All Wales WCCS IT System to support high quality clinical records	Annual review of all tiers of audits		Phase 1	Aug-22	Sep-22	Head of Governance

6.3	Improve & strengthen the implementation of policy-driven clinical practice across the Division	Problem: inconsistent adherence to MH&LD policy and procedures can lead to risk in patient safety, clinical outcomes and patient experience.	Actions	Outcome	Incidents / Complaints due to avoidable risks.	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
6.3.1	Ensure that all staff are fully awareness of current BCU and Division policy and procedures	Some staff are unaware of existing or latest policy and procedures. Impact: inconsistent clinical practice. Risk: impact on clinical safety, outcomes, patient experience.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Briefing to be distributed to all teams - policy and procedures access • Introduction of Policy of the month in the Staff Briefing to include in Supervision/Team meetings **Improvement actions:** • Policy recommendation: risk management included as standing agenda item (operational teams) • Induction pack updated with policy and procedures link **Assurance actions:** • Annual audit • Spot checks / unannounced visits / observations	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy survey completed		Phase 1	Aug-22	Jan-23	Quality and Safety Lead
6.3.2	Review, strengthen and optimise how staff can access policy and procedures	Some staff are unaware of how to access the policy and procedures.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review that all policy and procedures are available on the MH&LD Hub Betsinet and all staff know how to access them **Improvement actions:** • Desktop icon to policy and procedures to be installed by IT **Assurance actions:** • Annual audit hard copy policies and procedures to ensure all old versions removed • Spot checks / unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents		Phase 1	Jul-22	Jan-23	Quality and Safety Lead
6.3.3	Ensure that there is a process in place to monitor and update the Division's policy and procedures within prescribed review timescales	Inconsistent implementation of policy and procedures must be identified and addressed. Impact: policy not followed and inconsistent clinical practice. Risk: impact on clinical safety, outcomes, patient experience.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Governance in place and programme of review and updating underway **Improvement actions:** • Project to review all Div. policy and procedures • Consider implementation of on line versions **Assurance actions:** • Annual audit of management evidence procedures • Spot checks / unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy Sub-group audit		Phase 1	Aug-22	Jan-23	Quality and Safety Lead
6.3.4	Ensure that a policy improvement plan is developed, fully implemented and assured	The current policy improvement plan may require some adjustments in relation to any issues identified above.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review policy development capacity required for North Wales and recruitment of dedicated policy officer capacity **Improvement actions:** • Project to improve / update Div. policy and procedures **Assurance actions:** • Annual audit of policy and procedures	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy improvement plan signed off		Phase 1	Aug-22	Jan-23	Quality and Safety Lead

6.4	Strategy, Model of Care and Operating Model development	Problem: there is no current explicit Model of Care to form the strategic Vision of how North Wales Mental Health Services will operate in the Medium / Long term	Actions	Outcome		RAG rating	Programme Phase	Start date	Complettion date	Medical Lead
6.4.1	Complete the development of a Clinical Strategy, Model of Care and Operating Model	A lack of capacity for developing and implementing clinical strategy	**Immediate assurance actions:** • Rapid review of current work completed by Clinical Strategy Group **Improvement actions:** • Allocation of Clinical Lead • Allocation of Project Manager capacity • Alignment with Together 4 Mental Health Strategy development process • Consultation with stakeholders in T4MH workshops • Completion of final documentation for Clinical Strategy, Div Model of Care and Div Operating Model • Identification of care pathway implementation i.e. project manager requirements **Assurance actions:** • Annual review of Clinical Strategy	The Mental Health & Learning Disabilities Division will have a clear unifed all age mental health strategy focused on supporting current and projected population health needs	Quadruple Aim objectives		Phase 1	Aug-22	Dec-22	Medical Director
6.4.2	Ensure the development of overarching public health outcomes model is selected / developed to align to the Div Imp Plan	Lack of alignment between population health assessment and divisional resource planning	**Immediate assurance actions:** • Clearly defined KPIs with baseline provided within MH&LD Div Imp Plan (see tab called KPIs) **Improvement actions:** • Establish public health and MH&LD outcomes / performance working group • Establish strategic outcomes in conjunction with T4MH Strategy, Clinical Strategy, Model of Care, Operating Model lead **Assurance actions:** • Co-review of population health outcomes + Div KPIs to evidence improvement based on successful implementation	The Mental Health & Learning Disabilities Division will have a clear strategic outcomes framework which will form the basis of all project initiatives	Quadruple Aim objectives		Phase 1	Dec-22	Mar-23	Medical Director

KEY PERFORMANCE INDICATORS - MH&LD DIV IMPROVEMENT PLAN - Year 1

Section	Metric	Data Source	Baseline - March 2022	Projected % Improvement	Incremental improvement trajectory - 30/09/22 Planned	30/09/22 Actual	28/10/2022 Planned	28/10/2022 Actual	30/11/22 Planned	30/11/22 Actual	31/12/22 Planned	31/12/22 Actual	31/01/23 Planned	31/01/23 Actual	28/02/23 Planned	28/02/23 Actual	31/03/23 Planned	31/03/23 Actual	30/04/23 Planned	30/04/23 Actual	Commentary
1	**FUNDAMENTALS OF CARE**																				
	All staff have a comprehensive understanding of their roles & responsibilities																				
	Mandatory Training, Level 1 and Level 2 compliance to increase from 80.9% to 85%, relevant to post.	Divisional Performance Report	80.90%	5%																	
	PADR compliance increase from 78% to 85%	Divisional Performance Report	78.00%	9%																	
	Supervision compliance increase from 693 to 3036	Divisional Performance Report	693	338%																	
	Ward accreditation - increase number of White standard wards from 3 to 0	Ward Accreditation	3	100%																	
	Improve record keeping in line with BCU policy/procedure, guidance e.g. MHM & Mental Health Act																				
	Information Governance Training - compliance to remain above 85%	Divisional Performance Report	85.23%	0.00%																	
	Review Inpatient/ward based care processes e.g. ward rounds, shift handovers, Patient Status At a Glance																				
	Reduction in the number of delayed discharges patients from 18 To 9	Divisional Performance Report	18	50%																	
	Reduction of DTOC bed days from 1125 to 563	Divisional Performance Report	1125	50%																	
	Improve the delivery of care to patients with Dementia																				
	Dementia Awareness training compliance increase from 78% To 85%	Divisional Performance Report	78%	9%																	
	Improve the delivery of Crisis Care including psychiatric liaison																				
	Emergency Department - increase % of service users assessed by Psychiatric Liaison within one hour from 62.5% To 80%	USC report	62.50%	28.00%																	
	Maintain 100% of service users, admitted to hospital who have not received a gate keeping assessment by the CRHT service that have received a follow up assessment by the CRHT service within 24 hours of admission.	CHRT	100%	0%																	
	Maintain 100% of adult user admitted to Unit by 9am - 9pm that have received a gate keeping assessment by the CRHT service prior to admission	CHRT	100%	0%																	
2	**LEADERSHIP, EMPOWERMENT, CULTURE & OD**																				
	Strengthen sustainability & stability of leadership roles																				
	Reduce the number of Senior Leadership Roles vacant from 1 To nil	Divisional Performance Report	1	100.00%																	
	Increasing leadership visibility, at all levels, with a purpose																				
	Numbers of areas visited by DSLT and attendance at local Tier 1 areas meeting increased from 0 To 1 per month	Divisional Performance Report	0	100%																	
	Develop an open and honest culture where staff feel empowered																				
	Increase number of staff who have undertaken coaching qualification from 7 To 12	WW& U	7	71%																	
	Strengthen communication & engagement with staff and partners (internal & external)																				
	Increase number of MH&LD Briefings per year from 8 to 12	Divisional Performance Report	8	50%																	
3	**SAFE & EFFECTIVE CARE**																				
	Reduction of incidents in relation to falls, medication errors and the deteriorating patient																				
	Reduce number of Falls resulting in harm or death from 35 to 18	QSE report	35	48%																	
	Reduction in number of medication error from 15 to 7	QSE report	15	53%																	
	Reduction in number of never events from ? To ?	QSE report	TBC																		
	Improving the recognition of safeguarding adults at risk and ensure appropriate pathway is followed																				
	Respect - increased % of staff trained from ? To ?	QSE report	TBC																		
	PICSS - increased % of staff trained from ? To ?	QSE report	TBC																		
	Reduce the number of patient restraints from 62 per month to 31	QSE report	62	50%																	
4	**INDIVIDUAL & TIMELY CARE (Strategic Lead - HoO)**																				
	Right care at the right time in the right place																				
	Reduction in number of mixed cohorting incidents to nil.	QSE report	2	100%																	
5	**ENVIRONMENT, RESOURCE & WORKFORCE (Strategic Lead: Head of P&P / HoW)**																				
	Understanding Roles, capability - skills, knowledge & practice																				
	Reduction in agency usage from £631,000 to £473,250	Divisional Performance Report	£631,000	25%																	
	Reduction in overtime usage from £84,000 To £63,000	Divisional Performance Report	£84,000	25%																	
	Sickness absent rate reduced from 9.52 To 6%	Divisional Performance Report	9.52%	37%																	
	Increase the number of starters joining the MH&LD Division from 16 WTE to 30 WTE per month	Divisional Performance Report	16	88%																	
	Decrease the number of staff leaving the MH&LD Division from 15 WTE to 7 WTE	Divisional Performance Report	15	53%																	
	Managing daily caseload and staffing incl. rostering																				
	Success rate increased from 19% to 50%	Power BI	19%	163%																	
	Average number of applicants per vacancy increased from 0.9 to 3	Power BI	1%	233%																	
	Number of nurses recruited to post increased from 5 WTE per month to 6.6 WTE	Power BI	4.5	32%																	
	Number of HCA's recruited to post increased from 4.3 WTE To 6.3 WTE per month	Power BI	4.3	46%																	
	Number of A & C recruited to post increased from 3.5 to 5.5 WTE per month	Power BI	3.5	57%																	
	Number of Medical staff recruited to post increased from 1.5 to 2.5 WTE per month	Power BI	1.5	66%																	
6	**STRATEGY, AUDIT, OUTCOMES AND ASSURANCE (HoG / HoF)**																				
	Strengthening Governance, risk and course correction (learning)																				
	Increase in the number of residents engaging with ICAN services from 1103 to 1500	ICAN report	1103	36.00%																	
	Reduce the % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health from 74.29 to 50%	Divisional Performance Report	74.29%	33.00%																	
	Reduction in Number of suicides per year capita from 11.5/100,000 to nil	TBC	11.5	100.00%																	
	Reduction in number of concerns from 28 per month to 20	QSE	27	29.00%																	
	Increase number of compliments from 16 per month to 30	QSE	16	87.00%																	

PROGRAMME ON A PAGE: HIGH LEVEL SUMMARY - DRAFT			
Mental Health and Learning Disabilities			**PLAN STATUS**
Executive Accountable Owner	Teresa Owen	TIMEFRAME FOR DELIVERY	**Plan Developed** 23/05/2022
Senior Responsible Owner	Carole Evanson		**Date Revised** 22/07/2022
Workforce Lead	Claire Thomas-Hanna		**Version** V0.16
Project Managers	See Workstream Leads below		

REPORTING FRAMEWORK
Divisional SLT Business
Divisional Workforce Group
OLM

APPROVALS				
DSLT	QIA	EQIA	DPIA	OLM

PROGRAMME OUTCOMES	
Outcome Number	**Outcomes to be Delivered**
	High Priority - Short Term (0-6 months)
1	**MH&LD Divisional Workforce plan** - will be in place, with agreed key milestones
2	**Workforce will be respected and empowered,** appropriately informed and trained and demonstrate the BCU values whilst supporting people with skill and compassion.
2a	**Culture** in the organisation will be improved.
2b	**Workforce Transformation - Service changes and developments** will be managed by inspirational and skilled leaders and the values of kindness and compassion will be central within the organisation **(workstream 3 ref: 2b)**
3	**Comprehensive recruitment plan (for priority groups)** - there will be a clear plan describing a recruitment plan for Nursing, HCA's, A & C and Medical staffing for the Division which will transform workforce recruitment from reactive to proactive **(workstream 3)**
3a	**Just R Marketing Campaign** will be in place, with agreed key milestones **(workstream 3 ref 3a)**
4	**Welsh Essential roles** will have appropriate Job Description and Person Specifications in place **(see workstream 3 ref: 4)**
5	**Coaching programme implementation** - a Coaching Programme will be in place with an increased number of trained coaches, linking into the wider organisation **(workstream 2 ref:5)**
6	**Emotional Wellbeing support for staff** - every member of staff will be offered flexible and responsive support, at the right time, through the systematic availability of emotional support including signposting to additional services as appropriate **(worksream 1 ref:6)**
7	**Manager's Handbook** - will be available, describing key processes, systems and procedures to improve staff management and increase leadership skills **(workstream 1 ref:7)**
8	**Sickness theme analysis** - a procedure will be in place to explore and review sickness in different parts of the Division to identify any relevant themes, support requirements and identify interventions **(see workstream 1 ref:8)**
9	**Career pathway development -** there will be clearly defined career pathways, including development of an Apprenticeship Programme for A & C staff. **(Worksream 2 ref: 9)**
10	**Skills and competencies framework** - a description will be in place of what specific skills are required for staff groups working in the in distinct service areas and specialisms **(Workstream 2 ref: 10)**
11	**Training plan to address skill gaps and priority areas** - gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place **(Workstream 2 ref:11)**
12	**Demand and capacity analysis (whole system) -** Inpatient and Community services will be adequately resourced having the right staff, at the right time with the right skills **(see workstream 5 ref:12)**
13	**Comprehensive retention plan** will be in place with key milestones **(workstream1 ref:13**
14	**Estates** will be scoped to ensure adequate provision for current and future service needs. (linked to Estates Programme)
15	**MH&LD Joint Partnership Group Meeting** will be in place to colloboarate and engage with staff side reperesentative.
	Medium Priority - Long term (>12 months)
16	**MH&LD Staff Induction booklet** - describing key aspects of the Division and induction requirements will be available **(Workstream 2 ref: 16)**
17	**Leadership development opportunities** - a description of Leadership skills development opportunities and expectations will be developed and made available **(workstream 2 ref:17)**
18	**MH&LD TRiM support following incidents** - a process will be in place for supporting staff through incidents as well as the provision of emotional support, including post-incident support, and increasing TRiM support **(Workstream 1 ref:18)**
19	**Student feedback** - on MH&LD placements will be disseminated to all staff and reviewed by the MH&LD Workforce Group **(Workstream 2 ref: 19)**
20	**New Starter Questionnaire** - themes from the New Starter Questionnaires will be available and shared with the MH&LD Workforce Group, in addition to themes from Exit Interview **(Workstream 1 ref: 20)**
21	**Reflect & learn survey** - a clear description of themes collated from the 'MH&LD Reflect & learn survey' will be shared with staff in all services including the themes from the BCU staff survey to be incorporated into service plans **(see workstream 1 ref:21)**
22	**WW&U description** - there will be a clear description of how the WW&U Service links with the Respect & Resolution processes **(workstream 1 ref: 22)**

Benefit Number	**Organisation Benefits to be Delivered**
1	**Quality / Access / Patient Experience / Optimum Capacity / Staff Wellbeing** - staff retention will increase, applicants will increase and the number of vacancies will reduce.
2	**Quality / Staff Wellbeing** - targets for mandatory training , PADRs and supervision will improve by 5.7% against a Q1 20/21 baseline
3	**Staff Wellbeing / Optimum Capacity / Value assurance** - Relative reduction in the costs of the variable pay bill due to improved retention and sickness/ absence rates (in the context of predicted increases due to post Covid), decrease reliance on agency staffing and spend
4	**Staff Wellbeing / Optimum Capacity** - staff will report improvements in their work/ life balance and quality of their work experience
5	**Staff Wellbeing / Optimum Capacity -** MHLD will be viewed as an excellent employer which people want to work for, and stay with
6	**Quality / Patient Experience** - the Patient survey will show an improvement in patient experience when compared to a 19/20 baseline
7	**Staff Wellbeing / Optimum Capacity** - a process will be in place for supporting staff through any incidents
8	**Staff Wellbeing / Optimum Capacity** - Staff will be able to access coaching, counselling and emotional support through clearly defined routes and proactive input into staff emotional needs will be in place
9	**Quality / Staff Wellbeing / Optimum Capacity** - staff will be clear about what skills they should have for the specialisms they work in and managers will be able to plan skills development
10	**Staff Wellbeing / Optimum Capacity -** Divisional Managers will understand the impact of the WW&U Service
11	**Quality / Patient Experience / Staff Wellbeing / Optimum Capacity** - time and attention spent on activities and processes that do not require clinical skill will be reduced
12	**Quality / Access / Patient Experience / Staff Wellbeing / Optimum Capacity** - there will be an increase in applicants applying for Welsh Essential posts
13	**Staff Wellbeing / Optimum Capacity** - managers will demonstrate enhanced leadership qualities which will result in a reduction in grievances, disciplinary hearings etc. against a 19/20 baseline

PROGRAMME WORKSTREAMS		
Programme Reference	**Work stream**	**Description**
1	"Wellness, Work & Us" Service (WWU) + MH&LD Reflect and Learn Survey/BCU staff survey	Provide clarity about the services delivered and functioning of the WW&U Service over the next two years, and going forward. Understand the themes from the survey, capture you said, we did we are going to do themes and progress to actions
2	MH&LD Training & Development Group	Embed a cross-Divisional, multi-disciplinary approach to developing and agreeing skills development and provide clarity regarding mandatory training requirements
3	Recruitment & Development	Understand the journey of staff through the service and factors that impact on recruitment and retention, considering how the Reflect and Resolution policy can effectively support
4	Performance metrics	Establish KPI's, targets, metric's, monitor, review and reporting.
5	Establishment/Demand&Capacity Review	To complete Inpatient and Community service establishment review. Workforce Modelling

KEY RISKS TO DELIVERY (High risks only; for full risk details see programme risk log)	
Risk ID	**Description**
1	**Capacity for attending training** - staffing pressures may prevent attendance at training , workshops and meetings
2	**Unplanned costs for training** - unpredicted costs related to recruitment and training
3	**Pandemic / winter pressures response** - impact of Covid19 Pandemic and increased winter pressures may prevent staff from being released from their work areas
4	**Baseline information** - to establish KPIs may not be available and therefore may affect the ability to demonstrate tangible impact of interventions
5	**Capacity of programme team -** The capacity of the Workforce Work stream Group members
6	**Estates** - fit for purpose/capacity to enable new service recruitment
7	**Structure changes** - potential changes to MHLD Divisional structure may have an impact on the delivery

KEY ISSUES

Issue ID	Description	Likelihood	Consequence	Risk score	Mitigation	Residual Likelihood	Residual Consequence	Residual Risk Score	Owner	Open/ Closed
1	Capacity of leads? TBC							0		

HIGH LEVEL PLAN

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable Lead	RAG	Commentary

1. "Wellness, Work & Us" Service (WWU) - **Named Strategic Lead: Isabelle Hudgell**	6. Emotional Wellbeing support for staff & Staff Wellbeing	6.1	Set up / update working group to include the below actions:	Short Term	IH		
		6.2	To progress with Student counsellors to support MH&LD Counsellor, to enable continuation of counselling support and enable dedicated counselling support across the division, and to continue with the quantatitive and qualitative monitoring and reporting of the support provided		IH		
		6.3	Understand and describe the benefits and impact of implementing a Just Culture within the Division (SBAR)		IH		
		6.4	Senior leadership service visits		HOP's		
		6.5	Wellbeing sessions available to all staff		LM		
		6.6	Menopause support		IH		
		6.7	Review available Benefit packages and introduce additional staff benefits where feasible (Gym Membership, Financial Planning,Pension Advice, relationship Support)		IH		
		6.8	Review Child care support arrangements and assessthe feasibility of introducing support				
		6.9	Review Flexible working arrrangements and identify improvements to be implmented in line with staff requirements		?		
		6.10	Review current performance management / disciplinary processes and identify opportunities to improve the process within appropriate timescales		?		
	7. A manager's handbook will be available which describes key processes, systems and procedures	7.1	Consult with managers to identify workable solutions to support new leaders to engage in reflective solution-focused practise whilst developing emotional maturity and understanding	short term	IH/RJ		
		7.2	Create a working group to develop a manager's handbook (including newly appointed and experienced managers, 3rd year student, WW&U (links with Respect and Resolution Process?), Workforce)		IH/RJ		
		7.3	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		IH/RJ		
		7.4	Include Checklist of staff performane cycle including 1-2-1s, mid-year reviews, appraisals etc to support line managers to appropriately manage staff		MF		
		7.5	Include checklist of available staff policies / code of conduct to support line managers in supporting their staff		RJ		
	8. Sickness theme analysis to reduce absences	8.1	Establish subgroup to develop and implement action plan to reduce absences based on presenting themes	short term	LM/MF/GC	On going	
		8.2	Review sickness rates by department and reason				
		8.3	Identify themes based on above				
		8.4	Review / develop return to work discussion process		LM/MF/GC	On going	
	13. Develop a comprehensive retention plan	13.1	Identify staff turnover rates		IH		
		13.2	Identify staff attrition by role, department, service area, age		WW&U		
		13.3	Review themes from exit interviews		WW&U		
		13.4	Identify and analyse themes		WW&U		
		14.5	Identify subgroup to develop and implement action plan based on themes to increase retention rates		WW&U		
	15. MH&LD Joint Partnership Group Meeting -	15.1	Terms of Reference drafted		CE	Completed	
		15.2	Kick off meeting completed		CE	Completed	
		15.3	Terms of Reference approved by Group		CE	Completed	
		15.4	Workforce plan approved by Group		CTH		

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
	11. Gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place			Short Term	T & D Group	On going	
		11.1	Progress with WARRN training across the Division		RJ	On going	
		11.2	Roll out Risk Assessment scheme of HCA across the Division, which was piloted in Ty Llewelyn		RJ	On going	
		11.3	Progress with Suicide Awareness training course across the Division. Dates arranged for September and October 2022		RJ	On going	
		11.4	Convene training groups for service areas and identify clear training needs: Learning Disabilities SMS Forensic/Rehab Perinatal CHC Adult Inpatient MH Older Persons Inpatient MH Adult Community MH Older Persons Community MH Management		IH/HOPS	On going	
		11.5	Develop a training plan for all levels of the Division (and BCU where applicable) to move forward		T&D Group	On going	

2. MH&LD Training and Development Named Strategic Lead: Isabelle Hudgel and Robyn Jones	5. Coaching Programme implementation	5.1	Identify target audience for coaching eg. managers, staff in need etc	Medium Term	MF					
		5.2	Identify / articulate coaching programmes		MF					
		5.3	Clarify active coaches and their progress through training.		MF					
		5.4	Describe coaching activity across the Division		MF					
		5.5	Ensure a clear pathway is in place to receive and record coaching referrals		MF					
	10. Develop a skills & Competency framework	10.1	Identify roles that require a competency framework	Medium Term	IH/RJ					
		10.2	Map out the required skills and competencies required for those roles by engaging with relevant clinical governance channels		IH/RJ					
		10.3	Identify training requirements and available courses to achieve the required competencies		IH/RJ					
		10.4	Identify training plan for staff within those roles to be assessed and set timescales for staff to complete required training		IH/RJ					
	9. Career Pathway Development	9.1	Map out possible career pathway development for lower bands and A&C roles	Medium Term	IH/RJ					
		9.2	Identify available apprenticeship levy / funding		IH/RJ					
		9.3	Identify relevant training providers and courses to establish apprenticeship routes		IH/RJ					
		9.4	Identify support eg. functional skills to enable A&C and lower bandings to qualify for apprenticeship roles		IH/RJ					
		9.5	Develop apprenticeship policy and process detailing roles available within apprenticeship scheme		IH/RJ					
		9.6	Discuss / Further consideration for the career pathway of ANP post		IH/RJ					
		9.7	Discuss / scope further development of a career pathways for students		IH					
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable Lead**	**RAG**				
3. Recruitment & Development Named Strategic Lead: Claire Thomas-Hanna (TBC)	2b. Workforce Transformation	2b.1	Establish process / working group to redesign current workforce processes to increase capacity and identify new ways of working	**short term**						
		2b.2	Review current rostering arrangements and use of e-rostering to identify opportunities to ensure adequate service cover at all times							
		2b.3	Review current staff Bank process and identify opportunities to increase number of Bank staff and increase utilisation of Bank staff - scope possibility of joint staff Bank across the ICS							
		2b.4	Review opportunities to incentivise existing staff to cover additional shifts / join the Bank eg. part time staff; retirees etc							
		2b.5	Review Division application process and identify opportunities to streamline and enhance the process to reduce timescales and to attract more suitable candidates -review and revise application forms, asking relevant clear questions -review and articulate appropriate terms and conditions clearly in JDs eg. promote flexible working; training & development etc. -ensure language in JDs and PSs is inclusive to encourage applications from a diverse group of individuals -current HR support to issue offer letters, contracts, DBS and reference checks at pace							
		2b.6	Review equaities & diversity within the Division, reviewing WRES data, existing policies etc. to identify areas for improvement to ensure all staff groups feel included and report high satisfaction							
		2b.7	Review current use of volunteers and scope opportunities to increase / introduce volunteers							
		2b.8	Scope feasibility of enabling staff movement across the organisation / ICS to enable staff to move around at periods of high demand eg. digital staff passports							
		2b.9	Review staff communications across the Division and include relevant updates in existing bulletins to keep staff informed on priorities and plans to with a channel to enable them to provide feedback into plans							
		2b.10	Review staff work stations(including home working arrangements) to provide the necessary support to reduce the high level of absences as a result of back pain							
		2b.11	Update / Develop set templates to support managers to manage and have relevant conversations with their staff eg. 1:1s, mid year reviews, appraisal cycle, wellbeing conversation templates							
		2b.12	Produce a welcome pack for all new staff detailing good to know info about the organisation and division, who's who, code of conduct, policy check list, health & wellbeing offers, how to obtain advice etc.							
	3. Twelve month recruitment plan	3.1	Confirm budgeted establishment	**short term**	AJ	Completed				
		3.2	Determine gaps and identify vacancies		**GC/LM**					
		3.3	Break vacancies down by directorate, area, staff category, banding		**GC/LM**					
		3.4	Review service delivery priorities, incidents and areas of highest need		**GC/LM**					
		3.5	Produce recruitment plan in line with above factors prioritising areas with high vacancy rates and of high need with a focus on nursing, HCAs, A&C, Medical staffing		**CTH**					
		3.6	Obtain feedback from managers to include in plan		**CTH**					
		3.7	Obtain sign off from steering group		**CTH**					
		3.8	Obtain sign off from relevant organisation governance		**CTH**					
		3.9	Highligh in plan the need for all divisions to progress to timely recruitment		**AJ**					
		3.10	All areas to allocate recruitment to one dedicated lead to ensure vacancies progress timely. Current vacancy rate 150 wte, agree feasible vacancy rate		HOP's					

		3.11	Ensure MH&LD Divisional EC panel stood up every Monday as priority so all EC request discussed, agreed and approved timely	Short Term July2022	DSLT		
		3.12	Review and correct any budget errors impacting vacancy progress		HOP's.JG		
		3.13	Ensure all staff allocated to recruitment activities have the necessary access and skills for progressing vacancies at every stage of the process		HOP's		
		3.14	To include in local area Performance report compliance with Trac KPI;s to improve timeliness of recruitment		BSM's		
		3.15	Include in plan actions to reduce interims and fixed term posts		CTH		
		3.15a	Director of Operations to meet with each local area HOP and Finance to review current fixed term and seconded posts		CE		
		3.16	Progress with MH&LD Divisional proposed Operating Model.		DSLT		
	3a. Just R To deliver a 12 month, content led, digital campaign and marketing strategy to raise the profile of the opportunities in the MH&LD Division	3a.1	Create task and finish group with local area representative to ensure engagement and collaboration from across the Division.	Short Term July 2022	AJ		
		3a.2	Agree key milestones and deliverable of the marketing campaign, including the provision of weekly dashboard reporting		AJ		
		3a.3	Plan virtual and face to face recruitment events		AJ		
		3a.4	Progress with creation of digital campaign including creation of video, flyers, posters, photos, testimonials etc.		IH		
		3a.5	Review and agree governance process		CTH		
		3a.6	Agree performance reporting (KPI's) and review on a frequent and regular basis		AJ/CL		
	4. All welsh essential roles	4.1	Develop action plan for up to date, bilingual, appropriate JD's and PS's for every role across the Division which are stored in the BCUHB Job Library	short term	AJ		
		4.2	Ensure there are appropriate bilingual JDs and PSs for every role across the in the BCUHB Job Library		AJ		
		4.3	Ensure JDs and PSs for Welsh essential posts are not in breach of Welsh Language criteria		AJ		
		4.4	Ensure all JDs have appropriate CAEJ number, verified by the Job Evaluation team		AJ		
		4.5	For Welsh Essential posts insure Welsh speaker included on Interview panel, and one question asked in Welsh to ascertain the level of welsh accomplishment		AJ		
5. 'Staffing Establishment' review Named Strategic Lead: Adrian Jones, ADON	5. Develop 'whole system' Demand and Capacity model (establishment review completed for inpatient -> capacity next)	5.1	Review 'North Wales Population Health Needs Assessment (2022)' + identify population health drivers (projected population increase/decrease by age group and area)	30/07/2022	AdJ		
			Complete 'Demand and Capacity analysis' for each service (inputs, activities, caseload / staffing / beds, outputs) + repeat referrals / attendances / admissions	30/08/2022	AdJ		
			Complete referral / admission 'deep dive' for each service e.g. referrer, referrer type, referral reason etc	30/09/2022	AdJ		
			Complete repeat referral (primary/community) / presentation (ED) / admission 'deep dive' analysis for each service	30/09/2022	AdJ		
			Develop 'whole system D&C model' with agregated service information	15/10/2022	AdJ		
	Scope staffing competencies, develop 'evidence based skill matrix', gap analysis and recommendations	5.2	Review 'qualifications / competencies' for all staff in each service (HR records / staff survey)	30/10/2022	IH		
			Review evidence base of 'What Works For Whom' by primary presenting reason / diagnosis + develop evidence based skills matrix	30/10/2022	IH/AdJ		
			Complete staffing/skillset 'gap analysis' based on current + projected D&C + updated recommendations to inform training + recruitment strategy	30/11/2022	IH/AdJ		
6. Link into Estate's Leads	Include Estates Leads in workforce programmes	6	Understand the available Estate from which services are deivered Understand the impact of estate constraints on staff delivery of services Link estates leads into workforce plans in line with available estate	30/11/2022	CL/KH		

Medium Priority 12 Months

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
1. "Wellness, Work & Us" Service (WWU) - Named Strategic Lead: Isabelle Hudgell	18. TRIMM Support following incidents	18.1	Review Division incident logs	Short term	IH/Gov		
		18.2	Identify areas of support		WW&U		
		18.3	Liaise with TRIM to commission relevant support		IH/Safeguarding		
		18.4	Progress with the TRiM SBAR (2 day training) proposing the training of 8 MH&LD staff to enable timely and local support to staff post incidents		IH	Completed	
		18.5	Obtain relevant sign off		IH		
	20. New starter Questionnaire / exit interview questionnaire	20.1	Review / develop new starter questionnaire	Medium Term	WW&U	Completed	
		20.2	Review / develop exit questionnaire		WW&U	Completed	
		20.3	Analyse and identify themes		WW&U		
		20.4	Share themes with workforce group and identify actions to be taken forward		IH		
		20.5	Dependent upon required actions, establish subgroup		IH		
	21. Reflect & Learn Survery	21.1	Review, Reflect & learn themes and feedback to all staff in the form of 'You said, we did!'		IH		
	22. A WW&U Betsinet page will link into the BCU Wellbeing page	22.1	Ensure WW&U is represented on Betsinet Wellbeing pages		LO		
		22.2	Review Reflect & Learn themes and feedback to all staff in the form of 'You Said. We Did..."		IH		
		22.3	Review the actions aligned to the BCUHB Staff Survey to ensure local area action plans are developed to progress.		LO		
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable**	**RAG**	
		17.1	Create sub-group of the 'Training & Development Group' to review available Leadership and Management training opportunities		FE/IH		

2. Training and Development **Named Strategic Lead: Isabelle Hudgell**	17. Leadership Development Opportunities	17.2	Describe essential skills development for Divisional Leaders and represent in the Guidebook (which guide book?)	Medium Term	IH		
		17.3	Identify, describe and disseminate to all staff further development opportunities for enhancing leadership skills		IH		
		17.4	Identify training approach (self teaching, tutorial, seminar? etc),		IH		
	19. Student Feedback on placements	19.1	Identify departments that have had student placements	Medium Term	IH		
		19.2	Develop student survey and ensure all students are provided with a copy of the survey to complete		IH		
		19.3	Analyse survey and collate themes from responses		IH		
		19.4	Share with workforce group		IH		
		19.5	Develop and implement plan to improve student experience to encourage students to take up roles within the division		IH		
	16. MH&LD Staff Induction booklet	16.1	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		WW&U		
		16.2	Exit Interview and New Entry Questionnaire collating information to enhance learning staff experiences, retrospective from last 12 months		WW&U		
		16.3	To continue to progress indicatives, plans and progress with the MH&LD Joint Partnership group to ensure engagement, awareness, collaboration is held with staff side representative.		WW&U		
		16.4	Produce comprehensive Induction checklst for managers and new starters		WW&U		
		16.5	Identify process to obtain Badges, access pass, uniform etc.		WW&U		

KEY PERFORMANCE INDICATORS -

Metric Ref	Metric	Data Source	Incremental improvement trajectory - Go Live Septement 2022							Commentary
			Data @ 30/7/2021	Data as @ 30/04/2022	Baseline as @ 31/08/2022	2 months @31/10/2022	4 months @31/12/2022	6 months @28/02/2023	8 months @30/04/2023	
1	Number of Nursing vacancies as % of wte - showing a month by month reduction trend	Vacancy report	125.93WTE/ 43.65%	141.35WTE/ 43.41%						
	Number of HCA vacancies as a% of wte) - showing month by month reduction trend	Vacancy report	15.89%	17.54%						
	Number of Admina & Clerical vacancies as a % of wte) - showing a month by month reduction trend	Vacancy report	15.34%	11.16%						
	Number of Medical vacancies as a % of wte - showing a month by month reduction trend	Vacancy report	16.74%	15.38%						
2	Average number of applicants for Nursing posts internal/external.	Vacancy report	0.9	2						
	Average number of applicants for HCA internal/external	Vacancy report	3.5	4.4						
	Average number of applicants for A&C internal/external	Vacancy report	1.1	1.6						
	Average number of applicants for Medical internal/external	Vacancy report								
4	Of the candidates who applied ,% how many came from Just R	Power BI Dashboard								
5	No. from Just R digital campaign recruited to nursing posts ? (Consider Shortlisting rate for Trac applicants/candidate criteria?)	Just R								
	No. from Just R digital campaign recruited HCA posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Admin and clerical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Medical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
6	Success rate Nursing showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate HCA showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Admin and Clerical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Medical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
7	EC portal process - time taken for each approval stage?	LM								
8	TRAC KPI DATA Notice Date to Authorisation Start Date - % completed within time frame of 5 days	Power BI Dashboard								
9	TRAC KPI DATA Time to Approve Vacancy Request - % completed within timeframe of 10 days	Power BI Dashboard								
10	TRAC KPI DATA Time to Shortlist - % completed within timeframe of 3 days	Power BI Dashboard								

11	TRAC KPI DATA Time to Update Interview Outcomes - % completed within time frame of 3 days	Power BI Dashboard									
12	TRAC KPI DATA Time to Approve References - % completed within time frame of 2 days	Power BI Dashboard									
13	TRAC KPI DATA - Vacancy Creation to Conditional Offer - % completed within time frame of 44 days	Power BI Dashboard									
14	Geographical location of applicants - top 5 - split for staff groups	Power BI Dashboard									
16	Source of Applicants - top 5 - split for staff groups.	Power BI Dashboard									
19	Increase Number of Exit Interviews completed, target 100% completion.	WOD			Data?						
20	% Sickness rate across the MHLD - reduction trend (comparative against other areas in BCU)	ESR - staff absence report Jun '21 - May '22			**9.45 %**	8.45% April & may '22					
22	Overtime spend - planned reduction	Finance report									
23	Agency spend - planned reduction	Finance report									
24	Bank spend - planned reduction	Finance report									
26	Improve completion of Supervision for all staff groups from 2087 per year to 8000 per year	ESR			**693** **(3,036 for year)**						
27	Improve PADR achievement from 71.9% to 85%	ESR			**80.90%**						
28	Improve Mandatory Training achievement from 78.8% Target 85%	ESR			**78.00%**						
29	No of staff attending Suicide awareness (no. / % of clinical staff) (check with MS/AJ if any other key training to also include)	T & D group									
30	No of staff attending WARRN training (no. / % of clinical staff)	T & D group									

PROGRAMME ON A PAGE: HIGH LEVEL SUMMARY - DRAFT			
Mental Health and Learning Disabilities			**PLAN STATUS**
Executive Accountable Owner	Teresa Owen	TIMEFRAME FOR DELIVERY	**Plan Developed** 23/05/2022
Senior Responsible Owner	Carole Evanson		**Date Revised** 22/07/2022
Workforce Lead	Claire Thomas-Hanna		**Version** V0.16
Project Managers	See Workstream Leads below		

REPORTING FRAMEWORK
Divisional SLT Business
Divisional Workforce Group
OLM

APPROVALS				
DSLT	QIA	EQIA	DPIA	OLM

PROGRAMME OUTCOMES	
Outcome Number	**Outcomes to be Delivered**
	High Priority - Short Term (0-6 months)
1	**MH&LD Divisional Workforce plan** - will be in place, with agreed key milestones
2	**Workforce will be respected and empowered,** appropriately informed and trained and demonstrate the BCU values whilst supporting people with skill and compassion.
2a	**Culture** in the organisation will be improved.
2b	**Workforce Transformation - Service changes and developments** will be managed by inspirational and skilled leaders and the values of kindness and compassion will be central within the organisation **(workstream 3 ref: 2b)**
3	**Comprehensive recruitment plan (for priority groups)** - there will be a clear plan describing a recruitment plan for Nursing, HCA's, A & C and Medical staffing for the Division which will transform workforce recruitment from reactive to proactive **(workstream 3)**
3a	**Just R Marketing Campaign** will be in place, with agreed key milestones **(workstream 3 ref 3a)**
4	**Welsh Essential roles** will have appropriate Job Description and Person Specifications in place **(see workstream 3 ref: 4)**
5	**Coaching programme implementation** - a Coaching Programme will be in place with an increased number of trained coaches, linking into the wider organisation **(workstream 2 ref:5)**
6	**Emotional Wellbeing support for staff** - every member of staff will be offered flexible and responsive support, at the right time, through the systematic availability of emotional support including signposting to additional services as appropriate **(worksream 1 ref:6)**
7	**Manager's Handbook** - will be available, describing key processes, systems and procedures to improve staff management and increase leadership skills **(workstream 1 ref:7)**
8	**Sickness theme analysis** - a procedure will be in place to explore and review sickness in different parts of the Division to identify any relevant themes, support requirements and identify interventions **(see workstream 1 ref:8)**
9	**Career pathway development -** there will be clearly defined career pathways, including development of an Apprenticeship Programme for A & C staff. **(Worksream 2 ref: 9)**
10	**Skills and competencies framework** - a description will be in place of what specific skills are required for staff groups working in the in distinct service areas and specialisms **(Workstream 2 ref: 10)**
11	**Training plan to address skill gaps and priority areas** - gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place **(Workstream 2 ref:11)**
12	**Demand and capacity analysis (whole system) -** Inpatient and Community services will be adequately resourced having the right staff, at the right time with the right skills **(see workstream 5 ref:12)**
13	**Comprehensive retention plan** will be in place with key milestones **(workstream1 ref:13**
14	**Estates** will be scoped to ensure adequate provision for current and future service needs. (linked to Estates Programme)
15	**MH&LD Joint Partnership Group Meeting** will be in place to colloboarate and engage with staff side reperesentative.
	Medium Priority - Long term (>12 months)
16	**MH&LD Staff Induction booklet** - describing key aspects of the Division and induction requirements will be available **(Workstream 2 ref: 16)**
17	**Leadership development opportunities** - a description of Leadership skills development opportunities and expectations will be developed and made available **(workstream 2 ref:17)**
18	**MH&LD TRiM support following incidents** - a process will be in place for supporting staff through incidents as well as the provision of emotional support, including post-incident support, and increasing TRiM support **(Workstream 1 ref:18)**
19	**Student feedback** - on MH&LD placements will be disseminated to all staff and reviewed by the MH&LD Workforce Group **(Workstream 2 ref: 19)**
20	**New Starter Questionnaire** - themes from the New Starter Questionnaires will be available and shared with the MH&LD Workforce Group, in addition to themes from Exit Interview **(Workstream 1 ref: 20)**
21	**Reflect & learn survey** - a clear description of themes collated from the 'MH&LD Reflect & learn survey' will be shared with staff in all services including the themes from the BCU staff survey to be incorporated into service plans **(see workstream 1 ref:21)**
22	**WW&U description** - there will be a clear description of how the WW&U Service links with the Respect & Resolution processes **(workstream 1 ref: 22)**

Benefit Number	**Organisation Benefits to be Delivered**
1	**Quality / Access / Patient Experience / Optimum Capacity / Staff Wellbeing** - staff retention will increase, applicants will increase and the number of vacancies will reduce.
2	**Quality / Staff Wellbeing** - targets for mandatory training , PADRs and supervision will improve by 5.7% against a Q1 20/21 baseline
3	**Staff Wellbeing / Optimum Capacity / Value assurance** - Relative reduction in the costs of the variable pay bill due to improved retention and sickness/ absence rates (in the context of predicted increases due to post Covid), decrease reliance on agency staffing and spend
4	**Staff Wellbeing / Optimum Capacity** - staff will report improvements in their work/ life balance and quality of their work experience
5	**Staff Wellbeing / Optimum Capacity -** MHLD will be viewed as an excellent employer which people want to work for, and stay with
6	**Quality / Patient Experience** - the Patient survey will show an improvement in patient experience when compared to a 19/20 baseline
7	**Staff Wellbeing / Optimum Capacity** - a process will be in place for supporting staff through any incidents
8	**Staff Wellbeing / Optimum Capacity** - Staff will be able to access coaching, counselling and emotional support through clearly defined routes and proactive input into staff emotional needs will be in place
9	**Quality / Staff Wellbeing / Optimum Capacity** - staff will be clear about what skills they should have for the specialisms they work in and managers will be able to plan skills development
10	**Staff Wellbeing / Optimum Capacity -** Divisional Managers will understand the impact of the WW&U Service
11	**Quality / Patient Experience / Staff Wellbeing / Optimum Capacity** - time and attention spent on activities and processes that do not require clinical skill will be reduced
12	**Quality / Access / Patient Experience / Staff Wellbeing / Optimum Capacity** - there will be an increase in applicants applying for Welsh Essential posts
13	**Staff Wellbeing / Optimum Capacity** - managers will demonstrate enhanced leadership qualities which will result in a reduction in grievances, disciplinary hearings etc. against a 19/20 baseline

PROGRAMME WORKSTREAMS		
Programme Reference	**Work stream**	**Description**
1	"Wellness, Work & Us" Service (WWU) + MH&LD Reflect and Learn Survey/BCU staff survey	Provide clarity about the services delivered and functioning of the WW&U Service over the next two years, and going forward. Understand the themes from the survey, capture you said, we did we are going to do themes and progress to actions
2	MH&LD Training & Development Group	Embed a cross-Divisional, multi-disciplinary approach to developing and agreeing skills development and provide clarity regarding mandatory training requirements
3	Recruitment & Development	Understand the journey of staff through the service and factors that impact on recruitment and retention, considering how the Reflect and Resolution policy can effectively support
4	Performance metrics	Establish KPI's, targets, metric's, monitor, review and reporting.
5	Establishment/Demand&Capacity Review	To complete Inpatient and Community service establishment review. Workforce Modelling

KEY RISKS TO DELIVERY (High risks only; for full risk details see programme risk log)	
Risk ID	**Description**
1	**Capacity for attending training** - staffing pressures may prevent attendance at training , workshops and meetings
2	**Unplanned costs for training** - unpredicted costs related to recruitment and training
3	**Pandemic / winter pressures response** - impact of Covid19 Pandemic and increased winter pressures may prevent staff from being released from their work areas
4	**Baseline information** - to establish KPIs may not be available and therefore may affect the ability to demonstrate tangible impact of interventions
5	**Capacity of programme team -** The capacity of the Workforce Work stream Group members
6	**Estates** - fit for purpose/capacity to enable new service recruitment
7	**Structure changes** - potential changes to MHLD Divisional structure may have an impact on the delivery

KEY ISSUES

Issue ID	Description	Likelihood	Consequence	Risk score	Mitigation	Residual Likelihood	Residual Consequence	Residual Risk Score	Owner	Open/ Closed
1	Capacity of leads? TBC							0		

HIGH LEVEL PLAN

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable Lead	RAG	Commentary

1. "Wellness, Work & Us" Service (WWU) - **Named Strategic Lead: Isabelle Hudgell**	6. Emotional Wellbeing support for staff & Staff Wellbeing	6.1	Set up / update working group to include the below actions:	Short Term	IH		
		6.2	To progress with Student counsellors to support MH&LD Counsellor, to enable continuation of counselling support and enable dedicated counselling support across the division, and to continue with the quantatitive and qualitative monitoring and reporting of the support provided		IH		
		6.3	Understand and describe the benefits and impact of implementing a Just Culture within the Division (SBAR)		IH		
		6.4	Senior leadership service visits		HOP's		
		6.5	Wellbeing sessions available to all staff		LM		
		6.6	Menopause support		IH		
		6.7	Review available Benefit packages and introduce additional staff benefits where feasible (Gym Membership, Financial Planning,Pension Advice, relationship Support)		IH		
		6.8	Review Child care support arrangements and assessthe feasibility of introducing support				
		6.9	Review Flexible working arrrangements and identify improvements to be implmented in line with staff requirements		?		
		6.10	Review current performance management / disciplinary processes and identify opportunities to improve the process within appropriate timescales		?		
	7. A manager's handbook will be available which describes key processes, systems and procedures	7.1	Consult with managers to identify workable solutions to support new leaders to engage in reflective solution-focused practise whilst developing emotional maturity and understanding	short term	IH/RJ		
		7.2	Create a working group to develop a manager's handbook (including newly appointed and experienced managers, 3rd year student, WW&U (links with Respect and Resolution Process?), Workforce)		IH/RJ		
		7.3	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		IH/RJ		
		7.4	Include Checklist of staff performane cycle including 1-2-1s, mid-year reviews, appraisals etc to support line managers to appropriately manage staff		MF		
		7.5	Include checklist of available staff policies / code of conduct to support line managers in supporting their staff		RJ		
	8. Sickness theme analysis to reduce absences	8.1	Establish subgroup to develop and implement action plan to reduce absences based on presenting themes	short term	LM/MF/GC	On going	
		8.2	Review sickness rates by department and reason				
		8.3	Identify themes based on above				
		8.4	Review / develop return to work discussion process		LM/MF/GC	On going	
	13. Develop a comprehensive retention plan	13.1	Identify staff turnover rates		IH		
		13.2	Identify staff attrition by role, department, service area, age		WW&U		
		13.3	Review themes from exit interviews		WW&U		
		13.4	Identify and analyse themes		WW&U		
		14.5	Identify subgroup to develop and implement action plan based on themes to increase retention rates		WW&U		
	15. MH&LD Joint Partnership Group Meeting -	15.1	Terms of Reference drafted		CE	Completed	
		15.2	Kick off meeting completed		CE	Completed	
		15.3	Terms of Reference approved by Group		CE	Completed	
		15.4	Workforce plan approved by Group		CTH		

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
	11. Gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place			Short Term	T & D Group	On going	
		11.1	Progress with WARRN training across the Division		RJ	On going	
		11.2	Roll out Risk Assessment scheme of HCA across the Division, which was piloted in Ty Llewelyn		RJ	On going	
		11.3	Progress with Suicide Awareness training course across the Division. Dates arranged for September and October 2022		RJ	On going	
		11.4	Convene training groups for service areas and identify clear training needs: Learning Disabilities SMS Forensic/Rehab Perinatal CHC Adult Inpatient MH Older Persons Inpatient MH Adult Community MH Older Persons Community MH Management		IH/HOPS	On going	
		11.5	Develop a training plan for all levels of the Division (and BCU where applicable) to move forward		T&D Group	On going	

2. MH&LD Training and Development Named Strategic Lead: Isabelle Hudgel and Robyn Jones	5. Coaching Programme implementation	5.1	Identify target audience for coaching eg. managers, staff in need etc	Medium Term	MF					
		5.2	Identify / articulate coaching programmes		MF					
		5.3	Clarify active coaches and their progress through training.		MF					
		5.4	Describe coaching activity across the Division		MF					
		5.5	Ensure a clear pathway is in place to receive and record coaching referrals		MF					
	10. Develop a skills & Competency framework	10.1	Identify roles that require a competency framework	Medium Term	IH/RJ					
		10.2	Map out the required skills and competencies required for those roles by engaging with relevant clinical governance channels		IH/RJ					
		10.3	Identify training requirements and available courses to achieve the required competencies		IH/RJ					
		10.4	Identify training plan for staff within those roles to be assessed and set timescales for staff to complete required training		IH/RJ					
	9. Career Pathway Development	9.1	Map out possible career pathway development for lower bands and A&C roles	Medium Term	IH/RJ					
		9.2	Identify available apprenticeship levy / funding		IH/RJ					
		9.3	Identify relevant training providers and courses to establish apprenticeship routes		IH/RJ					
		9.4	Identify support eg. functional skills to enable A&C and lower bandings to qualify for apprenticeship roles		IH/RJ					
		9.5	Develop apprenticeship policy and process detailing roles available within apprenticeship scheme		IH/RJ					
		9.6	Discuss / Further consideration for the career pathway of ANP post		IH/RJ					
		9.7	Discuss / scope further development of a career pathways for students		IH					
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable Lead**	**RAG**				
3. Recruitment & Development Named Strategic Lead: Claire Thomas-Hanna (TBC)	2b. Workforce Transformation	2b.1	Establish process / working group to redesign current workforce processes to increase capacity and identify new ways of working	**short term**						
		2b.2	Review current rostering arrangements and use of e-rostering to identify opportunities to ensure adequate service cover at all times							
		2b.3	Review current staff Bank process and identify opportunities to increase number of Bank staff and increase utilisation of Bank staff - scope possibility of joint staff Bank across the ICS							
		2b.4	Review opportunities to incentivise existing staff to cover additional shifts / join the Bank eg. part time staff; retirees etc							
		2b.5	Review Division application process and identify opportunities to streamline and enhance the process to reduce timescales and to attract more suitable candidates -review and revise application forms, asking relevant clear questions -review and articulate appropriate terms and conditions clearly in JDs eg. promote flexible working; training & development etc. -ensure language in JDs and PSs is inclusive to encourage applications from a diverse group of individuals -current HR support to issue offer letters, contracts, DBS and reference checks at pace							
		2b.6	Review equaities & diversity within the Division, reviewing WRES data, existing policies etc. to identify areas for improvement to ensure all staff groups feel included and report high satisfaction							
		2b.7	Review current use of volunteers and scope opportunities to increase / introduce volunteers							
		2b.8	Scope feasibility of enabling staff movement across the organisation / ICS to enable staff to move around at periods of high demand eg. digital staff passports							
		2b.9	Review staff communications across the Division and include relevant updates in existing bulletins to keep staff informed on priorities and plans to with a channel to enable them to provide feedback into plans							
		2b.10	Review staff work stations(including home working arrangements) to provide the necessary support to reduce the high level of absences as a result of back pain							
		2b.11	Update / Develop set templates to support managers to manage and have relevant conversations with their staff eg. 1:1s, mid year reviews, appraisal cycle, wellbeing conversation templates							
		2b.12	Produce a welcome pack for all new staff detailing good to know info about the organisation and division, who's who, code of conduct, policy check list, health & wellbeing offers, how to obtain advice etc.							
	3. Twelve month recruitment plan	3.1	Confirm budgeted establishment	**short term**	AJ	Completed				
		3.2	Determine gaps and identify vacancies		**GC/LM**					
		3.3	Break vacancies down by directorate, area, staff category, banding		**GC/LM**					
		3.4	Review service delivery priorities, incidents and areas of highest need		**GC/LM**					
		3.5	Produce recruitment plan in line with above factors prioritising areas with high vacancy rates and of high need with a focus on nursing, HCAs, A&C, Medical staffing		**CTH**					
		3.6	Obtain feedback from managers to include in plan		**CTH**					
		3.7	Obtain sign off from steering group		**CTH**					
		3.8	Obtain sign off from relevant organisation governance		**CTH**					
		3.9	Highligh in plan the need for all divisions to progress to timely recruitment		**AJ**					
		3.10	All areas to allocate recruitment to one dedicated lead to ensure vacancies progress timely. Current vacancy rate 150 wte, agree feasible vacancy rate		HOP's					

		3.11	Ensure MH&LD Divisional EC panel stood up every Monday as priority so all EC request discussed, agreed and approved timely	Short Term July2022	DSLT		
		3.12	Review and correct any budget errors impacting vacancy progress		HOP's.JG		
		3.13	Ensure all staff allocated to recruitment activities have the necessary access and skills for progressing vacancies at every stage of the process		HOP's		
		3.14	To include in local area Performance report compliance with Trac KPI;s to improve timeliness of recruitment		BSM's		
		3.15	Include in plan actions to reduce interims and fixed term posts		CTH		
		3.15a	Director of Operations to meet with each local area HOP and Finance to review current fixed term and seconded posts		CE		
		3.16	Progress with MH&LD Divisional proposed Operating Model.		DSLT		
	3a. Just R To deliver a 12 month, content led, digital campaign and marketing strategy to raise the profile of the opportunities in the MH&LD Division	3a.1	Create task and finish group with local area representative to ensure engagement and collaboration from across the Division.	Short Term July 2022	AJ		
		3a.2	Agree key milestones and deliverable of the marketing campaign, including the provision of weekly dashboard reporting		AJ		
		3a.3	Plan virtual and face to face recruitment events		AJ		
		3a.4	Progress with creation of digital campaign including creation of video, flyers, posters, photos, testimonials etc.		IH		
		3a.5	Review and agree governance process		CTH		
		3a.6	Agree performance reporting (KPI's) and review on a frequent and regular basis		AJ/CL		
	4. All welsh essential roles	4.1	Develop action plan for up to date, bilingual, appropriate JD's and PS's for every role across the Division which are stored in the BCUHB Job Library	short term	AJ		
		4.2	Ensure there are appropriate bilingual JDs and PSs for every role across the in the BCUHB Job Library		AJ		
		4.3	Ensure JDs and PSs for Welsh essential posts are not in breach of Welsh Language criteria		AJ		
		4.4	Ensure all JDs have appropriate CAEJ number, verified by the Job Evaluation team		AJ		
		4.5	For Welsh Essential posts insure Welsh speaker included on Interview panel, and one question asked in Welsh to ascertain the level of welsh accomplishment		AJ		
5. 'Staffing Establishment' review Named Strategic Lead: Adrian Jones, ADON	5. Develop 'whole system' Demand and Capacity model (establishment review completed for inpatient -> capacity next)	5.1	Review 'North Wales Population Health Needs Assessment (2022)' + identify population health drivers (projected population increase/decrease by age group and area)	30/07/2022	AdJ		
			Complete 'Demand and Capacity analysis' for each service (inputs, activities, caseload / staffing / beds, outputs) + repeat referrals / attendances / admissions	30/08/2022	AdJ		
			Complete referral / admission 'deep dive' for each service e.g. referrer, referrer type, referral reason etc	30/09/2022	AdJ		
			Complete repeat referral (primary/community) / presentation (ED) / admission 'deep dive' analysis for each service	30/09/2022	AdJ		
			Develop 'whole system D&C model' with agregated service information	15/10/2022	AdJ		
	Scope staffing competencies, develop 'evidence based skill matrix', gap analysis and recommendations	5.2	Review 'qualifications / competencies' for all staff in each service (HR records / staff survey)	30/10/2022	IH		
			Review evidence base of 'What Works For Whom' by primary presenting reason / diagnosis + develop evidence based skills matrix	30/10/2022	IH/AdJ		
			Complete staffing/skillset 'gap analysis' based on current + projected D&C + updated recommendations to inform training + recruitment strategy	30/11/2022	IH/AdJ		
6. Link into Estate's Leads	Include Estates Leads in workforce programmes	6	Understand the available Estate from which services are deivered Understand the impact of estate constraints on staff delivery of services Link estates leads into workforce plans in line with available estate	30/11/2022	CL/KH		

Medium Priority 12 Months

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
1. "Wellness, Work & Us" Service (WWU) - Named Strategic Lead: Isabelle Hudgell	18. TRIMM Support following incidents	18.1	Review Division incident logs	Short term	IH/Gov		
		18.2	Identify areas of support		WW&U		
		18.3	Liaise with TRIM to commission relevant support		IH/Safeguarding		
		18.4	Progress with the TRiM SBAR (2 day training) proposing the training of 8 MH&LD staff to enable timely and local support to staff post incidents		IH	Completed	
		18.5	Obtain relevant sign off		IH		
	20. New starter Questionnaire / exit interview questionnaire	20.1	Review / develop new starter questionnaire	Medium Term	WW&U	Completed	
		20.2	Review / develop exit questionnaire		WW&U	Completed	
		20.3	Analyse and identify themes		WW&U		
		20.4	Share themes with workforce group and identify actions to be taken forward		IH		
		20.5	Dependent upon required actions, establish subgroup		IH		
	21. Reflect & Learn Survery	21.1	Review, Reflect & learn themes and feedback to all staff in the form of 'You said, we did!'		IH		
	22. A WW&U Betsinet page will link into the BCU Wellbeing page	22.1	Ensure WW&U is represented on Betsinet Wellbeing pages		LO		
		22.2	Review Reflect & Learn themes and feedback to all staff in the form of 'You Said. We Did..."		IH		
		22.3	Review the actions aligned to the BCUHB Staff Survey to ensure local area action plans are developed to progress.		LO		
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable**	**RAG**	
		17.1	Create sub-group of the 'Training & Development Group' to review available Leadership and Management training opportunities		FE/IH		

2. Training and Development **Named Strategic Lead: Isabelle Hudgell**	17. Leadership Development Opportunities	17.2	Describe essential skills development for Divisional Leaders and represent in the Guidebook (which guide book?)	Medium Term	IH		
		17.3	Identify, describe and disseminate to all staff further development opportunities for enhancing leadership skills		IH		
		17.4	Identify training approach (self teaching, tutorial, seminar? etc),		IH		
	19. Student Feedback on placements	19.1	Identify departments that have had student placements	Medium Term	IH		
		19.2	Develop student survey and ensure all students are provided with a copy of the survey to complete		IH		
		19.3	Analyse survey and collate themes from responses		IH		
		19.4	Share with workforce group		IH		
		19.5	Develop and implement plan to improve student experience to encourage students to take up roles within the division		IH		
	16. MH&LD Staff Induction booklet	16.1	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		WW&U		
		16.2	Exit Interview and New Entry Questionnaire collating information to enhance learning staff experiences, retrospective from last 12 months		WW&U		
		16.3	To continue to progress indicatives, plans and progress with the MH&LD Joint Partnership group to ensure engagement, awareness, collaboration is held with staff side representative.		WW&U		
		16.4	Produce comprehensive Induction checklst for managers and new starters		WW&U		
		16.5	Identify process to obtain Badges, access pass, uniform etc.		WW&U		

KEY PERFORMANCE INDICATORS -

Metric Ref	Metric	Data Source	Incremental improvement trajectory - Go Live Septement 2022							Commentary
			Data @ 30/7/2021	Data as @ 30/04/2022	Baseline as @ 31/08/2022	2 months @31/10/2022	4 months @31/12/2022	6 months @28/02/2023	8 months @30/04/2023	
1	Number of Nursing vacancies as % of wte - showing a month by month reduction trend	Vacancy report	125.93WTE/ 43.65%	141.35WTE/ 43.41%						
	Number of HCA vacancies as a% of wte) - showing month by month reduction trend	Vacancy report	15.89%	17.54%						
	Number of Admina & Clerical vacancies as a % of wte) - showing a month by month reduction trend	Vacancy report	15.34%	11.16%						
	Number of Medical vacancies as a % of wte - showing a month by month reduction trend	Vacancy report	16.74%	15.38%						
2	Average number of applicants for Nursing posts internal/external.	Vacancy report	0.9	2						
	Average number of applicants for HCA internal/external	Vacancy report	3.5	4.4						
	Average number of applicants for A&C internal/external	Vacancy report	1.1	1.6						
	Average number of applicants for Medical internal/external	Vacancy report								
4	Of the candidates who applied ,% how many came from Just R	Power BI Dashboard								
5	No. from Just R digital campaign recruited to nursing posts ? (Consider Shortlisting rate for Trac applicants/candidate criteria?)	Just R								
	No. from Just R digital campaign recruited HCA posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Admin and clerical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Medical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
6	Success rate Nursing showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate HCA showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Admin and Clerical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Medical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
7	EC portal process - time taken for each approval stage?	LM								
8	TRAC KPI DATA Notice Date to Authorisation Start Date - % completed within time frame of 5 days	Power BI Dashboard								
9	TRAC KPI DATA Time to Approve Vacancy Request - % completed within timeframe of 10 days	Power BI Dashboard								
10	TRAC KPI DATA Time to Shortlist - % completed within timeframe of 3 days	Power BI Dashboard								

11	TRAC KPI DATA Time to Update Interview Outcomes - % completed within time frame of 3 days	Power BI Dashboard									
12	TRAC KPI DATA Time to Approve References - % completed within time frame of 2 days	Power BI Dashboard									
13	TRAC KPI DATA - Vacancy Creation to Conditional Offer - % completed within time frame of 44 days	Power BI Dashboard									
14	Geographical location of applicants - top 5 - split for staff groups	Power BI Dashboard									
16	Source of Applicants - top 5 - split for staff groups.	Power BI Dashboard									
19	Increase Number of Exit Interviews completed, target 100% completion.	WOD			Data?						
20	% Sickness rate across the MHLD - reduction trend (comparative against other areas in BCU)	ESR - staff absence report Jun '21 - May '22			**9.45 %**	8.45% April & may '22					
22	Overtime spend - planned reduction	Finance report									
23	Agency spend - planned reduction	Finance report									
24	Bank spend - planned reduction	Finance report									
26	Improve completion of Supervision for all staff groups from 2087 per year to 8000 per year	ESR			**693** **(3,036 for year)**						
27	Improve PADR achievement from 71.9% to 85%	ESR			**80.90%**						
28	Improve Mandatory Training achievement from 78.8% Target 85%	ESR			**78.00%**						
29	No of staff attending Suicide awareness (no. / % of clinical staff) (check with MS/AJ if any other key training to also include)	T & D group									
30	No of staff attending WARRN training (no. / % of clinical staff)	T & D group									

TIER 4: PHASED IMPLEMENTATION OF IMPROVEMENTS - HI LEVEL GANTT

Following prioritisation exercise, the improvement plan will commence with those 'must do' improvements

Key:
- In progress
- Complete
- Not yet started

	Week beginning	20-Jun-22	27-Jun-22	04-Jul-22	11-Jul-22	18-Jul-22	25-Jul-22	01-Aug-22	08-Aug-22	15-Aug-22	22-Aug-22	29-Aug-22	05-Sep-22	12-Sep-22	19-Sep-22	26-Sep-22	03-Oct-22	10-Oct-22	17-Oct-22
	Week Number	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*
Preparatory phase	Agree scope & main workstreams																		
	Commit to Programme methodology and taxonomy			Completed															
	SRO agreed			Completed															
	Programme Director appointed																		
	Committed additional programme support																		
	workstream leads agreed with dedicated time																		
	sub-streams agreed																		
	sub-streams PIDs in place																		
Stream 1	Workstream 1: Fundamentals of Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 2	Workstream 2: Leadership, empowerment, culture and OD																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 3	Workstream 3: Safe Care & Effective Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 4	Workstream 4: Individual & Timely Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 5	Workstream 5: Environment & Resource																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 6	Workstream 6: Audit, outcomes & assurance																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		

Phases

Teitl adroddiad: ***Report title:***	YGC Improvement Plan (Central IHC Journey to Excellence)
Adrodd i: ***Report to:***	Quality, Safety & Experience
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides a standing update on the progress being made with regards to Targeted Intervention (TI) at Ysbyty Glan Clwyd, and the evolution of the plan to a wider Central Integrated Health Community approach which is now being referred to as the Journey to excellence, reflecting the ambition of longer term goals. As previously outlined the plan is bringing a structured methodoogy to improvement work, supported by the Transformation and Improvement team and with dedicated senior on-site leadership and expertise through the Programme Director for Clinical Safety Improvement. The initial delivery of the plan has been delineated into shorter term assurance activities knows as the “sprint” phase, and heavily focused on the evidence required for HIW and as part of the TI maturity matrix, with a separate stream around the longer term transformational work to address root causes and implement sustainable solutions for the future. There has been regular liaison between WG colleagues and the Programme Director, along with other executive colleagues, and this was supplemented by a site visit from WG to see the work of the team in action. This work has provided an increasing amount of confidence that the foundations are in place with the previously described “shifting sands” now beginning to solidify. As this work draws towards its intended closure point a robust analysis has taken place to ensure activities have been delivered, and bringing a transition into the longer term work. This process has identified 2 actions around Children and Young People that remain outstanding and are being focused upon. With our historic challenges around embedding any improvements in mind, an audit plan is also being drawn up. This will be led by the Site Medical Director and the IHC Associate Director of Nursing to ensure that actions remain embedded into daily practice, and signs of regression can be identified and addressed at the earliest opportunity. A new cycle of meetings for the transformation phase has just commenced and progressed and will be described in the next report.

Argymhellion: ***Recommendations:***	The committee is asked to endorse the approach being taken and note the progress to date and consider how the framework being implemented can be replicable across BCU.			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Chris Stockport, Executive Director Transformation, Strategic Planning, and Commissioning; Gill Harris, Deputy CEO and Executive Director of Integrated Clinical Services (SRO)			
Awdur yr Adroddiad: ***Report Author:***	Gaynor Thomason, Programme Director Clinical Safety Improvement Geraint Parry, Quality Improvement Fellow, YGC			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	6 goals for Urgent and Emergency Care			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This plan addresses the improvements identified as being required by HIW.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A – standing update paper			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A – standing update paper			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	(CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping			

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Additional support is being provided through Improvement Cymru and the Institute for HealthCare Improvement (IHI) along with additional resource local. The finance implications are a standing item on the agenda for the YGC Improvement Group that reports into Cabinet, and expenditure is being closely monitored.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Any workforce implications arising as the Improvement Plan progresses will be addressed through linkages with the respective EDGs and Executive Team.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been through an iterative development within the IHC and all the activities described within are subject to scrutiny at the YGC Improvement Group, chaired by the SRO.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Continue to embed new systems and processes for managing improvements, and link in with colleagues across BCU for wider connectivity.	
Rhestr o Atodiadau: Appendix 1 – YGC Improvement Plan ***List of Appendices:*** Appendix 1 – YGC Improvement Plan	

Quality, Safety and Experience Meeting
1st November
YGC Improvement Plan (Central IHC Journey to Excellence)

1. Introduction / Background

This report is part of a regular update relating to the YGC site which is currently subject to Welsh Government Targeted Intervention arrangements. It sets out progress since the last update and how plans are maturing into a wider Integrated Health Community (IHC) plan, referred to as the Journey to Excellence.

2. Body of report

What has changed / what have we developed since the last update?
The predominant focus over the last period has been the intense scrutiny of the evidence in relation to the HIW requirements and ensuring regulatory requirements of the Targeted Intervention Maturity Matrix are met. There has been regular and ongoing dialogue internally between operational / clinical teams and the Health Board's governance team, supplemented by a series of meetings with Welsh Government and HIW, led by the Programme Director for Clinical Safety Improvement.

In addition to the submission of evidence there has been continual verbal updates, ensuring external stakeholders are fully briefed at each stage, understanding the progress and challenges, and able to provide contemporaneous challenge if required. Formal presentations have also taken place to HIW colleagues, augmented by a visit from Welsh Government officials to observe activities, and view the latest iterations of the improvement room on site and how this is evolving to ensure staff engagement.

Whilst the work of the "sprint" phase has been the priority, simultaneously the team have been developing the foundations for the journey to excellence phase, which was formally launched with a series of sessions on the 5th September with over 100 staff in attendance across 3 sessions. Crucially, this launch was across the IHC and marked an important part of the improvement journey in extending the approach beyond the acute site, identifying opportunities for more integrated solutions, aligned to the new operating model. As an example of this improved collaboration a later workshop ensued, led by community colleagues, exploring how actions taken to reduce conveyances and admissions to hospital are working, reviewing the discharge pathway and ensuring effective utilisation of resources.

Supplementing these sessions, September also saw the inception of the new Medical Integrated Board, a new collegiate clinical forum with HMT and Transformation attendance. A key distinction of the new forum is that it will not be led by an individual in a formal leadership role, but from within the ranks as a body working collaboratively to deliver change, and in conjuntion with the HMT and wider IHC leadership team and is a critical step in the journey around leadership, culture and OD. This group is also attended by Dr Alcolado, who has now commenced as Medical Improvement Director and key strands of early work will be around changing the acute medical model.

Workforce challenges remain at the forefront of activities and there has been a series of meetings with corporate workforce colleagues and the Programme Director to establish the current position with high risk vacancies and co-ordinate activities to mitigate risks. This work will be presented to the YGC improvement group, chaired by the Deputy CEO on the 20th October, and subsequently to Cabinet on the 3rd November, with a diverse

approach to our recruitment activities being promoted. Building upon the workforce theme, recent meetings have also taken place with corporate colleagues around developing the concept of a Betsi MDT approach, where corporate teams take a joint approach to supporting challenges in operational services. Led by the Transformation Director, this work is leaning upon learning that has already emerged from work in YGC and how to ensure that cross cutting themes run through each of our workstreams in an embedded manner.

There is some positive news with regards to recruitment of ED Consultants with 3 individuals successful at interview during September. Job plans are currently being worked through, overseen by the Office of the Medical Director, to ensure a smooth transiton into the organisation for these individuals.

An important strand of recent work has been around ensuring connectivity between activities in YGC/Central IHC and the wider Heath Board, ensuring that as new systems and processes are developed that early learning is shared and can be replicated across the organisation. This has included collaboration around the development of metrics for success, which also identified opportunities for how these metrics could be weaved into the Primary Care Away Day. This has later extended to conversations with colleagues in East and West around the programme set up and opportunities for shared learning, which will also include an MDT visit from YG colleagues to YGC.

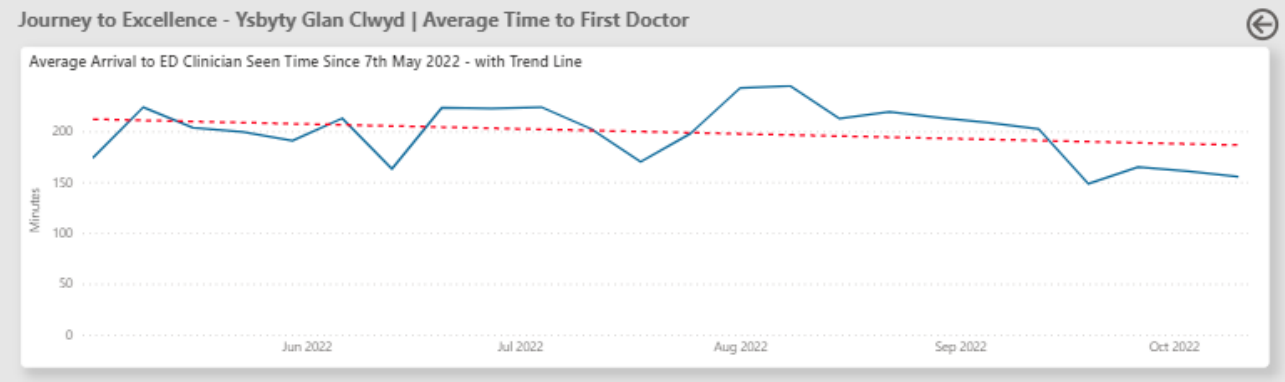
A key action arising out of the YGC improvement group was to develop a local mock inspection process, which was implemented first in ED, and following review and iteration was then deployed to vascular. This process, including colleagues from our sister sites, provided an important independent assessment of issues, ensuring identification ahead of external inspection, and will become an important process moving forward and one to be shared across all sites.

The support from the Institute for HealthCare Improvement (IHI) and Improvement Cymru is a key strand of working, and during September the IHI coaching for Improvement course began with 10 members of staff going through the course. A further 26 names have already been identified for the Leading for Improvement programme and these will form the backbone of our longer term sustainable change through an upskilled workforce. This is also being augmented through a specific programme of coaching for the IHC leadership team, co-ordinated through our own workforce department. Improvement Cymru have also begun their onsite work around Real Time Demand and Capacity.

In addition to the mock inspection, a range of work continues to take place for vascular, including work to transition the current action plan into a format compatible with the journey to excellence process. As the sprint phase comes to a close this is an area where the Programme Director for Clinical Safety Improvement will begin to provide an increased amount of oversight. Discussions around dual operating policy out of hours have progressed with a policy approved, and work is now ongoing around the practical implications of this. Work has also progressed around the development of a diabetic foot pathway.

What Improvements has this led to?

As part of the iterative cycle of improvement the START model in ED continues to evolve and go through tests of change. The diagnostics element of the process is working well and leading to improved pathway progression with strong linkage between the triage process and the critical task of tracking investigations. The ability to protect the rooms for ambulatory care is also leading to improved turnaround, and this is demonstrated in the following chart where over the past few weeks the average time to see a doctor has gradually reduced from a high point of 4hrs 4 minutes to 2hrs 35 minutes in the week commencing 10th October.



Recent weeks have seen a noticable improvement in medical engagement, facilitated through the aforementioned Medical Integrated Board. Whilst the formal meeting cycle is intended to be monthly, in kick-starting the work of the forum, weekly meetings have occurred, spurred by a desire within the group to help shape change and work in collaboration with the leadership team. In particular engagement around the progression of a new medical model is gathering momentum with proactive plans being developed, and a strong peer to peer challenge for colleagues to bring forward solutions and a desire to engage with resolving problems.

A stronger clinical focus in winter planning is also evident with clinicians engaging with our colleagues from Lightfoot around opportunities to manage seasonal pressures in a different way. An early practical example of changes in ways of working is the commencement of more formal specialty in-reach to ED each morning, helping to improve earlier decision making and reducing transit times within ED.

These less tangible measures are a critical part of our improvement journey, reflecting the methodology being deployed where our cross cutting workstreams (eg. Leadership and culture) are running through the core of each of our clinical improvement packages, and the early signs are encouraging with a palpable sense on the site that a corner is being turned and site wide engagement evident.

This is further reflected in a recent press visit to the site, meeting with colleagues in ED and the site management team and observing daily processes to manage pressure on the site. This resulted in a very positive press article which articulated the improved morale of staff on the shop floor. Importantly this feedback vindicated the approach that has been undertaken with the improvement work, where an over-arching process has been put in place and a framework to deliver success, but one that facilitates a bottom-up approach that engages staff in the change. Small, incremental steps of change have taken place, and this is reaping rewards with staff in the service owning the changes.

This approach has led to an improved atmosphere and morale, and is providing a better workplace environment for staff, which in turn leads to improved and safer patient care.

More specifically, the visit reassuringly highlighted that staff were fully accepting that mistakes had been made, and that there was no denial of the problem or any evidence of a blame culture. Staff were focused now on rectifying mistakes and had even reflected that whilst entering targeted intervention had been a humbling experience that in practice it had actually proved to be a positive impact for the site, and provided a spur that had brought everything into sharper focus and actually brought everyone together across the site which hadn't been evident previously. Staff had also reflected that it hadn't taken one substantial shift but more importantly a series of smaller yet significant changes and that the visibility of leadership had improved with staff being supported to enact the changes that they know are needed.

This is further reflected in the following data where the increasing number of 12hrs stays in ED has been halted, and begun to see a slight reduction. At this stage, utilising recognised improvement methodologies, it is too early to describe this as a recognisable improvement with too few data points, but nevertheless an encouraging sign of some of the "green shoots" of recovery and a critical area of focus for our overall success, as a decompressed ED is a key lever to many of our wider success criteria, with strong interdependencies for system success.

What are our concerns?

Whilst the START model is beginning to embed, the crowding in the Emergency Department still persists and the START area is being noted as the only place available to see patients which creates challenges for doctors in competing for clinical space to undertake appropriate and dignified assessment. It is also evident that the system does not function as highly overnight when senior decision making is reduced, and this will be reviewed further, along with the requirement for more options to be available to stream patients away from the ED.

Recent insights to the improvement group have also continued to highlight the pressing problem across the site of long length of stay patients, and the impact that this has on risk continuing to be compressed within ED. This will continue to be a key focus of activities as the journey to excellence phase begins to accelerate.

Achieving consistency across Board Rounds remains a perennial challenge and remains high amongst priorities. With support from Digital colleagues, various training materials and videos are being pulled together and this will feature amongst the work Dr Alcolado is focused upon, utilising feedback from recent audits. The importance of this is reflected both in the lack of enough early flow for ED and also that discussions are highlighting

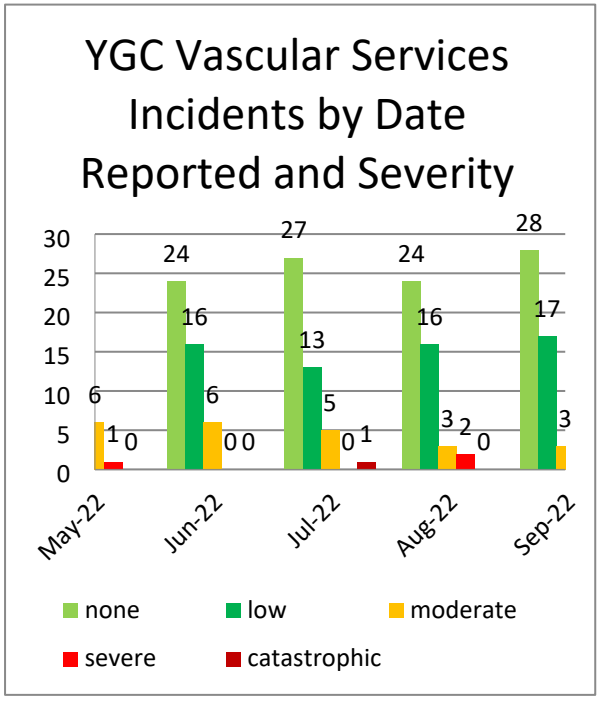
that discharges that take place post midday are considered to be less safe, including those transferred to Community Hospital.

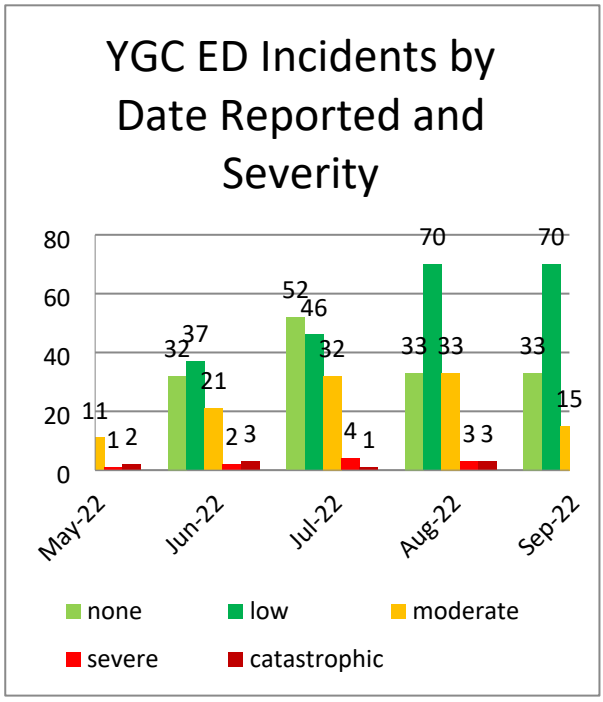
Work around SDEC has highlighted various challenges in relation to Radiology and a range of issues are being worked through, with a particular focus upon communication and administration issues to ensure smooth running and a seamless service for patients. In addition, issues remain around the ability for ANP's to request certain tests which causes significant issues given that the SDEC service is heavily built upon ANP's as opposed to junior doctors.

Activities within the workforce sphere remain a concern with critical vacancies in high risk areas. There is a requirement for a reconciliation between HR data and finance held data to ensure absolute synergy, and a pressing need for the pace and diversity of our recruitment activities to progress, with at this stage the range of our work not as mature as we would desire. This is the key focus for the an upcoming Improvement group meeting to address the issues and alleviate any concerns.

There also remains some concern around the safety huddles. Whilst significant progress has been made and evidence of good huddles occurring there is variable consistency across huddles which requires addressing. This is a recognised phenomena in change implementation and one that has been identifed through the audit type activities taking place, and this will lead to a focused piece of remedial work with the teams to ascertain the challenges, and ensure good practice is being spread right across the team.

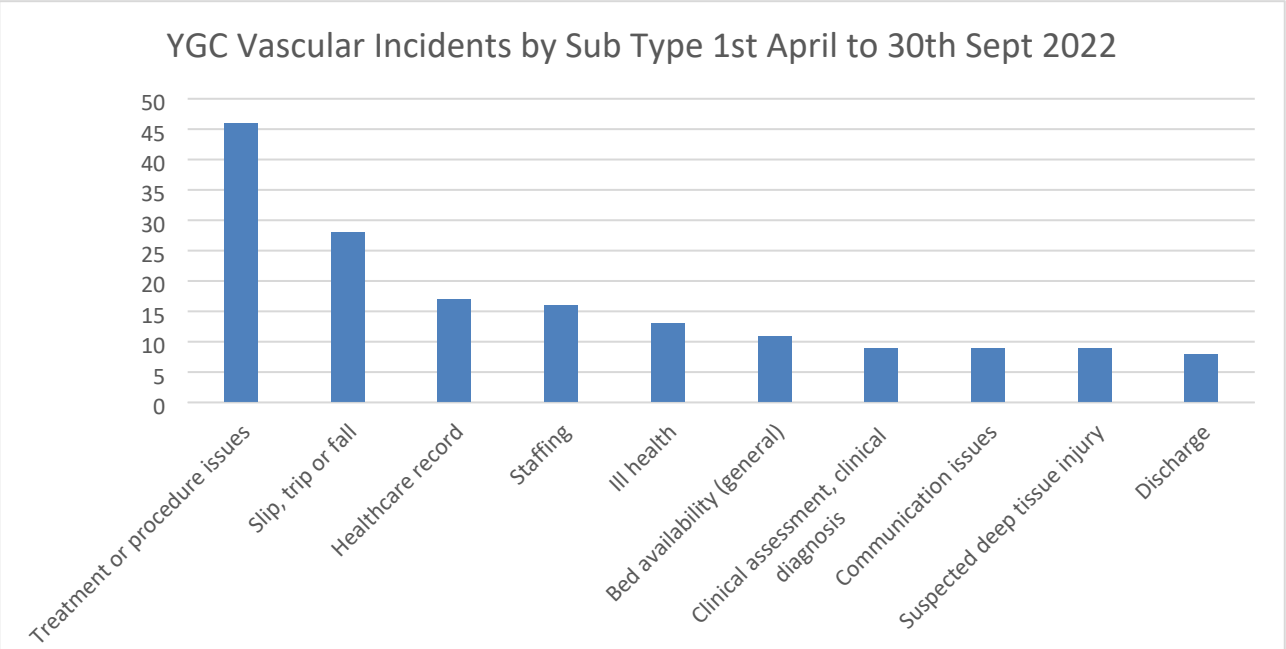
In triangulating risks we also continue to review our incidents, with ED and vascular incidents by grade reflected in the charts below.Whilst more data points are required for increased assurance, incidents in the 3 highest graded categories are demonstrating lower numbers. An increased number of lower graded incidents is evident in ED and will be investigated further in line with standard processes, however this may be reflective of increased engagement and reporting, and that learning from these more minor incidents and near misses is beginning to be noted.

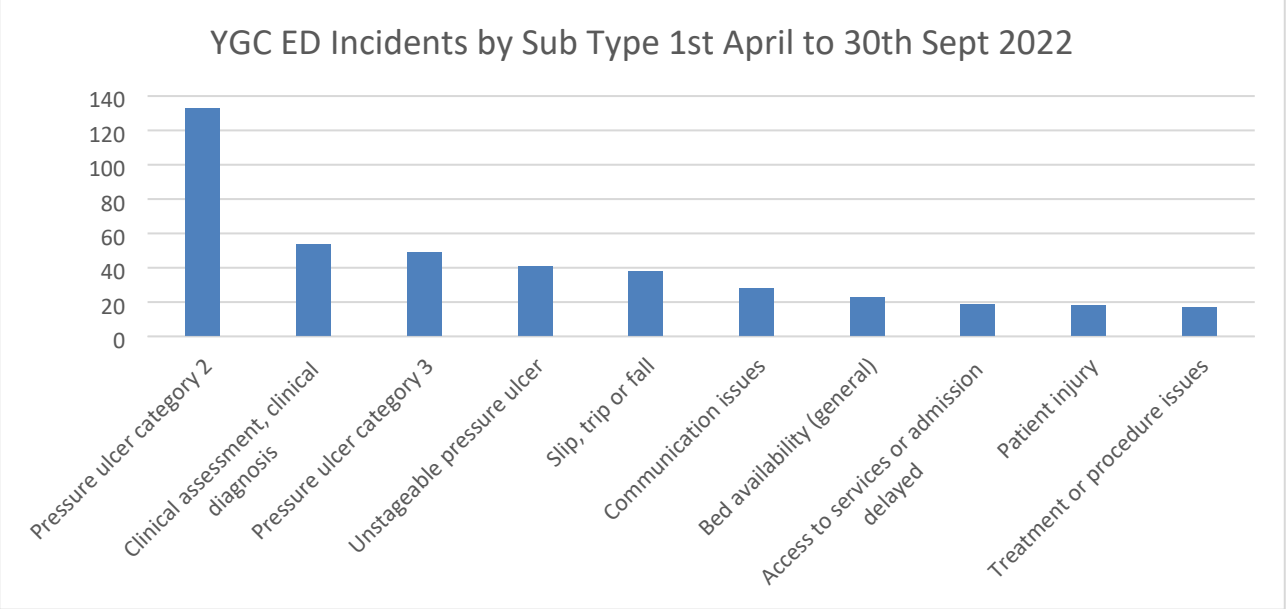




Note: Where Aug and Sep data match, these have been verified

In addition to monitoring trends a more detailed review of themes is undertaken reviewing the reasons for incidents and fed into learning and teaching. Whilst in vascular treatment or procedure issues is the most common reason, within ED pressure ulcers remains the most common reason for incidents, with the majority of these being evident upon arrival.





What is the focus for the next period?

The main focus for the coming period will be to embed the new 6 weekly programme cycle and ensure robust project management arrangements, and the tracking of actions through each cycle. This will involve beginning to embed the metrics into the programme cycle, ensuring they are reviewed through each meeting, objectively identifying what is working, and where challenges are arising ensuring appropriate course correction.

Building upon a number of the areas identifed as being of the concern, the following activities will be taken forward

- Reviewing the workforce and rostering for START

- Exploring the concept of ‘Clinically Ready to Proceed’
- Undertake training with staff around how to better prepare patients from SDEC who need Radiology tests
- Reviewing sign off processes for ANP’s when requesting CT’s
- Reviewing an ENT and Orthopaedic pathway for SDEC
- A focus on embedding 7 day working in SDEC

Building upon recent work around Vascular, further work will be undertaken around a Vascular transition plan, supported by the arrival of a programme manager. This involves translating the existing action plan from the Royal College of Surgeons review, correlating this with the actions from Vascular Quality Panel and undertaking a thematic review akin to the proess that was undertaken for the wider YGC plan. Key to this is ensuring that the cross cutting themes run through the vascular plan in the same manner, and leads are being identified to take forward the various strands of work.

The first set of project meetings related to planned care took place in the week commencing 10th October and this work will accelerate during the next period. Groundwork has taken place around outpatient utilisation , using the 6-4-2 model which specifies expectations around booking 6, 4 and 2 weeks prior to the clinic. The upcoming work will be focused around clinical engagement and ensuring adherence to the 6 weeks leave policy. This same methodology is being mirrored for theatre management with similar themes prevalent and the development of a SOP to be undertaken. In terms of effective pathway management and ensuring that patients receive appropriate preparation for surgery a review of the pre-operative assessment process is planned, which is key to underpinning a reduction in elective cancellations.

Following concerns around Never Events, work has taken place around the World Health Organisation (WHO) checklist over the past few months. The groundwork has been focused around audit of current practice and testing engagement with the process and this will now be broadened and a wider group of stakeholders brought into the project. A WHO improvement group will be set up to address the issues highlighted around compliance, standardise the checklist and update work on process mapping, and the development of a ‘hot’ checklist process for emergency scenarios.

As the new operating model begins to settle in further work will be undertaken around the governance framework and how decisions will be made. A draft framework is in development with a proposal for an IHC Transformation Board and further dialogue will take place around how these proposals will align with BCU wide groups and link into the cabinet. The IHC leadership team will also begin to formalise their leadership walkabouts with a series of visits planned across the YGC site.

Building upon the recent discussions regarding collaboration and ensuring connectivity across all areas of BCU an MDT visit from a team at Ysbyty Gwynedd is also planned to share the learning thus far and ensure that where opportunities for improvement are identified that they can be deployed BCU wide without waiting lengthy periods to review and that 2-way shared learning can ensue.

Additionally, the development of a wider more targeted recruitment campaign will take place, led by workforce colleagues and overseen by the YGC Improvement Group.

3. *Budgetary / Financial Implications*

There are no specific budgetary implications associated with this paper. Finance is a standing item on the YGC Improvement Group agenda, chaired by the SRO and expenditure is being tracked closely through this group.

4. Risk Management

The following risks are established corporate risks.

CRR Ref 3873 – Inability to deliver safe, timely and effective care

CRR 20.06 – Record keeping

More recently a further risk around the pay for locums has been added to the YGC improvement risk register.

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications***

Not applicable

Teitl adroddiad: ***Report title:***	Vascular Services Update
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022
Crynodeb Gweithredol: ***Executive Summary:***	This paper is to update the committee on the improvements in the quality, safety and experience in the vascular service, and to summarise key operational and planning issues of relevance. Longitudinal clinical outcome data is providing assurance of improvement.
Argymhellion: ***Recommendations:***	The committee is asked to Note the progress in the vascular improvement plan and the imminent move to using a maturity matrix to monitor progress Note the progress which has been made to stabilise the consultant workforce, improve the clinical leadership of the service and further develop relationships with peer services. Note the assurance arising from longitudinal clinical outcome data. Note that current Emergency, Preparedness, Resilience and Response (EPRR) framework is likely to become unnecessary soon (but that it will remain as an option if the situation becomes more fragile). Note the review of vascular services by Healthcare Inspectorate Wales is now due to take place in December 2022. Note the issue of a Prevention of Future Deaths report following an inquest into the death of a patient with ischaemic lower limbs.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director

Awdur yr Adroddiad: ***Report Author:***	Dr Emma Hosking, Acting Deputy Executive Medical Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Prevention of future deaths notice to be issued. The Vascular Service requires significant improvement under the HIW NHS escalation process. The Health Board is working closely with professional regulators.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not required at this time			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required at this time			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The CRR and EPRR are continually updated to reflect the current situation.			

	CRR22-25: risk of failure to provide full vascular service due to lack of available consultant workforce CRR22-26: Risk of significant patient harm because of sustainability of the acute vascular service
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Covered in the IMTP
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The planned changes to the workforce are supportive of the existing staff and will increase sustainability further.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	None currently
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 1.1 Failure to consistently provide safe provision of care to patients at YGC, resulting in significant harm to patients, poor patient experience and a high number of complaints and claims, as well as a loss of public confidence
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** **1. Vascular improvement plan** ***2.*** **Vascular risk register**	

Quality, Safety and Experience Committe
1 November 2022

North Wales vascular Service improvement plan update

Introduction

The health board implemented a hub and spoke model for vascular services in April 2019. The model has been supported by the Royal College of Surgeons (RCS) and Welsh Government.

The health board commissioned a review from the RCS in 2020 to assess the quality of the new service and this resulted in two reports published in 2021 and 2022. After the second report the health board convened a vascular quality review panel (VQRP) with internal and external subject matter experts.

In November 2021 the vascular steering group (VSG) was formed and now monitors the vascular improvement plan (VIP). The VSG has lay and Community Health Council members.

The independent chair of the VQRP has escalated specific concerns to the executive medical director throughout the process and these have been dealt with via formal governance processes.

This paper summarises the progress against several key actions in the vascular improvement plan. In future, the maturity matrix tool will be used to monitor improvement. The tool will enable the health board to understand the level of improvement needed within the vascular services, identify strengths and weaknesses, set out the shared purpose, focus of the vascular priorities, and identify common themes and issues on the transformation journey.

The matrix highlights the essential steps for success and provides reassurance that the focus is on the right priorities, simultaneously bringing areas into the forefront that will require more focused support and attention. The wider team can share knowledge and use this to identify the right areas for investment.

Current situation

The Vascular Network Nurse Director has started a thematic analysis of the key areas in the VIP and the VQRP reports, using the Systems Engineering Initiative of Patient Safety (SEIPS). This tool uses a “Human Factors” based approach and will support prioritising the key actions, transformation and service redesign needed to embed processes that optimise patient safety.

Work has also commenced on a review of all the serious incidents with the aim of theming them, understanding the root cause of the recurrent issues, putting actions and systems in place to reduce the top five incidents and ensuring the lessons are shared and change embedded.

Documentation

Weekly audits have shown a marked improvement in notes entries and consent processes. Initial clerking entries in the emergency department need to improve further.

MDT discussions

Stoke now provide support to BCU surgeons for MDT discussions regarding all patients who need aortic surgery.

Vascular improvement plan (VIP)

The format of the VIP is changing to a maturity matrix. The service is making steady progress against the actions.

Patient safety and experience

An incident in March 2022 originally described as a never event has been downgraded following investigation. There were no serious or catastrophic incidents in September. The vascular helpline remains available.

Amputation rates and outcomes

The major amputation incidence is now stable with mortality and caseloads centrally placed compared to other UK units. The annual incidence of major amputation is within reported norms of 5-25 per 100K patients per year. The data does not support the perception that the amputation rates have increased since the network started, or that they are out of step with other UK vascular services.

Inter-hospital transfer

The newly established intra-hospital transfer group is addressing the key clinical risks associated with delays in WAST (Welsh Ambulance Service Trust) transfers between the three hospitals. The coroner praised the action plan in the inquest on October 18th in which she recorded a narrative verdict with respect to the death of a patient with bilateral ischaemic limbs secondary to blood clot in the aorta.

Resilience of the service and the EPRR arrangements

The service is now more resilient and there are nine consultant surgeons taking part in the on-call rota. Out of hours operating on patients who need aortic surgery is extremely rare. Peer support from Stoke is established. Following careful review, it is likely that the current dual on-call arrangements will cease alongside the improvement of middle grade support out of hours. The EPRR support is also likely to be unnecessary soon thanks to the stability which now exists, but this can be re-instated at short notice if required.

Budgetary / Financial Implications

There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the surgical directorate at Glan Clwyd Hospital.

Risk Management

There are three risks on the CRR linked to vascular services: CRR22-25: risk of failure to provide full vascular service due to lack of available consultant workforce.

CRR22-26: Risk of significant patient harm because of sustainability of the acute vascular service.

CRR22-30: Risk that a lack of robust and consistent leadership can contribute to the safety and quality concerns.

Teitl adroddiad: ***Report title:***	Patient Safety Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Dr Kath Clarke, Assistant Director of Patient Safety Sarah Musgrave, Patient Safety Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There is confidence in the data provided in the report, however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N/A

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Safety Report	

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

Patient Safety Report to the QSE Committee August-September 2022

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University Health Board

Patient Safety Report
August 2022 - September 2022

INTRODUCTION

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

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

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

Definitions

The following definition of a nationally reportable patient safety incident applies:

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

The timescale for reporting such incidents nationally is within seven working days.

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

Never Events are defined as patient safety incidents that are preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened because of a specific incident for that incident to be categorised as a Never Event. Information on Never Events are detailed in a separate section further in the report

NATIONALLY REPORTABLE INCIDENTS (NRI) – PERFORMANCE

During August and September 2022, 25 nationally reportable incidents were reported to the Delivery Unit. There has been no significant change in the number of reportable incidents since the previous report for June and July 2022.

The following table provides a breakdown of NRIs per health community/service:

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
Health Community West: YG	1	3	1	9	0	8	2	3	0	1	3	6	37
Health Community West: Primary and Community	0	1	1	1	0	5	1	0	0	0	2	0	11
Health Community Central: YGC	2	3	3	6	8	4	4	2	6	4	3	3	48
Health Community Central: Primary and Community	0	3	1	2	3	3	0	0	0	0	0	1	13
Health Community East: WMH	1	6	4	0	0	6	0	1	1	3	2	0	24
Health Community East: Primary and Community	0	2	1	1	0	2	0	0	2	1	0	1	10
Women's and Midwifery	0	3	3	0	0	1	0	0	1	2	1	1	12
Diagnostics and Clinical Support	1	0	0	0	0	0	0	1	0	0	0	0	2
Cancer Services	0	0	1	0	1	0	0	0	0	0	0	0	2
Mental Health and Learning Disability	1	0	1	1	0	1	0	0	0	0	1	1	6
Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	6	21	16	20	12	30	7	7	10	11	12	13	165

There has been a gradual increase in reportable incidents since April 2022, with Health Community West, Ysbyty Gwynedd accounting for 9 of the 25 reportable incidents in the reporting period. However, the position remains lower than the previous year. The main themes continue to be falls, healthcare acquired pressure ulcers (HAPUs) and recognition and escalation of the deteriorating patient.

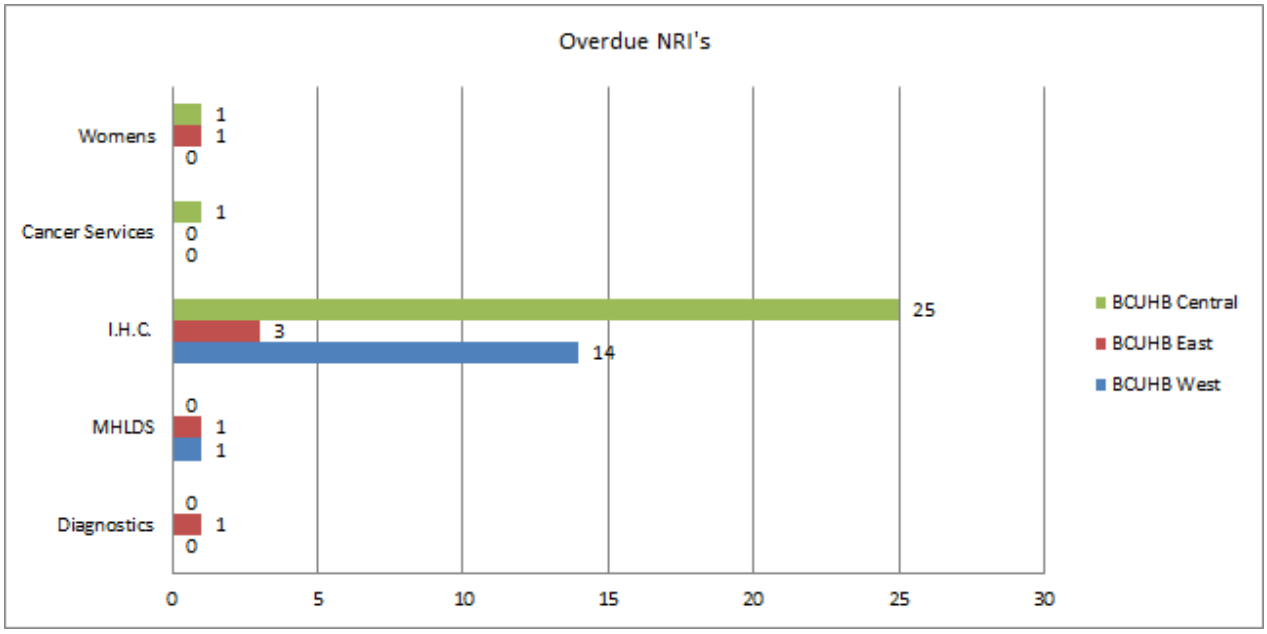
The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population.

Time period	BCUHB incidents/100,000 population	All Wales incidents/100,000 population
Oct/Nov 2021	3.8	3.0
Dec /Jan 2022	4.3	3.2
Feb/March 2022	6.2	3.8
April /May 2022	2.9	2.9
June/July 2022	3.4	2.7
Aug/Sept 2022	3.8	3.3
AVERAGE	**4.0**	**3.1**

Given the small numbers involved, and the reporting requirements for certain incidents which can fluctuate, the average should be considered a more useful comparison than an individual two-month period.

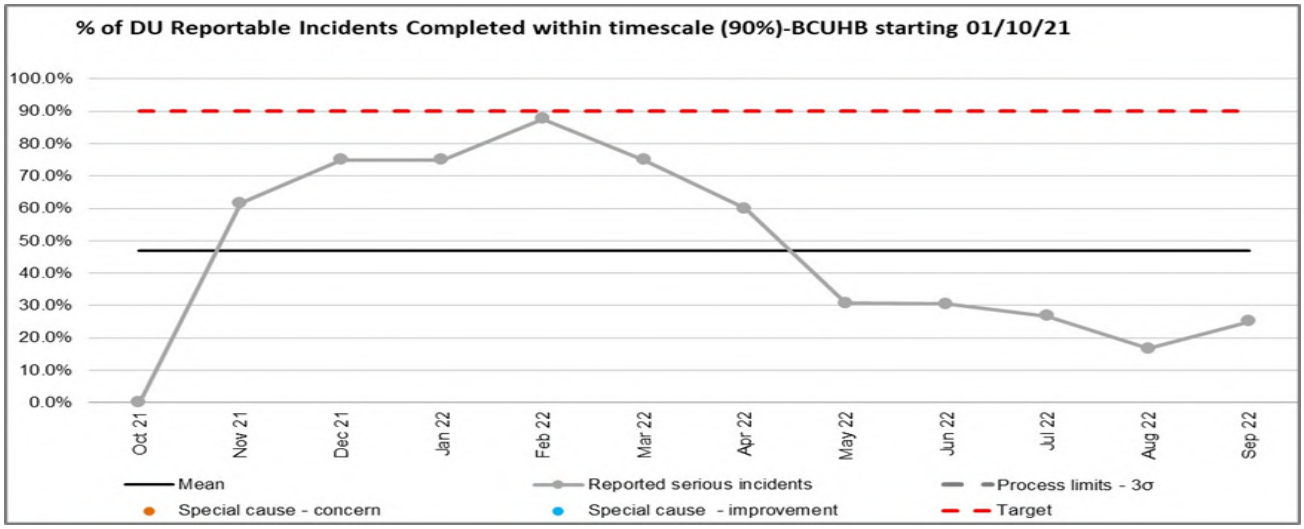
In addition to the above mentioned nationally reportable incidents, there were 22 Early Warning Notifications (EWN) reported, 15 of which were in relation to healthcare associated infections (Clostridium difficile & Covid-19 outbreaks) and two of which were PRUDIC incidents. The other notifications relate to incidents that may attract media attention.

At the time of writing, the total number of national reportable incidents open is 76 of which 48 are overdue.



Overall investigation closure rate within timeframe was 16.7% in August, increasing slightly to 25% in September. Weekly reports highlight the divisional performance.

Recognising the delays to full investigations, the Patient Safety Team continue to place particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.



NATIONALLY REPORTED INCIDENTS (NRI) – LEARNING

There were 25 NRIs, for the two-month time period covered in this report. The NRIs recorded during this period can be broken down as follows

Falls n=5
Grade 3 or above Health Acquired Pressure Ulcer n=4
Health Community Acquired Infection (resulting in death) n=1
Delay in diagnosis n =6
Deteriorating patient n=4
Death in custody n=1
Incident of unusual circumstance n=1
Never Event n=3

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and a proportionate investigation. The learning and actions from each are recorded on the Datix Cymru Safety management system.

During August and September 14 RLP meetings took place into the most serious incidents.

The sharing of learning from incidents (beyond the immediate service) is achieved through clinical governance/quality meetings and networks, and through safety alerts where appropriate.

The system sharing and embedding of learning remains a risk for the organisation (and is contained on the Board Assurance Framework). Plans are in place to strengthen the extracting, sharing, and embedding of learning to include:

- A weekly 'Harm Free Care' Meeting
- A new "lessons learned" on a page template
- A new Monthly Patient Safety Bulletin
- A new central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process
- A new organisation-wide Learning Forum.

Themes identified from Nationally Reported Incidents (excluding Never Events)

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). Currently, the following are the identified themes:

- Recognition and escalation of deteriorating patient
- Falls
- Healthcare acquired pressure ulcers (HAPU)

These three theme areas are underpinned by a recurring issue of record keeping, that whilst not directly causal to an incident occurring, is contributory to the circumstances that create unsafe conditions.

Never Events, whilst being a sub-set of Nationally Reportable Incidents, are detailed separately in a section below.

The following section provides a summary of some of the themes and the actions underway.

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=8)

There have been four incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. One in Wrexham Maelor Hospital, two in Ysbyty Gwynedd and one in women's services.

Over the last year, the following related incidents were reported as NRIs:

Recognition and escalation of deteriorating patient	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
YGC	0	1	2	4	2	1	3	2	3	1	0	0	19
WMH	1	0	0	0	0	2	0	0	0	0	1	0	4
YG	1	2	0	1	0	3	1	0	0	0	2	2	12
Central Area	0	0	0	0	1	0	0	0	0	0	0	0	1
Womens	0	0	0	0	0	1	0	0	0	0	1	0	2
Total	2	3	2	5	3	7	4	2	3	1	4	2	38

The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR Group) was set up in March 2022 to investigate the rapidly Totalchanging environment of Sepsis recognition, and to then improve the process of auditing Sepsis management across the Health Board through a task and finish process. After summer break the group is keen to complete the updated response to Sepsis.

The group has discussed the mechanism of observation-triggered review and agreed on the NEWS+ scoring system that accounts for the conscious level of patients as part of the established early warning score. Minor modifications will be made to the current observation chart.

The next task will be to look at the deteriorating patient with NEWS+ >=3 and decide how to define the probability of Sepsis within that group of patients. A screening tool has been proposed which incorporates recommendations from NICE and the AoMRC (Academy of Medical Royal Colleges) statement. Once this has been approved in the STEAR group it will be forwarded fro board approval and implementation will then begin.

Sub-theme identified: endoscopy

A theme was identified with regards to delay in diagnosis of patients who had an endoscopy carried out by an insourced company. This was because of the belief that an endoscopy

had been completed with the scope reaching the caecum, however this has subsequently been proven not to be the case. As a result, patients may have come to harm due to delay in diagnosis. Plans are in place to meet with the insourcing company to discuss the next clinical steps, for example and audit of colonoscopy reports across the insourcing cohort.

Falls (n=5)

Within the reporting period there were a total of 5 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is a reduction from 9 in the previous period This is broken down as follows:

Central Acute (3), West Acute (2)

Over the last year, the following falls were reported as NRIs:

Reportable falls	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
YGC	1	1	1	2	4	2	0	0	1	2	1	1	16
WHM	0	1	3	0	0	2	0	1	1	2	0	0	10
YG	0	0	1	7	0	2	1	3	0	0	1	1	16
Central Area	0	0	0	0	2	1	0	0	0	0	0	0	3
East Area	0	0	0	0	0	0	0	0	2	1	0	0	3
West Area	0	0	0	1	0	3	1	0	0	0	0	0	5
MHLD	0	0	0	0	0	1	0	0	0	0	0	0	1
Cancer Services	0	0	1	0	0	0	0	0	0	0	0	0	1
Total	1	2	6	10	6	11	2	4	4	5	2	2	55

On review of initial learning from these incidents, there are ongoing themes that can be identified that contribute to these falls:

- Staff oversight
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells
- Reliance on alarm equipment
- No lying and standing BP taken.

Immediate actions include localised training and the increasing of awareness through sharing incidents details. The impact of this awareness and training is then monitored and measured through the ward accreditation process.

There were 6 investigation reports relating to falls during this period that were approved following a review at the Incident Learning Panel.

An update from the Health Board's Falls Strategic Group is detailed below:

- The implementation of the bedside learning model has been introduced to each IHC. The approach has been well received by the leads and wards who are extremely supportive and are fully engaged with this ward based model to learning in real time with the real challenges our patients and environments pose. The model does require significant resource (Staff) to implement successfully, which the IHC are struggling to resource consistently to give significant momentum, due to the increasing challenges moving into the winter period.

- The Strategic Inpatient Falls group are unable to provide the assurance that the bedside learning model is currently being implemented with pace. There is a risk that the Health Board will not meet the expectations of the HSE in terms of risk assessment and interventions for every adult Inpatient, should a revisit by HSE take place. More so, our patients and staff are at risk of harm in addition to Health Board reputation. Corporate team members, who have the sufficient skills and expertise are therefore supporting where possible to mitigate this risk, whilst discussions are underway by Executives to assess the feasibility establishment of an MDT for each IHC. .

- The issue of risk assessment completion and implementation of identified actions has been escalated to the Corporate Risk Register and is going through the scrutiny stages.

- Following a review of availability and accessibility to 'Flat lifting' equipment by the Health Board Health and Safety team, it has been highlighted that there is no access to flat lifting equipment within the Wrexham Maelor and Ysbyty Gwynedd. 'Flat lifting' equipment is patient handling equipment designed to raise a patient from the floor following a fall that ensures spinal control is maintained, and if the patient has a suspected hip fracture following a fall. The current practice in these areas relies on staff having the knowledge on how to use the 'scoop' from the Emergency Department and locating a minimum of eight staff to manually lift patient safely from the floor. This can be challenging if the patient has a higher body weight or is a bariatric patient.

- The Welsh Government published Standards for the Provision of Services to People with Overweight and Obesity in Wales. The document outlines proposed standards for Health Boards and their partners to deliver equitable and effective care to those who are overweight or obese in Wales in line with the All Wales Weight Management Pathway. BCUHB is required to report against the delivery of these standards twice a year to Welsh Government. Standard 3 - *'People with higher body weights are treated with dignity and respect and do not feel stigmatised due to a lack of appropriate equipment or facilities. This includes patient transport and emergency* services' is particularly relevant to patient safety and quality. In response to the requirement to implement and report on the delivery of this standard, an internal BCUHB group has been established led by the Public Health department to begin mapping how the health board is delivering against this priority and the improvements that are required to ensure these patients are treated with dignity and respect.

- Falls dashboards have been developed within the current Datix incident management system as an interim to support wards with access to their falls data easily. This is a temporary solution following the break in the data feed to the Health Board reporting mechanism Nursing Information Intelligence Portal (NIIP) since the implementation of the current version of Datix. It is still unclear when the national solution will be completed, the Health Board Informatics team are aware and involved in seeking a solution.

Grade 3 or above healthcare associated pressure ulcer (n=4)

Within the reporting period there were a total of 4 grade 3, grade 4 or ungradable healthcare associated pressure ulcers reported to the Delivery Unit. This is broken down as follows:

Acute West (1), Acute East (1), Area Central (1) and Area West (1)

Over the last year, the following HAPUs were reported as NRIs:

Avoidable HAPU	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
YGC	0	0	0	0	0	0	0	0	1	0	0	0	1
WHM	0	5	0	0	0	1	1	0	0	1	0	0	8
YG	0	0	0	1	0	0	0	0	0	0	0	0	1
Central Area	0	2	1	1	2	0	0	1	1	0	0	1	9
East Area	0	2	0	0	0	2	0	0	0	0	0	1	5
West Area	0	1	0	1	0	0	0	0	0	0	2	0	4
Total	0	10	1	3	2	3	1	1	2	1	2	2	28

The recurring themes are:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation

All investigations from pressure ulcer investigations are reviewed weekly at local harms meetings. In addition, the sharing of findings at local level is reflected through the raising of awareness at safety briefs. The impact of the increased awareness is then monitored and measured through the ward accreditation process.

There were 5 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation.
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

When looking at Intentional Rounding (IR) as a theme alone, the ILP has identified issues with IR to include inconsistency, gaps in IR, variation in frequency, issues not identified despite IR and lack of knowledge and training. As such the ILP has recommended the following:

- Review guidance and documentation regarding IR.
- Establish IR training and education.
- Ensure that registered practitioners are accountable for IR.
- Consider implementation of senior nurse/matron rounding.

An update from the Health Board's HAPU Improvement Group is detailed below:

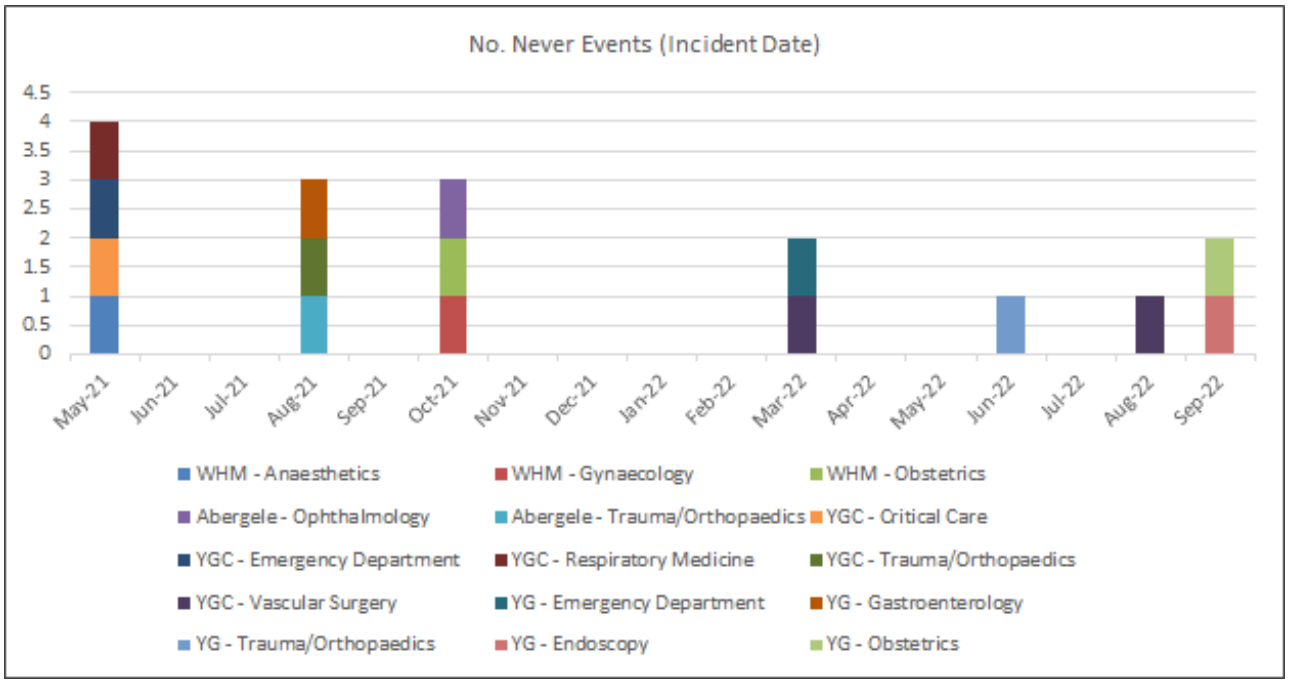
The first HAPU improvement group was held on the 25th of August with the first focused collaborative meeting on the 6th October and a follow-on workshop on the 25th October. The data suggests a reduction in HAPU in September; however, it is too early to say if this is due to the collaborative or monthly variation.

The overall aim of the collaborative is a 50% reduction in all reported Health Acquired Pressure Ulcers with 100% reduction in avoidable Healthcare Acquired Pressure Ulcers across BCUHB (hospital and community) by April 2024.

NEVER EVENTS

In the current financial year, April to September 2022/23, four never events have been reported, compared to seven in the same timescale in 2021/22.

Twelve Never Events were reported in 2021/22, compared to five in 2020/21 and six in the full year of 2019/20.



The primary theme (11 of 12 incidents) is surgical safety.

In response, the Health Board recognised the role of human factors in the prevention and mitigation of systemic failure on patients, families, and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

The BCUHB Transformation and Improvement Directorate appointed a Quality Improvement Fellow specifically dedicated to theatres; the aim of this work is to support the teams in relation to consistently using the WHO checklist and addressing the causes of never events. A six month timescale was agreed, (1 April - 1 October 2022), with initial focus to be placed at YGC theatres for the first 3 months due to an increase in never event incidents. The remaining three months were expected to see the roll out the learning to Abergele Hospital, Ysbyty Gwynedd and Wrexham Maelor Hospital. The QI Fellow and designated YGC WHO Improvement Group, have undertaken observational audits and departmental surveys which directed their attention to complete review of their current WHO checklist in order to ensure relevance, eliminate duplication and waste and incorporate human factor elements into this process.

The improvement activities to date include:

- Team process mapping session - reviewing WHO process identification of risks/vulnerability.
- Benchmarking current process with other sites and NHS providers and external visits.
- Observational audits reviewing distraction at checklist completion and compliance.
- Analysis of theatre computer system (WPAS) data for reporting accuracy.
- Review of historic internal theatre audits.
- Audit of completion of WHO documentation and correlation with computer entries.
- A full team review and re-design of the YGC WHO checklist in conjunction with the 5 Steps to Safer Surgery and WHO guidelines - amendments to overall questioning style, content and format in order to promote collaborative communication, improve engagement, avoid duplication and eliminate waste.
- Re-designing and relocating the ‘Pre-brief’ stage of the checklist to include:
    - Awareness of staff entering theatre following this stage – re-introductions must then take place.
    - Encouragement of open team communication – expanding on anaesthetic and surgical plans.
    - Providing greater writing space in order to reduce need to comment on operating lists – providing one source and greater clarity for the team.
    - Verbal prompts endorsing ‘speaking up for patient safety’ and a round room check for staff to raise concerns before proceeding.
    - Patient’s post operative bed location.
    - Confirmation of blood products, group and save requirements and specialist equipment availability.
- PDSA cycles completed to systematically gain knowledge in relation to the optimum timing and delivery of all elements of the checklist:
    - Pre–brief – Operating surgeon must be present – check must stop at interruptions.
    - Sign In – ‘Stop for the Sign In’ – promoting all activity to stop whilst being conducted.
    - Time Out – ‘Pause before you Prep’, scrub team waiting until all team members are scrubbed, anaesthetic team ready and completed prior to knife to skin. All staff to confirm happy to proceed.

    - Sign Out – work continues in this area to ensure no staff leave theatre prior to completion.
    - Debrief – Core team reviewing process and meaningful triangulation of data from the debrief. Working with clinicians to consider implementation the structured framework 'TALK' to promote clinical debriefing which aligns with Safety II principles empowering staff to act and improve.
- In theatres, name and role boards purchased for immediate introduction to all theatres to improve team communication and engagement.
- Current WHO checklist now placed on view in theatre next to the operating list for staff to review.
- WHO Improvement Group lead in every theatre.
- Bespoke surgical safety human factors training discussions with AQuA building on the current training.

YGC staff Covid sickness levels, annual leave commitments and clinical demands have resulted in reduced team engagement. Whilst the QI Fellow has created a revised WHO checklist (v6) and continued to drive the project, the project requires further time in which to support the team to ensure checklist reliability and long-term sustainability. An extension has therefore recently been granted for a further 6 months.

Despite these challenges, work around surgical safety has continued in Ysbyty Glan Clwyd as outlined above. In addition, the WHO Improvement Group are currently at version 6 of their revised WHO checklist; an initial test took place on the 5th October 2022 at Abergele Hospital orthopaedic theatres which was positively received, and work continues within that team over the next week before the WHO Improvement Group re-convene to discuss the findings. Focus on this roll-out has superseded the plan to introduce an Emergency theatre - NCEPOD 'Hot WHO' project as well as a review of the Debrief element of the checklist at the request of the theatre manager. Both will be continued by the group as future projects.

The improvement work has also now spread to theatres in East following meetings with the East IHC Director of Nursing, Theatre Manager and Matron. Endorsement and support for this work was granted with an invitation to join the Theatre Utilisation Group to share findings and garner support from the clinical leads.

In addition, the Clinical QI Fellow has been meeting with staff from Ophthalmic Theatres in Abergele where observational audits/surveys have been undertaken and findings shared with the Head of Nursing.

The plan is for the WHO improvement group to conduct a team simulation session with the new WHO checklist on the Clinical Governance Day.

<u>New Never Events</u>

Within the current reporting period three new Never Events reported, detailed immediately below. Investigations into the incident are ongoing.

Retained Foreign object – Following reprocessing of instrument set following surgery, it was noted that one of the drill bits was broken. It was not noticed during the surgery and initial investigation has shown that although the post operative instrument set check is shown as completed on computer, the paper checklist was not completed.

Learning – The importance of following the correct process for the checking of drill bit integrity and completion of documentation

Retained Swab – Following normal delivery of baby, bleeding noted within vagina requiring suturing by registrar. Sometime later, mother noted object within vagina and on examination midwife noted unintentionally retained swab.

Learning – Importance of following procedures for swab counts, and the need for second checker.

Procedure carried out on wrong patient - Patient A was waiting for a procedure as a day patient in the endoscopy unit. Staff member called the patient from the waiting room using only their surname. No further identification checks were carried out by this member of staff or any other member of the team carrying out the procedure thereafter. Patient A underwent procedure which was listed for Patient B. Patient A and Patient B who were in the waiting room at the same time had the same surname.

Learning – When identifying a patient always ask the patient sensitively (or a relative / carer if present) if the patient can state the correct information: full name, date of birth and address as per Patient Identification Policy.

Closed Never Events

Wrong site surgery - A Patient brought in by ambulance to Emergency Department with abdominal pain and following triage was diagnosis of ectopic pregnancy was made. Patient was taken to theatre an surgery undertaken laparoscopically. Three litres of blood were found in the peritoneal cavity.

The surgeon saw what he thought was an ectopic pregnancy coming out of the right tube, and as it was easily accessible, the surgeon removed it (right salpingectomy by Ligasure). Suctioning the blood from the pelvis, the surgeon then identified a ruptured tubal pregnancy (not actively bleeding) on the left side and performed a left salpingectomy with ligature.

In response to the investigation, the following actions are being taken forward:-

- Lessons learned around the importance of visualisation of both tubes prior to surgery being made to be circulated across the Health Board and reinforced through clinical governance forums.

To note, two incidents previous reported as Never Events have been submitted for downgrade following investigation, as it was concluded that they did not meet the criteria of a Never Event. A further never event is also under consideration for downgrade. If approved, this would reduce the previous year figure to nine.

Open Never Event Investigations

The following Never Event investigations remain underway.

Incident date	Incident Description	Current status
Retrospective incident 10/05/2021	Retention of a foreign object	The investigation is in the final stages and arrangements in place to meet with family
20/08/2021	Wrong site surgery	Rejected at ILP – more robust action plan required
22/08/2021	Retention of a foreign object	Investigation completed, action plan at approval stage
06/03/2022	Wrong site surgery	Investigation complete. Currently with vascular team for accuracy check
22/06/2022	Wrong implant	Investigation ongoing

INDEPENDENT INVESTIGATIONS

There are currently three independent external investigation ongoing as commissioned by the Health Board:

Location	Incident	Update
CMHT (East) MHLD	Patient known to Community mental health team arrested on suspicion of murder	Final report with service and action plan being developed. Due for review at ILP in October 2022.
Childrens Services (Central)	Death of child shortly after transfer to Alderhey after admission through ED and surgery in YGC.	External Investigating Officer identified and review ongoing.
Womens services (West)	Maternal death	External Investigating Officer identified and review ongoing.

Additionally, a thematic review into a cluster of major obstetric haemorrhages is due to completion and will be detailed in the next report.

NEAR MISS INCIDENTS

Near miss incidents can be a valuable source of learning. These are patient safety incidents that had the potential to cause harm, but on this occasion, harm was prevented.

Top 10 by Sub Type	Regional Services				Central	East	West	Total
	MHDLS	Womens	Diagnostics	Cancer	HC	HC	HC	
Staffing	9	1	0	0	4	9	6	29

Aggressive/threatening behaviour	18	0	0	0	0	2	2	22
Treatment or procedure issues	1	2	1	0	7	2	4	17
Slip, trip or fall	2	0	0	0	4	5	5	16
Clinical assessment, clinical diagnosis	2	2	0	0	4	3	3	14
Medication prescribing error	1	0	0	1	4	4	2	12
Communication issues	0	3	0	0	3	5	0	11
Transfer	3	0	0	0	2	3	0	5
Discharge	1	0	0	0	1	1	2	5
Healthcare record	0	1	0	1	3	0	0	5
Total	37	9	1	2	32	34	24	136

The table above shows the ten most occurring “near miss” incidents by type of incident. It shows that “staffing” (wards being short staffed) has featured across the board in terms of near misses.

Also significant are the number of near miss incidents where patients within a mental health setting have exhibited threatening or aggressive behaviour and where serious harm has been avoided to patients and staff.

PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on the vital role in identifying significant national safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales.

There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity.

Organisations are required to confirm that they have achieved compliance by the date stated.

Open Alerts

Reference	Title	Applicable To?	Type	Date action underway	Deadline	Notes
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	BCU-wide	Patient Safety Solution - Notice	27/05/2021	31/12/2021	Clinical policy progressing through approval process. Deputy Executive MD now providing leadership to progress

						completion. Expected completion within 2 months.

Closed Alerts

No alerts have been closed for the time period

LITIGATION

During this bi-monthly period of August and September 2022, 57 claims or potential claims were received against the Health Board. Of these, 51 related to clinical negligence and 6 related to personal injury.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by Legal and Risk (Health Board's solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. The number of new claims received has increased over the last two months, which has been as expected and it is believed this figure will continue to rise as the Health Board begins to deal with the effects of cancelled procedures and appointments.

During the bi-monthly period, 29 claims were closed. Of these, 22 related to clinical negligence and seven related to personal injury. The total costs for the total closed claims in this period amounted to £16,072,834.86 before reimbursement from the Welsh Risk Pool.

The most significant claims related to:

Birth related claim – (2009) (£8,008,504.70)

Learning:

- To ensure that a fetal heart is monitored appropriately at all times, there are local policies available which are in line with NICE guidance. The BCUHB '*Use of Electronic Fetal Monitoring in Labour'* policy is inclusive of indications for use and highlights a requirement where there is an abnormal heart rate.
- The use of stickers to interpret a CTG have been introduced (Page 8-9). All CTG traces for labouring women are assessed hourly by the midwife caring for the woman and then again by the senior midwife on duty to provide fresh eyes and a second opinion, for antenatal CTG the review is completed half hourly.
- Staff also attend an in house PROMPT training day on an annual basis, taking part in simulated obstetric emergencies where they are required to take all appropriate actions inclusive of acute events such as cord prolapse, CTG interpretation and escalation to other healthcare professionals.
- As part of mandatory training all midwives and obstetricians are required to complete CTG training annually which comprises of case reviews which require decision making about CTG interpretation and escalation.

Birth related claim - (2005) (£5,742,162.56)

Learning:

- To ensure that a fetal heart is monitored appropriately at all times, there are local policies available which are in line with NICE guidance. The BCUHB '*Use of Electronic Fetal Monitoring in Labour'* policy is inclusive of indications for use and highlights a requirement where there is an abnormal heart rate.
- The need to use a Pinard stethoscope or a portable sonicaid when listening to the fetal heart rate before applying electronic monitoring or when labour is considered to be low risk and the midwife is assessing fetal wellbeing.
- As part of mandatory training all midwives and obstetricians are required to complete CTG training annually which comprises of case reviews which require decision making about CTG interpretation and escalation. Staff also attend an in house PROMPT training day on an annual basis, taking part in simulated obstetric emergencies where they are required to take all appropriate actions inclusive of CTG interpretation and escalation to other healthcare professionals.

Birth related claim – (2009) (£1,554,301.68)

Learning:

- Guidelines are in place for the management of hypoglycaemia to support staff, which is inclusive of flow charts for the management for babies at risk of hypoglycaemia and for babies with symptoms and signs potentially attributable to hypoglycaemia.
- All midwives meet with their Clinical Supervisors for Midwives (CSfM) for a minimum of four hours every year as required by the national recommendations from the Chief Nursing Officer. Where a deficiency in a particular skill is recognised by the midwife or a line manager, a CSfM is available to work alongside the midwife to offer the required support until the standard is consistently met.
- The CSfM complete annual audits of all aspects of maternity records and the audits are presented to the Women's Quality, Safety & Experience Sub-Group annually.
- The CSfM also facilitate notes audits with midwives throughout the year and each midwife is required to audit two sets of her/his own notes and to bring the audit form to Group Supervision.

Incorrect take home medication (2009) (£92,456.87)

Learning:

- A check for medication is to be completed by Registered Nurse at bedside. Alert has been issued to nurses in respect of this.
- Audit completed regarding safety of take home medication and use of discharge checklist.
- Process map developed to outline process of dealing with medication for inpatients on the ward.

Delay in diagnosis (2016) (£104,737.04)

Learning:

- The Case has been discussed at a Discrepancy meeting and learning shared.
- The Radiologist concerned has completed a review of this case with their supervisor.

Delay in diagnosis (2013) (£67,209.58)

Learning:

- Emergency and Radiology departments have been participating across the Health Board to review systems in place to improve and ensure a consistent and robust system for reporting and acting on results in a timely and safe manner in line with National Patient Safety Agency (NPSA) Alert 16 – Failure to Act Guidance & Regulations.
- Action has been taken to remind all doctors of the importance of reviewing diagnostic investigation results prior patient discharge.

As expected, the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The themes remain similar. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

The following themes have been identified for personal injury:

1. Slips/trips
2. Violence & Aggression

PI claims savings due to discontinued or favourable settlements for this period £50,498. These are financial savings for providing evidence to L&R, which allows for a denial of Health Board liability in a matter leading to a claim being discontinued or in the case of favourable settlements; we have been able to negotiate a lower compensation payment due to the investigative work of the Legal Services Team and L&R.

All settled claims require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool to reclaim costs.

The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. BCUHB's share of the increase will be 17.07% and the current forecast predicts an additional cost of £2.56m in addition to the contribution already made, creating a significant impact on the overall financial position. The Finance Division are aware, and it will be included as a potential risk

until things are finalised later in the year. National discussions are underway; however, this figure succinctly reflects the increasing costs arising from liability claims across the NHS.

INQUESTS

During the relevant time period, August and September 2022, 64 new inquests or requests for information from the coroner were received from the Coroners in North Wales.

34 inquests were concluded between during August and September 2022. The distribution of the inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

There are currently 44 inquests with NWSSP Legal and Risk Services support in progress across the health board. Some are in initial stages and others are awaiting inquest date, and various stages in between.

New Chief Coroner Guidance (Guidance No.44 Disclosure)

The above guidance was issued and circulated in September and relates to the disclosure of witness statements, investigation reports and any other documents the Coroner may have requested as part of their investigation. The Coroner issues a timescale for such requests and is aware of related applicable timescales of which the Health Board should abide by e.g. PTR guidance on investigation timescales. The Coroner has referred to the guidance recently in relation to the delayed submission of an investigation reports.

In the period of this report, there were no new Regulation 28 (PFD) reports issued by HM Coroner to the Health Board.

In the period of this report, there were no new responses sent to HM Coroner in relation to previously received Regulation 28 (PFD) reports.

Although a Regulation 28 (PFD) report was not issued, HM Coroner occasionally requests further information from the Health Board following an Inquest. In the period of this report, the following response has been sent to HM Coroner in relation to previous requests for further information:

Patient experienced two inpatient falls, the second of which resulted in a fractured neck of femur. Following orthopaedic surgery, the patient spent five hours in the Recovery Department post operatively. The delays were due to a bed being unavailable. Post operatively there was no documented treatment plan or escalation plan. The ITU team were not informed that the patient was unwell pre or peri-operatively and had no communication about any plan of care in the event of deterioration. On arrival to the ward, he had a reduced level of consciousness. Following review by the Acute Intervention Team he was referred to the on call Anaesthetist and the Critical care Consultant. He was immediately re-admitted to the High Dependency Unit but later died. At the inquest, the conclusion was Accidental death. The Coroner indicated that she was not making a PFD report on the basis that she was provided with the investigation report, action plan and updated position and evidence.

Coroner's request for further evidence in relation to the action plan provided:-

3. The Health Board's position regarding the audit in 2019 – query about the audit process and what happens following.

4. An explanation on the progress of the action plan from conclusion of the investigation to the action plan.
5. Further information on compliance in relation to proper record keeping.

The site Director of Nursing responded to the Coroner's request as follows;

a. In relation to the outlier audits that commenced in 2019, in relation to an auditing of the outlier matrix which is a supportive tool to help identify patients who are suitable to be cared for in an area outside of their speciality. It accounts for factors such as cognitive impairment and complexity of clinical condition. The use of the tool is audited locally by the site team as part of the regular tier 2 audit cycle and any issues of concern are taken through Patient Safety and Quality Group. An aligned action plan will be presented to any issues identified.
b. The action plan formulated from the initial incident is agreed at the time the report is submitted. However, all improvement is continuous and as we learn, there are different things that may become relevant and important for us to address and the action plan is updated. An example of this is the e-learning programme for falls that all staff are expected to complete. This wasn't available at the time of the completion of the action plan for the inquest investigation but is a new and relevant item in the prevention of such incidents in the future.
c. Auditing of Doctors documentation is in an early phase of maturity. Whilst there has been an abundance of opportunities to comment and observe documentation, for example through the incident review process or the mortality review process there has not been a formal audit as such recently. The STAR tool is currently under adaption, which will address this gap and this being implemented in service.

CONCLUSION

This report provides the Quality, Safety and Experience Committee with information and analysis on patient safety including Nationally Reportable incidents and Never Events occurring in the last two months.

Of note, the themes arising from nationally reportable incidents (including Never Events) remains as previously reported. This includes falls, healthcare acquired pressure ulcers, surgical safety and the recognition and response to deteriorating patients. Improvement work is underway in these areas as detailed above.

Focused work is underway to address the issue of overdue and delayed investigation reports. The primary sites of concern are Ysbyty Glan Clwyd and Ysbyty Gwynedd and the Patient Safety Team are working with the new IHC Teams to address this issue promptly.

The QSE Committee is asked to note the report.

Report title:	Human Tissue Authority (HTA) Compliance report (Licence number 12153)		
Report to:	**Quality Safety Experience Committee (QSE)**		
Date of Meeting:	Tuesday, 01 November 2022	Agenda Item number:	
Executive Summary:	**Inspection report on BCUHB mortuary compliance with HTA licensing standards.** **Inspection date: 14/15 July 2022** **Summary of inspection findings**: The full HTA report is provided as an appendix. The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation. The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet shortfalls identified during the inspection. HTA found that the Ysbyty Glan Clwyd Mortuary ('the establishment') met the majority of the HTA's standards, with 7 major and 4 minor shortfalls identified against standards for: • Governance and quality systems • Traceability • Premises, facilities and equipment Specifically, partial assurance can only be provided with respect to full resolution of four inspection findings before the HTA deadline. However, a Corrective and Preventative Action (CAPA) plan has been agreed with HTA, with all actions ideally to be completed within the current financial year. **Review of BCUHB Mortuary Security:** Following the publicised incident at the Maidstone and Tunbridge Wells NHS Trust mortuary (November 2021), an initial review of mortuary security at all Health Board premises was undertaken. This highlighted a range of concerns regarding security control systems and variation in the ability to audit access. Subsequently, a more detailed security review was commissioned for the three District General Hospital (DGH) mortuaries, and was undertaken in April / May 2022. The report is attached as an appendix. A low level of assurance was identified at all three DGH mortuary sites, predominantly linked to absence of robust Closed Circuit Television (CCTV) systems and auditable door access controls. Ysbyty Gwynedd and Wrexham Maelor mortuaries were identified as the highest risk, with physical upgrades prioritised to these areas. Thus far, upgraded CCTV and new door access control system has been installed in Ysbyty Gwynedd. Work is now commencing on the process of restricting access to key authorised personnel, whilst ensuring legitimate access is not compromised, especially during out of hours periods. For the Wrexham Maelor mortuary, quotations for CCTV and door access systems have been obtained with orders imminent, and installation to follow. Security upgrades to the Ysbyty Glan Clwyd mortuary will be identified and progressed thereafter. A task and finish approach will be undertaken to complete a further security review of community hospital mortuaries. It is anticipated that all physical and procedural actions will be completed within this financial year.		

Recommendations:	The Board is asked to note: response to HTA inspection findings / progress with security review.			
Executive Lead:	Nick Lyons			
Report Author:	Bernadette Astbury / David Fletcher			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Inspection report on BCUHB mortuary compliance with HTA licensing standards.

Inspection date: 14/15 July 2022

Summary of inspection findings:
The full HTA report is provided as an appendix. The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation. The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet shortfalls identified during the inspection.

HTA found that the Ysbyty Glan Clwyd Mortuary ('the establishment') met the majority of the HTA's standards, with 7 major and 4 minor shortfalls identified against standards for:

- Governance and quality systems
- Traceability
- Premises, facilities and equipment

Specifically, partial assurance can only be provided for full resolution of four inspection findings before the HTA deadline. However, a Corrective and Preventative Action (CAPA) plan has been agreed with HTA, with all actions ideally to be completed within the current financial year.

Significant assurance that the following inspection findings will be fully addressed before the HTA deadline(s):

- GQ1c Storage Practices
- T1c Viewing Identity Check
- T1d Same/similar name process
- PFE2c Freezer Capacity
- GQ2c Tissue Audit
- GQ3c Staff Training

Acceptable assurance that the following inspection finding will be fully addressed before the HTA deadline:

- PFE2e Fridge and Freezer Alarms

Partial assurance that the following inspection findings will be fully addressed before the HTA deadline:

- PFE1e Security Arrangements

- PFE2d Fridge and Freezer
- PFE1a Flooring
- PFE3a Hydraulic Trolleys

PFE1e Security Arrangements (Major finding with actions due 16/11/22)
Inspection finding: The establishment does not have a system in place to review records of access to the mortuary to ensure that it is limited to those with a legitimate right of access. Furthermore, the establishment does not have a register to record visitors and contractors who enter the mortuary sites.

- Door access to the Wrexham Maelor Mortuary is currently not auditable – quotes for remedial works have been received and currently awaiting orders to be raised and start dates. Currently unable to meet HTA compliance until this work is complete and an initial audit has been conducted. A clear plan with confirmed timelines will submitted to HTA to address this finding.

PFE2d Fridge and Freezer (Major finding with actions due 16/11/22)
Inspection finding: Satellite Site - Wrexham Maelor Mortuary
A former viewing area has been converted into a cold store room which is used for bariatric bodies. The refrigeration unit in this room leaks water onto the floor and mould has formed on the ceiling and walls which cannot be removed.

PFE1a Flooring (Minor finding with actions due 16/12/22)
Satellite Site Wrexham Maelor Mortuary
The coating on the floor in the main body store area is showing signs of wear. This is exposing the concrete beneath which is of a porous nature, making it difficult to clean and decontaminate.

PFE3a Hydraulic Trolleys (Minor finding with actions due 16/12/22)
A number of the hydraulic trolleys across the three sites have areas of rust requiring attention.

- Business cases for discretionary capital has been prepared and prioritised for the three findings above. A clear plan with confirmed timelines will submitted to HTA to address these findings.

Review of BCUHB Mortuary Security:
Following the publicised incident at the Maidstone and Tunbridge Wells NHS Trust mortuary (November 2021), an initial review of mortuary security at all Health Board premises was undertaken (acute DGH and community hospital). This highlighted a range of concerns regarding security control systems and variation in the ability to audit access. Subsequently, a more detailed security review was commissioned for the three District General Hospital (DGH) mortuaries, and was undertaken in April / May 2022. The report is attached as an appendix.

A low level of assurance was identified at all three DGH mortuary sites, predominantly linked to absence of robust Closed Circuit Television (CCTV) systems and auditable door access controls. Ysbyty Gwynedd and Wrexham Maelor mortuaries were identified as the highest risk, with physical upgrades prioritised to these areas. Thus far, upgraded CCTV and new door access control system has been installed in Ysbyty Gwynedd. Work is now commencing on the process of restricting access to key authorised personnel, whilst ensuring legitimate access is not compromised, especially during out of hours periods.

For the Wrexham Maelor mortuary, quotations for CCTV and door access systems have been obtained with orders imminent, and installation to follow. Security upgrades to the Ysbyty Glan Clwyd mortuary will be identified and progressed thereafter.

A task and finish approach will be undertaken to complete a further security review of community hospital mortuaries. It is anticipated that all physical and procedural actions will be completed within this financial year.	
Link to Strategic Objective(s):	
Regulatory and legal implications	HTA post mortem sector
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Mortuary Regulatory Compliance Risk to not maintaining HTA regulatory compliance. • This is due to mortuary facilities requiring maintenance/repairs, lack of freezer capacity, ageing equipment and the potential for unauthorised access to mortuary facilities in the acute hospital sites • This may result in inability to maintain regulatory compliance, safeguard the dignity of the deceased and integrity of human tissue.
Financial implications as a result of implementing the recommendations	Capital business cases: • HTA compliance-related estates remedial works • Mortuary trolleys
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	
Links to BAF risks: (or links to the Corporate Risk Register)	
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: **Implementation of recommendations**	
List of Appendices: 1 **-** HTA inspection Report; 2 - HTA CAPA plan; 3 - Mortuary Security Report (acute locations).	

Inspection report on compliance with HTA licensing standards
Inspection date: **14 and 15 July 2022**

Glan Clwyd Hospital

HTA licensing number 12153

Licensed under the Human Tissue Act 2004

Licensed activities

The table below shows the activities this establishment is licensed for and the activities currently undertaken at the establishment.

Area	Making of a post-mortem examination	Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation	Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose
Hub site **Glan Clwyd Hospital**	Licensed	Licensed	Licensed
Mortuary	*Carried out*	*Carried out*	*Carried out*
Pathology lab	-	-	-
Maternity	-	-	-
A&E	-	*Carried out*	-
Satellite site **Ysbyty Gwynedd Bangor**	Not licensed	Licensed	Licensed
Mortuary (satellite site)	-	*Carried Out*	Carried Out
Maternity	-	-	-

A&E	-	*Carried out*	-
Satellite site **Wrexham Maelor Hospital**	Not licensed	Licensed	Licensed
Mortuary (satellite site)	-	*Carried out*	*Carried out*
Maternity	-	-	-
A&E	-	*Carried Out*	-

Summary of inspection findings

The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Although the HTA found that Glan Clwyd Hospital ('the establishment') had met the majority of the HTA's standards, 7 major and 4 minor shortfalls were found against standards for Governance and quality systems, Traceability, and Premises, facilities and equipment.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Compliance with HTA standards

Major shortfalls

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are governed by documented policies and procedures		
c) Procedures on body storage prevent practices that disregard the dignity of the deceased	The establishment does not have a procedure for carrying out and recording condition checks of bodies in storage, or the actions taken to expedite release from the mortuary and/or prevent deterioration to the body. At the time of the site visit there was one body which had been in refrigerated storage for over 60 days with no accompanying record of condition checks nor actions taken. *(See shortfall under PFE2(c) regarding freezer capacity)*	**Major**
T1 A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail		
c) Three identifiers are used to identify bodies and tissue, (for example post mortem number, name, date of birth/death), including at least one unique identifier	Although three identifiers are checked on the deceased when preparing a body for viewing, the procedure does not include a final check using a minimum of three points of identification of the deceased provided by the visitors prior to them entering the viewing room.	**Major**
d) There is system for flagging up same or similar names of the deceased	The establishment has a written procedure for flagging up same or similar names. However, this system has not yet been fully implemented across the sites. The inspection team observed at least one occurrence at each site where two or more of the deceased with the same name had not been highlighted in accordance with the written procedure.	**Major**

PFE1 The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue.		
e) Security arrangements protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access.	The establishment does not have a system in place to review records of access to the mortuary to ensure that it is limited to those with a legitimate right of access. Furthermore, the establishment does not have a register to record visitors and contractors who enter the mortuary sites. *(See advice item 2 below)*	**Major**
PFE2 There are appropriate facilities for the storage of bodies and human tissue.		
c) Storage for long-term storage of bodies and bariatric bodies is sufficient to meet needs	The establishment does not have sufficient freezer storage capacity to meet the need for long-term storage of bodies. At the time of the inspection all freezer storage was in use and there were at least two bodies awaiting transfer to the freezer. Although the establishment has a fridge unit which can be converted into freezer storage to provide a further four spaces, this unit is currently used as a containment unit for cases arriving out of hours from the community in a state of decomposition or infestation. There is no freezer space for bariatric bodies.	**Major**
d) Fridge and freezer units are in good working condition and well maintained	<u>Satellite Site - Wrexham Maelor</u> A former viewing area has been converted into a cold store room which is used for bariatric bodies. The refrigeration unit in this room leaks water onto the floor and mould has formed on the ceiling and walls which cannot be removed.	**Major**

e) Fridge and freezer units are alarmed and the alarms are tested regularly to ensure that they trigger when temperatures go out of upper or lower set range	Hub Site - Glan Clwyd The external storage unit is linked to a remote temperature monitoring and alarm system but the alarm and call out procedure are not tested. The standalone fridge for early pregnancy remains is not alarmed. Satellite Site - Ysbyty Gwynedd Bangor The fridge used to store pregnancy remains and perinatal bodies has an audible alarm but it is not linked to the remote monitoring and alarm system. This means that there would be a delay in identifying and rectifying a fridge failure if it occurred out-of-hours.	**Major**

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
GQ2 There is a documented system of audit		
c) Regular audits are carried out of tissue being stored so that staff are fully aware of what is held and why and to enable timely disposal of tissue where consent has not been given for continued retention	The establishment has a robust system for managing tissue taken at post mortem examination which includes ongoing checks to ensure any outstanding instructions for disposal are followed up in a timely manner. However, the retained tissue is not subject to regular wholescale audits.	**Minor**

GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks		
c) Staff are assessed as competent for the tasks they perform	The establishment has recently implemented a comprehensive competency assessment framework for mortuary staff. At the time of the inspection, most staff had completed the competencies, however some had not. On occasion the hospital site team need to access the mortuary and assist with out-of-hours viewings. Although they are accompanied by trained porters, there is no specific mortuary training in place for members of the hospital site team. At the Wrexham Maelor Satellite, funeral directors access a small body store area to admit bodies to the mortuary out-of-hours. Although training is provided on an ad-hoc basis, there is no formal arrangement or record of training for these funeral directors.	**Minor**
PFE1 The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue.		
a) The premises are clean and well maintained.	<u>Hub Site - Glan Clwyd</u> The floor in the Post Mortem room has split along a central seam allowing slight water ingress and egress which prevents full decontamination. <u>Satellite Site Wrexham Maelor</u> The coating on the floor in the main body store area is showing signs of wear. This is exposing the concrete beneath which is of a porous nature, making it difficult to clean and decontaminate.	**Minor**

PFE3 Equipment is appropriate for use, maintained, validated and where appropriate monitored		
a) Items of equipment in the mortuary are in good condition and appropriate for use	A number of the hydraulic trolleys across the three sites have areas of rust requiring attention.	**Minor**

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

Advice

The HTA advises the DI to consider the following to further improve practice:

Number	Standard	Advice
1.	GQ1(g)	The DI is advised to nominate HTA representatives (Persons Designated) in the Accident & Emergency departments and to extend the invitation to the HTA governance meetings to these representatives.
2.	GQ2(a)	The DI is advised to introduce regular audits of mortuary access across all sites to include a crosscheck of legitimate rights of access to the mortuary against frequency, duration and patterns of attendance to ensure access is in line with the purpose for which it was granted. (*See shortfall under PFE1(e)*)
3.	GQ6	The establishment has an extensive suite of risk assessments and the DI may wish to consider consolidating some of the risk assessments to facilitate staff awareness. For example, the risk assessments RA 39-42 all relate to viewing of the deceased.
4.	T1(c)	The DI may wish to consider the introduction of a standard release form, which can be used by funeral directors for the release of bodies. This form could include the relevant identification information to check against the mortuary register and identification band on the body before being released.
5.	PFE1(d)	The rear mortuary door at the hub site opens onto a courtyard area secured by gates which are accessed by swipe card. The door has a pin code entry system. The DI is advised to ensure that the pin code is changed

		regularly until the planned upgrade to swipe card access is installed.
6.	PFE2(e)	The establishment has a temporary storage unit which has recently been decommissioned. The DI is advised to ensure that if it is brought back into use it is connected to the remote temperature monitoring and alarm system.
7.	PFE2(i)	The DI is advised to clarify the scope of the contingency plan within MORT.0098 (Mortuary Contingency plan) to confirm that these arrangements apply in the event of a power failure.

Background

Glan Clywd Hospital has been licensed by the HTA since 2007. This was the fourth inspection of the establishment; the most recent previous inspection took place in September 2017.

Since the previous inspection, post mortem activity has ceased at both the Wrexham Maelor and Ysbyty Gwynedd Bangor satellite sites. All post mortem activity is now carried out at the Glan Clwyd Hub site and the licence for the making of a post mortem has been removed from the two satellite sites.

Description of inspection activities undertaken

The HTA's regulatory requirements are set out in Appendix 1. The inspection team covered the following areas during the inspection:

Standards assessed against during inspection

All 72 HTA licensing standards were covered during the inspection (standards published 3 April 2017).

Review of governance documentation

The inspection included a review of the establishment's governance documentation relating to licensed activities. This included policies and procedural documents relating to licensed activities, cleaning records for the mortuary and post-mortem room, records servicing of equipment, ventilation reports, audits, risk assessments, meeting minutes, incidents and staff training records.

Visual inspection

The inspection included a visual inspection of all three sites including the mortuary body stores and viewing rooms as well as the PM room at the hub site.

Audit of records

Glan Clwyd Hospital (Hub) - Audits were conducted for three bodies in refrigerated storage. Body location and identification details on bodies were crosschecked against the information recorded in the paper mortuary register. No discrepancies were found. Audits of traceability were conducted for tissue blocks and slides from four PM cases where tissue was held on site, including audits of the consent documentation for the retention of these tissues. No discrepancies were identified.

Wrexham Maelor (Satellite) – Audits were conducted for three bodies in refrigerated storage. Body location and identification details were crosschecked against the information on the electronic mortuary register. No discrepancies were found.

Ysbyty Gwynedd Bangor (Satellite) – Audits were conducted for two bodies in refrigerated storage and one in freezer storage. Body location and identification details were crosschecked against the information on the electronic mortuary register. One minor discrepancy was identified but traceability of tissue was not affected.

Meetings with establishment staff

Staff carrying out processes under the licence across the different sites were interviewed including the DI, mortuary manager, APTs, portering staff, and pathology staff.

Report sent to DI for factual accuracy: 8th of August 2022

Report returned from DI: 15th of August 2022

Final report issued: 16th of August 2022

Appendix 1: The HTA's regulatory requirements

Prior to the grant of a licence, the HTA must assure itself that the DI is a suitable person to supervise the activity authorised by the licence and that the premises are suitable for the activity.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

Its programme of inspections to assess compliance with HTA licensing standards is one of the assurance mechanisms used by the HTA.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. They are grouped under four headings:

- consent
- governance and quality systems
- traceability
- premises facilities and equipment.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that there has been a shortfall against a standard, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is provided.

HTA inspection reports are published on the HTA's website.

Appendix 2: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004 (HT Act) or associated Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the HT Act or associated Directions

   or

   A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

   A critical shortfall may result in one or more of the following:

   - A notice of proposal being issued to revoke the licence
   - Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
   - A notice of suspension of licensable activities
   - Additional conditions being proposed
   - Directions being issued requiring specific action to be taken straightaway

2. **Major shortfall:**

   A non-critical shortfall that:

   - poses a risk to human safety and/or dignity, or
   - indicates a failure to carry out satisfactory procedures, or
   - indicates a breach of the relevant Codes of Practice, the HT Act and other relevant professional and statutory guidelines, or

- has the potential to become a critical shortfall unless addressed

or

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. **Minor shortfall:**

   A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

   This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based review or at the time of the next inspection.

   In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. Establishments must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

After an assessment of the proposed action plan establishments will be notified of the follow-up approach the HTA will take.

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	GQ1c - 30/10/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Storage Practices		
Inspection finding: The establishment does not have a procedure for carrying out and recording condition checks of bodies in storage, or the actions taken to expedite release from the mortuary and/or prevent deterioration to the body. At the time of the site visit there was one body which had been in refrigerated storage for over 60 days with no accompanying record of condition checks nor actions taken.			
Corrective and Preventative Action: 1. Body identified at the time of the site visit has been released to the Funeral directors. 2. SOP MORT/0003 will be updated to include a check on the condition of bodies. 3. A weekly body check sheet will be introduced so that bodies who may require freezer storage are easily identified. 4. All relevant staff will be made aware of the changes and training/competency plans updated as required.			
Deadline for completion of corrective and preventative action:	30/10/2022 00:00		

HTA Use Only

Action for HTA:	30/10/2022 00:00
Compliance information to be submitted: Please submit the following: - Updated SOP MORT/003; - Proforma body check sheet; - copy of updated competency; and - confirmation all staff training updated.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	T1c - 16/11/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Viewing Identity Check		
Inspection finding: Although three identifiers are checked on the deceased when preparing a body for viewing, the procedure does not include a final check using a minimum of three points of identification of the deceased provided by the visitors prior to them entering the viewing room.			
Corrective and Preventative Action: 1. An amendment will be made to MORT/0054 – viewing instructions the viewing SOP to include asking for 3 identifiers prior to entering the viewing room. This will include the requirement to pre-prepare the family member on the phone, before they come to the Mortuary for the viewing. 2. All relevant staff, including hospital site teams will be made aware of the changes and training/competency plans updated as required.			
Deadline for completion of corrective and preventative action:	16/11/2022 00:00		

HTA Use Only

Action for HTA:	16/11/2022 00:00
Compliance information to be submitted: Please submit: - Revised SOP MORT/0054 - Updated competency - Dates of training update for staff on new procedure.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	T1d - 30/9/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Same/similar name process		
Inspection finding: The establishment has a written procedure for flagging up same or similar names. However, this system has not yet been fully implemented across the sites. The inspection team observed at least one occurrence at each site where two or more of the deceased with the same name had not been highlighted in accordance with the written procedure.			
Corrective and Preventative Action: 1. An amendment will be made to MORT/0111 - Deceased with same or similar name, to specify that similar name includes all levels of closeness of name. Same forename, same surname or same forename and surname. Examples will be included. 2. All relevant staff will be made aware of the changes and training/competency plans updated as required.			
Deadline for completion of corrective and preventative action:	30/09/2022 00:00		

HTA Use Only

Action for HTA:	30/09/2022 00:00
Compliance information to be submitted: Please submit: - Revised SOP MORT/0111 - Revised Competency - Dates training update provided to staff.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE1e - 16/11/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Security Arrangements		
Inspection finding: The establishment does not have a system in place to review records of access to the mortuary to ensure that it is limited to those with a legitimate right of access. Furthermore, the establishment does not have a register to record visitors and contractors who enter the mortuary sites.			
Corrective and Preventative Action: 1. A procedure will be written describing the process for accessing and reviewing mortuary access records. 2. Purchase of a new system in Wrexham to allow improved audits of access 3. An audit of access records for the three hospital mortuaries will be completed 4. Regular future audits of mortuary access records will be scheduled. 5. SOP MORT/0055 – visitors and contractors will be updated to include the requirement for all visitors and contractors to sign the register. Checks will be made as part of the mortuary access audit. 6. All relevant staff will be made aware of the changes and training/competency plans updated as required.			
Deadline for completion of corrective and preventative action:	16/11/2022 00:00		

HTA Use Only

Action for HTA:	16/11/2022 00:00
Compliance information to be submitted: Please submit the following: - Copy of SOP for accessing and reviewing mortuary access records; - Purchase order/invoice for new system for auditing access; - Dates of initial audits undertaken and any non-conformances identified; and - Copy of revised audit schedule to show audits.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE2c - 16/11/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Freezer Capacity		
Inspection finding: The establishment does not have sufficient freezer storage capacity to meet the need for long-term storage of bodies. At the time of the inspection all freezer storage was in use and there were at least two bodies awaiting transfer to the freezer. Although the establishment has a fridge unit which can be converted into freezer storage to provide a further four spaces, this unit is currently used as a containment unit for cases arriving out of hours from the community in a state of decomposition or infestation. There is no freezer space for bariatric bodies.			
Corrective and Preventative Action: 1. 4 additional spaces have been identified using the Fridge/freezer unit at YGC. Testing is taking place in order to determine suitability of it being used as a freezer. 2. SOP describing monitoring of condition and time of stay. 3. Updated contingency plans to include the transfer of bodies in the event of reaching freezer capacity. 4. Business plans will be developed for the purchase of additional freezer capacity			
Deadline for completion of corrective and preventative action:	16/11/2022 00:00		

HTA Use Only

Action for HTA:	16/11/2022 00:00
Compliance information to be submitted: Please submit the following: - outcome of testing at YGC and confirmation that freezers now in use or alternative arrangements made; - SOP for body condition checking; and - Updated contingency arrangements.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE2d - 16/11/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Fridge and Freezer		
Inspection finding: Satellite Site - Wrexham Maelor A former viewing area has been converted into a cold store room which is used for bariatric bodies. The refrigeration unit in this room leaks water onto the floor and mould has formed on the ceiling and walls which cannot be removed.			
Corrective and Preventative Action: 1. The leaking refrigeration unit will be repaired or replaced 2. The room will be refurbished. 3. All mould will be removed from walls and ceilings			
Deadline for completion of corrective and preventative action:	16/11/2022 00:00		

HTA Use Only

Action for HTA:	16/11/2022 00:00
Compliance information to be submitted: Please provide the following: - maintenance/repair record for refrigeration unit; - Photographs of (unoccupied) room to show mould removed; - Photographs to show refurbishment or evidence of capital funding for renovation and detailed plans.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE2e - 16/11/2022	**Level of Shortfall (major or minor only)**	Major
Short Description	Fridge and Freezer Alarms		

Inspection finding: Hub Site - Glan Clwyd
The external storage unit is linked to a remote temperature monitoring and alarm system but the alarm and call out procedure are not tested.
The standalone fridge for early pregnancy remains is not alarmed.
Satellite Site - Ysbyty Gwynedd Bangor
The fridge used to store pregnancy remains and perinatal bodies has an audible alarm but it is not linked to the remote monitoring and alarm system. This means that there would be a delay in identifying and rectifying a fridge failure if it occurred out-of-hours.

Corrective and Preventative Action: 1. Perform alarm testing as described in MORT/0120 Monitoring and testing of storage conditions
2. Review contents of the fridges without alarms or remote monitoring and determine suitable storage conditions for the contents.
3. Relocate any early pregnancy remains requiring refrigerated storage into one of the alarmed fridges/body storage.
4. Review all cold storage to ensure remote monitoring and alarm systems are place before use, include in plans for alarm testing.

Deadline for completion of corrective and preventative action:	16/11/2022 00:00

HTA Use Only

Action for HTA:	16/11/2022 00:00

Compliance information to be submitted: Please submit the following:
- MORT/0120 to show monitoring and testing as applicable to all sites;
- Dates of most recent alarm testing at all three sites; and
- Evidence of the outcome following the review of all cold storage to ensure alarm systems are in place and documented plans for alarm testing.

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	GQ2c - 16/12/2022	**Level of Shortfall (major or minor only)**	Minor
Short Description	Tissue Audit		
Inspection finding: The establishment has a robust system for managing tissue taken at post mortem examination which includes ongoing checks to ensure any outstanding instructions for disposal are followed up in a timely manner. However, the retained tissue is not subject to regular wholescale audits.			
Corrective and Preventative Action: 1. Introduce a monthly audit on all tissue taken at post mortem (to be changed to quarterly once audit is established). Update the mortuary audit calendar			
Deadline for completion of corrective and preventative action:	16/12/2022 00:00		

HTA Use Only

Action for HTA:	16/12/2022 00:00
Compliance information to be submitted: Confirmation from DI that audit is added to the schedule and has been carried out at least once.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	GQ3c - 16/12/2022	**Level of Shortfall (major or minor only)**	Minor
Short Description	Staff Training		

Inspection finding: The establishment has recently implemented a comprehensive competency assessment framework for mortuary staff. At the time of the inspection, most staff had completed the competencies, however some had not.

On occasion the hospital site team need to access the mortuary and assist with out-of-hours viewings. Although they are accompanied by trained porters, there is no specific mortuary training in place for members of the hospital site team.

At the Wrexham Maelor Satellite, funeral directors access a small body store area to admit bodies to the mortuary out-of-hours. Although training is provided on an ad-hoc basis, there is no formal arrangement or record of training for these funeral directors.

Corrective and Preventative Action:

1. All mortuary staff will complete the competency assessment framework
2. Introduce training plan for all members of the hospital site teams who assist with out of hour's viewings. All relevant staff will complete the training.
3. Review and formalise funeral directors training and ensure that there is a training record in place for all who access the mortuary facilities out of hours

Deadline for completion of corrective and preventative action:	16/12/2022 00:00

HTA Use Only

Action for HTA:	16/12/2022 00:00

Compliance information to be submitted: DI confirmation that all above action points are complete.

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE1a - 16/12/2022	**Level of Shortfall (major or minor only)**	Minor
Short Description	Flooring		
Inspection finding: Hub Site - Glan Clwyd The floor in the Post Mortem room has split along a central seam allowing slight water ingress and egress which prevents full decontamination. Satellite Site Wrexham Maelor The coating on the floor in the main body store area is showing signs of wear. This is exposing the concrete beneath which is of a porous nature, making it difficult to clean and decontaminate.			
Corrective and Preventative Action: 1. The floor in the post mortem room will be repaired 2. The coating on the floor of the main body storage area will be repaired or replaced to ensure that it is non porous.			
Deadline for completion of corrective and preventative action:	16/12/2022 00:00		

HTA Use Only

Action for HTA:	16/12/2022 00:00
Compliance information to be submitted: DI to confirm in writing that above actions are complete.	

Corrective and preventative action (CAPA) plan

Glan Clwyd Hospital - 12153 - Routine on 12/7/2022

Please complete the blanks below

HTA Standard	PFE3a - 16/12/2022	**Level of Shortfall (major or minor only)**	Minor
Short Description	Hydraulic Trolleys		
Inspection finding: A number of the hydraulic trolleys across the three sites have areas of rust requiring attention.			
Corrective and Preventative Action: 1. Limit use of trolleys that have rust on them. 2. Review maintenance records to ensure all trolleys are under service contract and have LOLER certification and are safe to use. 3. Capital equipment case for the purchase of replacement trolleys to be completed. 4. LEEC will be onsite 21st September and will be asked if further repair to areas with rust is possible.			
Deadline for completion of corrective and preventative action:	16/12/2022 00:00		

HTA Use Only

Action for HTA:	16/12/2022 00:00
Compliance information to be submitted: Please submit evidence of repair to or replacement of trolleys following LEEC visit.	

Teitl adroddiad: ***Report title:***	Quality Regulation Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with an updated position in relation to Healthcare Inspectorate Wales and Care Inspectorate Wales activity for the period August to September 2022.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Erika Dennis, Quality Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Steps to achieve acceptable assurance have commenced and are noted in the 'HIW Position August – September' of this report.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales, whilst Care Inspectorate Wales (CIW) are the independent inspectorate and regulator of social care in Wales.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- AMaT Inspection Dashboard Overview	

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

Quality Regulation Report to the QSE Committee August-September 2022

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Regulation Report to the QSE Committee August - September 2022

INTRODUCTION

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services, and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

In line with Welsh Government's plan, A Healthier Wales, health and social care must be designed as a whole system, delivered in accordance with quality and safety outcomes, which is central to the work of HIW.

HIW check that healthcare services are provided in a way which maximises the health and wellbeing of people. In addition, they focus on the quality of healthcare provided to people and communities as they access, use and move between services, and adapt their approach to ensure they are responsive to emerging risks to patient safety.

HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

INTERNAL PROCESS

The Quality Directorate manage the internal HIW / regulatory process and activity for the Health Board on behalf of the Chief Executive and Executive Director of Nursing and Midwifery.

The team are currently reviewing and updating the Health Board's HIW Protocol. Process mapping exercises have taken place with key colleagues across the Health Board. The draft protocol was shared on the Health Board's policies consultation page in August 2022, which determined further engagement with staff is required. The Quality Directorate are also engaging with HIW to ensure the protocol reflects their processes and timescales, and to consider any improvements we need to make to the management of regulatory activity and subsequent learning and improvement approaches.

Once finalised, the protocol will be submitted for further discussion and ratification in line with our process for policies and written control documents. The protocol will then be reviewed annually to account for any improvements and regulatory changes.

IMPROVING ASSURANCE AND DATA

A new database for capturing HIW intelligence , the AMaT system, was implemented at the beginning of August 2022. AMaT is a well-established audit management and tracking system and is used by NHS bodies across England and Wales. Whilst the Health Board recently implemented the software for clinical auditing, we are one of the first in Wales to use the system's 'inspection module'. However, Health Boards are collaborating to use AMaT for a wider arrange of clinical assurance and effectiveness functions.

The AMaT inspection module will enable the Health Board to manage all recommendations, information requests, actions and evidence before, during and following an inspection. It provides the following benefits for inspections:

- Real time overview of the progress of all recommendations and actions;
- Improved approval process for actions and evidence of completion;
- Linking themes and regulations to recommendations;
- Timely notifications and overdue alerts to ensure evidence and actions are completed.

This is a positive change as the system will help to improve our ability to triangulate data and provide assurance that we are improving patient care, managing risk, and complying with reporting requirements.

Migration of HIW data from DatixWeb, from 01 April 2022 has taken place and the Quality Directorate is currently 'trialling' the systems inspection module to capture and track HIW activity and improvement. The Quality Directorate will support responsible leads with accessing, updating and uploading evidence to the system, as HIW activity is received and inputted into the system.

The committee are asked to note that the Health Board continue to work with the AMaT Super User Group Wales to develop the inspection module further, along with networking with other trusts across Wales. This includes the embedding of the Health and Care Standards for Wales and the dashboard, to provide clear visuals of our audit data, giving us real-time insight into how well we are performing, and providing the ability to react swiftly to implement change and improvements where necessary.

Moving forward, the system should support our organisation's whole system approach to quality.

HIW ACTIVITY – AUGUST TO SEPTEMBER 2022

In relation to the data supplied within this report, the Committee are asked to note the migration of data from DatixWeb to AMaT from 01 April 2022 is complete and data validation remains in progress. Should any inconsistencies be identified, these will be rectified and highlighted in the next report to the committee.

Furthermore, this report reflects most recent activity or issues which require noting by the committee. All other inspection activity captured in Appendix A remain in progress with the accountable leads / services. The Quality Directorate are still in the process of supporting services with updating improvement actions on the AMaT system.

Services Requiring Significant Improvement (SRSI)

Inspection of Glan Clwyd Emergency Department

On 9 May 2022, Healthcare Inspectorate Wales (HIW) identified the Emergency Department, Ysbyty Glan Clwyd as a Service Requiring Significant Improvement (SRSI). During the most recent inspection (3-5 May 2022) HIW identified areas where the health board's actions in response to the previous Quality Check had not led to improvement.

HIW is working with the Health Board to ensure improvements are made in a timely manner. The SRSI status will be updated and the Health Board de-escalated, once HIW is satisfied that necessary improvements have been achieved.

During August 2022, a review of all four improvement plans for the site was undertaken in order to have a clear position on progress, including any immediate action required to make the service safe.

The table below outlines the progress made with the improvements required following both HIW inspections in March and May as reflected in Appendix A.

Quality Check on 8 March 2022	Unannounced onsite inspection that took place on 3-5 May 2022
14 HIW Recommendations made **54 Service Improvement Actions agreed** **8** actions are 'Completed' **5** actions are 'Partially Complete (Overdue)' **41** actions are 'Overdue'	**30 HIW Recommendations made** **139 Service Improvement Actions agreed** **28** actions are 'Completed' **109** actions are 'Partially Complete (Overdue)' **1** actions is 'Overdue' **1** action is 'Unable to complete'
*The above figures do not reflect the full progress made as part of the YGC Improvement Plan as the team have only recently started to update the position on the AMaT system with the immediate make it safe actions taking priority	

Although a number of the service actions remain overdue or partially complete on the system, progress is being made led by the Programme Director for Clinical Safety Improvement and evidence is being uploaded and subject to validation.

The actions taken from the May report include consolidation of the initial actions referred to in the improvement plan submitted to HIW in March with priority given to the immediate make it safes. This was highlighted to the Quality Safety and Experience Committee (QSE) in September 2022. As such, cross-referencing of the evidence is now underway and this will improve the reported position as the data is validated.

The YGC Improvement Programme Team have undertaken a review to ensure that moving forward, the service improvements are supported by a clear improvement methodology. This means that the agreed actions are being audited as part of a structured improvement cycle.

As a result, as changes are made they are subject to audit and review to ensure that they are embedded. Only at this stage would they be considered 'Fully Complete' for the purposes of the action plan. Evidence is then uploaded to the AMaT system and approved or rejected via the Patient Safety and Quality Group (PSQG).

The Executive Director of Nursing and Midwifery will be holding check and challenge meetings with the service to identify progress and delays, and allocating resource to ensure progress is made and the next report clearly shows an improved, validated and evidence based position.

Review of the Health Board's Vascular Service

In February 2022 HIW designated BCU Vascular Services as a Service Requiring Significant Improvement (SRSI). This was in response to the Royal College of Surgeons (RCOS) Clinical Record Review Report, published on 20 January 2022, which identified a number of concerns that indicated a risk to patients using the vascular service.

As a consequence of the RCOS report and the SRSI designation, HIW are undertaking a local review during October and November 2022 to examine progress made by the Health Board in relation to the RCOS recommendations, and whether measures taken in addressing the RCOS recommendations are sustainable and ensure that patients receive safe care of good quality. The outcome of this review will enable HIW to consider whether the vascular service can be de-escalated as a SRSI

The fieldwork phase of the review will consist of a number of different activities, including reviewing notes and data The Health Board's Medical Executive Director, has nominated a key contact for HIW

as the Centre Integrated Health Community Director of Operations, and they will coordinate the activities. Discussions have taken place and the fieldwork will take place during October 2022, with onsite visits commencing later in the review.

National Review - Patient Flow (Stroke Pathway).

In December 2021, HIW notified the Health Board of it's the National Review. The focus of the review is to gain a greater understanding of the challenges that healthcare services face in relation to how patients flow through healthcare systems, and to test if arrangements for patient flow are robust.

In order that HIW can assess the impact of patient flow challenges on the quality and safety of care for patients, they decided to focus their review on patients travelling through the stoke pathway. This includes the point of requesting an ambulance, through to a patients discharge from hospital or transfer of care to other services.

HIW have linked the review to their previous thematic review of Patient Discharge from Hospital to General Practice. The review made 13 recommendations for Health Board's to act upon. HIW requested a response which was provided earlier this year in February 2022, which would inform their Patient Flow review, and may also be published as a national summary.

In February 2022, HIW notified the Health Board that an onsite inspection at Glan Clwyd Hospital would take place 9 to 10 August 2022, with the focus of the visit on patient flow concentrating on the stroke pathway, from the point of a patient arriving in an ambulance, or self-presenting at an Emergency Department (ED), through to discharge from hospital or transfer of care to other services. The dates were later changed to 25 – 27 July by HIW due to operational arrangements. No immediate or serious concerns were raised by HIW.

The visit was identified as purely an information gathering exercise and the evidence collated will be analysed in due course and will form part of the national report which will be drafted later this year/early 2023. The report will contain recommendations to Health Boards, Local Authorities and Welsh Government.

The status of both reviews are outlined below;

1. National Review – Patient Flow (Stroke Pathway) Patient Discharge from Hospital to General Practice Action Plan

Of the 13 recommendations made in the Patient Discharge from Hospital to General Practice Action Plan submitted to HIW, 6 actions are overdue. The Quality Directorate are progressing these overdue actions with the Programme Director for Unscheduled Care who is ensuring that the action plans aligns with the Urgent and Emergency Care (UEC) Improvement Programme. As above, evidence will only be accepted where it demonstrates compliance.

2. National Review – Patient Flow (Stroke Pathway) Inspection of Glan Clwyd Hospital

Awaiting report and recommendations

National Review of Mental Health Crisis Prevention

In May 2022, the Health Board were asked to respond to the HIW National Review of Mental Health Crisis Prevention in the Community published on 10 March 2022.

In the latter part of 2023, HIW will again contact each Health Board for an update on action plans in order to establish if each has been completed and whether actions implemented to date have been sustainable.

Appendix A, confirms the progress which the service have made to date. Responsible leads within the service have proceeded updating the actions on the AMaT system. For further assurance in the meantime, the service have provided the following update;

The Crisis Care Development Programme is to bring BCU's current provision of care for people experiencing mental health crisis more closely in line with the recommended service features and functions published in wider documentation (including the HIW Report, Mental Health Crisis Care Concordat Report, Delivery Unit Report), supported by an action plan developed by our Mental Health service.

Two model maps have been produced: one to detail the 'theoretical' model by which care is delivered, and an accompanying version incorporating detailed operational obstacles preventing care being consistently delivered in accordance with the theoretical model. This mapping exercise has received contributions by stakeholders representing the following:

• Older Persons Mental Health
• Adult Mental Health
• The Local Crisis Care Project Team
• General Practice • Psychiatric Liaison
• Early Intervention in Psychosis
• Perinatal Services
• Substance Misuse Services
• Eating Disorder Services
• Divisional Operational Leads

The resulting picture has been shared with the members of the Crisis Care Steering Group for review and agreement for the purposes of considering the map to be a divisionally held and agreed picture of Crisis Care is currently delivered. The next phase involves carrying out a gap analysis between the current model of care - effectively representing 'where we are now' - and 'where we'd like to be', which is informed by the action plan.

At present, the governing mechanism from Crisis Care is the Crisis Care Steering Group reports to the Clinical Strategy Group.

The Regional Crisis Care Concordat meeting, the membership of which comprised many of the organisations likely necessary to provide a multi-agency approach to the strategic planning of Crisis Care, such as North Wales Police, WAST, Local Authorities, etc, have plans in place to reconvene it for the purposes of providing a multi-agency element to Crisis Care governance.

Inspection of Wrexham Maelor Emergency Department

Additionally, the Committee are advised that HIW undertook an inspection of the Emergency Department, Wrexham Maelor Hospital on 8 – 10 August 2022. No immediate concerns or serious issues were raised however at the time of writing the inspection process remains ongoing via review of clinical documentation.

The Health Board await the improvement plan from HIW and in the meantime, the service are taking steps to ensure the initial verbal feedback from the inspection is shared with staff across all sites, and service improvement is commenced.

From speaking with the Health Board's HIW Relationship Managers, the improvement plan should be received during October 2022.

HIW Concerns and Enquiries

The inspection module within the AMaT system was built based on Care Quality Commission (CQC) activity. The main purpose is to capture recommendations following inspections. The Quality

Directorate are working to tailor the module for capturing all HIW activity including concerns, enquiries and local / national reviews. Whilst these activities are captured on the system, at present the ability to theme the intelligence and pull qualitative data is limited and work is underway with AMaT and other Trusts / Health Boards across Wales to expand the systems capabilities for this.

Appendix A also provides an overview of any concerns received. Due to the above, there are limitations with reports at present. As such, Appendix A does not provide a description of each concern, or themes.

For the purpose of the committee, the issues which require attention are in relation to the Hergest Unit, Ysbyty Gwynedd where an increase in concerns / enquires have been received via HIW with approximately 5 concerns received since 1st April this year.

In September 2021, HIW visited the Hergest Unit. The service were issued with an immediate improvement plan due to areas of risk to patient safety. The following as some of the areas which required improvement:

- Governance, Leadership and Accountability (communication from senior management to staff)
- Workforce (staffing levels, resources and staff wellbeing)
- Dignified care (use of areas and sufficient staff cover for admissions)
- Peoples rights (record keeping, capacity assessments)
- Timely access (such as pathways)
- Peoples rights (completion of capacity assessments)
- Listening and Learning from feedback (patient and staff meetings)
- Managing risk and promoting health and safety (risk assessments and audits)
- Infection prevention and control (COVID-19)
- Medicines Management (use of medication management policy)
- Record keeping (accurate and consistent completion of records such as care plans)

The recent concerns/enquires received from HIW, relate to some of the above themes captured during the inspection last year. The matter has been escalated to the accountable directors within the service and the Quality Directorate will work with the service to conduct an internal HIW Quality Check by November 2022 and to support service improvement.

QUALITY GRAND ROUNDS PROGRAMME – HIW SESSION

Due to the increase in HIW activity over recent years, along with the Services Requiring Significant Improvement (SRSI), the Quality Directorate invited HIW to take part in the Quality Grand Rounds Programme in September 2022.

HIW presented to Health Board staff and discussed their role as regulators and how they operate. In addition, how the Health Board can, in accordance with the Health and Care Standards for Wales 2015, drive learning and improvement following HIW activity to ensure high quality care is achieved.

Feedback from the Quality Grand Rounds along with intelligence from our Quality Management Systems, help to develop the programme which is under review as whilst engagement from staff has been good so far, further engagement needs to be achieved, including that of clinical and operational staff.

CARE INSPECTORATE WALES (CIW)

As the independent regulator of social care and childcare in Wales, CIW register, inspect and take action to improve the quality and safety of services for the well-being of the people of Wales. They

work in partnership with other regulators such as Healthcare Inspectorate Wales, Wales Audit Office and the Older People's Commissioner.

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services.

Recently the Health Board has become aware that there are domiciliary services we provide which are not registered. Whilst the Health Board is registered a provider for multiple services, registration currently only includes 'Enhanced Community Residential Services', and now needs to include 'Home First Services (Ty Adref)', which is unregistered.

The Quality Directorate are liaising with CIW and key staff within the Health Board to ensure that the matter of registration is addressed without delay, and will assist CIW with exercising their regulatory requirements.

Inspections filtered by

Inspection origin
Healthcare Inspectorate Wales (HIW)

Inspection type
New

Summary					Actions							
No. of inspections	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
29	15/102 (15%)	4/16 (25%)	0	0	34	0	116	77	1	39	0	38

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22- 840 YGC ED HIW Inspection	0/30 (0%)	0	0	0	0	0	109	1	1	28	0	0
CE21-2140 Hergest Unit, MHLD	1/2 (50%)	0	0	0	0	0	0	1	0	0	0	1
CE21-2601 HIW Unannounced Inspection Tan y Coed, Bryn y Neuadd	11/12 (92%)	1/1 (100%)	0	0	0	0	0	1	0	0	0	12

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE21-2863 HIW National Review - Patient Flow (Stroke Pathway)	1/4 (25%)	3/5 (60%)	0	0	0	0	0	6	0	0	0	6
CE22-336 YGC ED HIW Inspection	0/13 (0%)	0/1 (0%)	0	0	0	0	5	41	0	8	0	0
CE22-261 HIW Quality Check, Emergency Department YG	2/4 (50%)	0	0	0	0	0	0	2	0	0	0	15
CE22-603 YG ED Staffing Concerns	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-741 Letter of Concern - Hergest Unit, MHLD	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-843 Ysbyty Glan Clwyd, Emergency Department - Service Requiring Significant Improvement	0	0	0	0	0	0	0	0	0	0	0	0
CE22-841 Letter of Concern - Hebog Ward, YG	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-907 Request for Assurance Ablett Unit, Dinas Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
HIW Enquiry Heddfan Unit, Hydref Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	MD	SD	WN	PIR	In progress	Part. complete	Part. complete (Overdue)	Overdue	Unable to complete	Completed (AA)	Rejected	Completed
CE22-957 Request for Assurance Ablett Unit, Dinas Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1008 Assurance around ED Staffing YG	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1178 - OFFICIAL SENSITIVE - Emergency Department, Ysbyty Glan Clwyd	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1177 HIW Assurances Required - WMH- ED	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-612 HIW Vascular Concerns	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	MD	SD	WN	PIR	In progress	Part. complete	Part. complete (Overdue)	Overdue	Unable to complete	Completed (AA)	Rejected	Completed
OFFICIAL SENSITIVE Concern- Bryn Y Neuadd	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1398 *OFFICIAL SENSITIVE* HIW Response Required - Wrexham Maelor Hospital	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1421 OFFICIAL SENSITIVE* YGC-ED Patient Safety Incident	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-1404 - *OFFICIAL SENSITIVE* Death In Custody AM	0/1 (0%)	0	0	0	0	0	0	1	0	0	0	0
CE22-1139 HIW-Concern-Seeking Assurances-Hergest Unit	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1118 HIW - Assurances Required-Rhoslan Surgery-COLWYN BAY	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-1121 IRMER Cardiac Catheterisation Service & Hybrid Theatre at Glan Clwyd Hospital	0/10 (0%)	0	0	0	0	0	2	9	0	3	0	4
CE21-1118 National Review of MH crisis prevention in community	0/10 (0%)	0/9 (0%)	0	0	34	0	0	15	0	0	0	0
CE22 -1474 OFFICIAL SENSITIVE* HEDDFAN ESCALATION REQUIRED	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-1547 - RE: Official PPO Final Report- P.W - HMP Berwyn	0	0	0	0	0	0	0	0	0	0	0	0
TEST	0	0	0	0	0	0	0	0	0	0	0	0
HIW Concern - Hergest - TO	0	0	0	0	0	0	0	0	0	0	0	0

Teitl adroddiad: ***Report title:***	Quality Achievements			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Committee with some of the Health Board's recent awards, achievements and recognitions in relation to Quality.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Erika Dennis, Quality Lead Manager Amanda Blaynee-Roberts, Quality Business Support Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	BAF21-10 - Listening and Learning

gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Quality Achievements	

Betsi Cadwaladr University Health Board
Quality Achievements

Llandudno Project Manager publishes cancer support book to help families

A member of staff from Llandudno Hospital has released a new book which helps parents talk to young children about cancer. Simone Baldwin, a project manager with the ALS Team based at Llandudno Hospital, used her own experience to write the children's book. Thanks to a range of fundraising, Simone is also providing free copies of her book to local libraries and schools.

Simone was diagnosed with a brain tumour when her son Sam was only six years old. However, she was unable to find a book or resource which helped her communicate her condition to her young son. The lack of resources for parents inspired her to create a picture book to read with children to help other parents to talk about tumour diagnosis.
Simone said: "I wanted to make sure for my son he was kept as informed as I felt he needed to be.

"I wrote a poem for young children called *Mummy Has a Lump,* to guide conversations about tumours, without using the words tumour or cancer. "The book includes a section for parents about my experiences and how I told my family. "Everyone's experiences are so unique, I hope that reading about my experiences will help other parents decide what feels right for them."

As well as working with a local illustrator to create the children's book, Simone teamed up with respected Welsh poet Rhys Iorwerth to develop a bilingual edition. Simone also created a GoFundMe page to raise funds to provide free copies for Conwy libraries, schools and charities. The book, which is now available on general sale, was released on September 14, 2022.

New research grant for Diabetes Dietetic Team

The diabetes dietetic team in East area have been awarded a Community of Scholars grant to collaborate with the Research Faculty at Glyndwr University. The project is taking place August 2022 to February 2023. The team had piloted an on-line group programme for newly diagnosed Type 2 diabetes.

The study "Toward patient Empowerment in Type 2 diabetes through a Patient-Centred Design Approach" has been approved by Glyndwr RESC. Working together with primary

care East colleagues, through workshops, the team is evaluating the whole process of engagement, referral and uptake to the programme, to inform a scalable roll-out.

Elaine Jennings, Service Lead for Diabetes BCUHB said: “We had co-produced the group session, New To Type 2 (N2T2), with patients, but the challenge now is to integrate this intervention into a pathway of care in a scalable way to enable widest possible access”.

The Community of Scholars aims to develop applied health research across North Wales.

Dr Rafiq Elmansy is the lead for Glyndwr and said: “It is an excellent opportunity to work with the dietetic team, GPs and diabetes practice nurses in a collaborative environment to learn more about patients' adherence to the online group programme and how to improve their adherence and experience.”

Victoria Williams, Diabetes and Renal dietetic team lead, said: “The funding has also given us an opportunity to improve knowledge, skills & confidence within our staff team to integrate research within usual care.”

First patients undergo robotic assisted surgery in Wales under innovative national programme

State-of-the-art surgical robots are now helping to treat colorectal and gynaecological cancer patients in Wales as part of the new National Robotic Assisted Surgery Programme.

The National Robotic Assisted Surgery Programme was introduced by the Welsh Government to improve outcomes for cancer patients by increasing the number of patients across Wales who have access to less-invasive, minimal access surgery (MAS). MAS offers well-recognised benefits to the patients, when compared to open surgery, including reduced pain, scarring and recovery time.

CMR Surgical’s Versius robot enables surgeons to perform complex procedures precisely and accurately, with the surgeon operating four robotic arms from an independent, open console.

Professor Jared Torkington, Consultant Colorectal Surgeon, said: “We are hugely excited about the start of the unique networked robotic programme in Wales, designed to improve the quality of surgery, attract and retain staff and work with the public in highlighting the importance of early presentation and existing screening programme in bowel and other cancers.”

Earlier this month, the first robotic cases were carried out within Gynaecology at Betsi Cadwaladr University Health Board.

New App to help transform the delivery of dementia care to be created in North Wales

A new digital app to help create more dementia-friendly environments and support patients is set to be developed and tested in North Wales.

The Health Board is working with experts from the University of Worcester to create the app, which will replace the current paper-based assessment tool used to assess how dementia-friendly care environments are.

The project is due to start in October and will initially involve staff from 12 wards from our acute and community hospitals and mental health wards in North Wales.

Once ready, the app will be made available globally to make it easier for staff to assess and improve care environments and improve the lives of people with dementia.

Sarah Waller CBE, Associate Specialist from the Association for Dementia Studies at the University of Worcester, previously led the development of the King's Fund Enhancing the Healing Environment (EHE) programme, which encouraged and enabled nurse-led teams to work in partnership with patients to improve the environment in which they deliver care.

Sarah said: "There is now growing evidence that dementia friendly design can promote inclusion, independence and quality of life for people living with dementia. We know that the results of assessments using the tools have led to improvements in the care environment for people living with dementia, their relatives and the staff that care for them. "We are grateful to the Health Board for funding this project and look forward to working with them on this development which will make the tools more accessible and easier to use".

Hypo Awareness Week 2022

3 October to 9 October 2022 is Diabetes Hypo Awareness Week.

Throughout the week, Diabetes and Endocrinology staff across North Wales have been raising awareness of hypoglycaemia.

Online dementia training opportunity

New fully online dementia training is available to Health Board staff with immediate effect.

Thanks to two sources of funding (Welsh Government and BCUHB's Education Department) this comprehensive dementia training is now available.

There is training at different levels according to whether staff need to be 'Informed', 'Skilled' or 'Influencers'. There is *mandatory* dementia awareness training already available in ESR.

The training is available 24/7, 356 days a year and is mapped to Skills for Care, The Good Work Framework, NHS Training Standards and National Occupational Standards. Staff can complete one or more modules at their own pace. Release time/other support is to be negotiated locally. Training is compatible with iPads, desktop PCs and phones. Each module would need approx. 2-3 days engagement time depending on individual learner needs and abilities.

Patient Champion of the Year

Congratulations to Diane Sweeney, activities co-ordinator at Mold Community Hospital, for being named Patient Champion of the Year for all her hard work and dedication.

Neonatal read-a-thon at Glan Clwyd Hospital

Staff at Glan Clwyd Hospital's Neonatal Unit have taken part in an engaging event promoting the importance of reading books, singing and talking to babies.

Books, donated by Book Trust Cymru and sourced from a World Book Day survey (2018), are being leant to parents on the unit to borrow and read the books to their young children.

Books highlighted in the '10 of the Best Books for NICU Readers' and available on the unit include: Each Peach Each Plum, The Wonderful Things You Will Be, I was a Preemie Just Like You and Guess How Much I Love You.

The event is part of the Little Readers Read-A-Thon an international event run by NIDCAP Centre, Australasia and Life's Little Treasures Foundation. NIDCAP stands for the New-born Individualised Developmental Care and Assessment Programme.

Neonatal Occupational Therapist Katy Fox said: "The whole event was really positive and gave us a great opportunity to focus on the benefits of families reading together. Reading to their babies can provide parents with a sense of control and a sense of normality, it is a lovely parent/infant occupation and promotes bonding by enabling parents to engage with their baby in a positive way."

Teitl adroddiad: ***Report title:***	Sepsis review			
Adrodd i: ***Report to:***	Quality Safety Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	Sepsis continues to contribute to mortality in BCUHB. Of the approximate 700 cases referred back from the Medical Examiner Service (MES) to the HB, 91 included sepsis either as a direct cause or a contributor to mortality. Within BCUHB we have invested in Acute Intervention Teams on the 3 acute sites, to provide direct patient care for the deteriorating patient. The AITs also provide education and support to front line staff around recognition and treatment of sick patients, with a particular focus on NEWS and the Sepsis 6 bundle In juxtaposition there is a rising pattern of anitmicrobial resistence (AMR) across North Wales. This results in a tension between the use of broad spectrum antibiotics as part of the early treatment of patients who may have sepsis. A national discussion is occuring relating to the potential to safely risk stratify sick patients and their need for urgent broad spectrum antibiotics. A reduction in use of broad spectruim antibiotics should reduce the risk of AMR continuing to increase. This has resulted in BCU (along with other HBs) being in transition from Sepsis 6 Bundle to a 'new' risk stratified tool.			
Argymhellion: ***Recommendations:***	The Committee is asked to note current progress and anticipate quarterly reports updating on the implementation			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons			
Awdur yr Adroddiad: ***Report Author:***	Dr Karen Mottart			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No – not applicable Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No – not applicable Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There are no related risks on the risk register
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	There are no related risks on the risk register
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** STEAR group to oversee implementation of new BCU wide sepsis pathway due by end of quarter 4	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1: BCU sepsis pathway	

QSE COMMITTEE MEETING IN PUBLIC
1st November 2022
REPORT TITLE: Sepsis: Review, reporting and improving

1. Cyflwyniad / Cefndir

Introduction/Background

1.1 NICE guidance clearly states that people with suspected sepsis are assessed using a structured set of observations to stratify the risk of severe illness or death.

1.2 If a patient develops sepsis the risk of mortality remains high. Mortality rates for a patient diagnosed with sepsis remains in the order of 20 to 30% across our acute sites. This has remained consistent over the previous 12 months. The focus on identifying those most at risk continues to be a challenge for clinical teams.

1.3 Thorughout Wales we have used NEWS, and more recently NEWS2 (a minor amendment to include a score if a patient is oxygen dependant), to provide a short hand assessment and communicaiton tool to describe the degree of physiological instability being experienced by a patient, i.e. how sick they are. NEWS2 looks at respiratory rate, oxygen saturation, blood pressure, pulse rate, level of consiousness / confusion, temperate. Each parameter is allocated a score, the higher the score the sicker the patient. The score can range from 0 ('normal') to a maximum of 20

1.4 Until recently The Sepsis 6 Bundle has been the 'gold standard' risk assessment tool for sepsis and antibiotic prescribing. The focus of Sepsis 6 Bundle has been on 'early recognition and treatment'.

1.5 A recent publication from the Academy of Medical Royal Colleges (AoMRC) - 'Statement on the initial antimicrobial treatment of sepsis' (published October 2022, replacing a previous statement May 2022) proposes a change in the way people with suspected severe sepsis are assessed and treated with antibiotics. The Statement proposes that NEWS2 should be used to supplement clinical judgement to risk assess the urgency of assessment and treatment. The recommendation is that patients are stratified depending on their NEWS with those with a higher score requiring an immediate response, quicker assessment and antibiotic treatment.

2. Corff yr adroddiad / *Body of report*

2.1 Monitoring sepsis identification and treatment: The Sepsis 6 bundle is used as the HB marker for compliance with recognition and treating sepsis. The data collected is linked to the 6 goals of early intravenous (IV) fluids, supplemental oxygen, measuring uring output, giving antibiotics, taking blood cultures and measuring serum lactate (an acid that develops during sepsis). All should be achieved within the first hour of identification of possible sepsis. The trigger for commencing the Sepsis 6 bundle is a NEWS of 3 or more with a high clinical suspicion of infection.

2.2 Sepsis 6 is one the HB tier 2 audits, i.e. it is mandated and continuous across all clinical areas. The majority of the data is collected via the emergency

departments (EDs) as they treat largest proportion of newly diagnosed septic patients. Current data indicates that the compliance with Sepsis 6 bundle is deteriorating – particularly regards the early delivery of antibiotics. Data from Septemeber indicates compliance as follows (with historic data in brackets)

Oxygen	89%(94%)
IV fluids	86% (91%)
Blood culture	84% (89%)
Urine monitor	87% (91%)
Lactate	77% (88%)
Antibiotics	56% (73%)

2.3 Investigation into the reason for the detrioration suggests that it may be linked, in part, to the introduction of Symphony (ED electronic patient record) as it entries for notes and interventions can not be retrospeciively time stamped. However the increased demands and poor 'flow' in our EDs must be considered as a factor in this deterioration.

2.4 Regards the significant deterioration in antibiotic compliance, discussion with prescribing clinical staff indicate that the current debate linked to the AoMRC Statement influences their urgency to prescribe for patients with a NEWS less than 6. See later

2.5 Current patterns of antimicrobial resistance: There is a global increase in the reistence of bacteria to antibiotics. The table below shows the percentage resistance patterns seen in E Coli bacteria (a common pathogen) across BCU. The rates highligted in red indicate resistance rates above the All Wales rates.

E.coli	co-amox	Pipercillin/ Tazobactam (PTZ)	Gent	PTZ/Gent	3rd Generation Cephalosporins	Amikacin	CoTrimoxazole	Fluroquinlones
BCU (n=412)	51.7	23.9	12.9	23.9	12.4	5.6	39.4	19.5
YWM (n=143)	53.1	30.1	14.0	30.1	16.8	7.7	38.5	21.7
YGC (n=114)	51.4	18.9	9.8	18.9	9.8	4.2	33.6	15.4
YG (n=144)	51.8	23.0	14.9	23.0	10.5	4.4	48.2	22.8

From: Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme. Public Heath Wales. Antibacterial Resistance in Blood Cultures in Wales 2021

2.6 The rates are increasing year on year and some of our antibiotics are no longer reliable in the fight against infection and sepsis. Piperacillin/Tazobactam (Tazocin©) has been used in recent years as the antibiotic choice in the Sepsis 6 bundle. The reason for this had been that it was effective in treating a broad spectrum of bacteria. The deveoping resistence to Tazocin is one of the reasons why medical staff are attempting to define the source of infection prior to prescribing, enabling them to use a more specific antibiotic. The work and investigaiton needed to determine the source of sepsis will delay the starting antibiotics

2.7 What are we doing about it? The benefits of the AoMRC statement are 2 fold (i) the sicker patients are focused on as a priority and (ii) allows healthcare

professionals more time to investigate and consider best treatment for the patient with a lower NEWS. It is estimated this stratification of risk assessment could reduce the use of broad spectrum antibiotics by up to 75%

2.8 The STEAR (Sepsis Triggers, Escalation and Antibiotic Stewardship Review) group was set up May 2022 in response to the initial AoMRC statement. It is a BCU wide group with membership from front line clinicians, AIT, microbiologists and antimicrobial pharmacists. They will oversee the transition to the new risk assessment tool for sepsis (see appendix 1). They will work wih the clinical effectiveness team and clincial staff to determine a new data set to measure compliance with the new tool.

2.9 The time frame for agreement and roll out of the new risk assessment tool is anticipated for end of Q4. Data collection for the new Sepsis Tier 2 audit is anticipated to commence in Q1 of 2023/24. The results of the audit will be tracked via both CEG and STEAR groups which will inform any necessary improvement and / or education needs depending on results.

2.10 A quarterly progress report will be provided to QSE

3. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

There are no budgetary implications associated with this paper per se. It assumes that all current education and escalation processes are already in place, and the use of antimicrobials will not be result in a higher financial burden than current practice.

However if it becomes apparent that additional resourses are required this will be included in future papers.

4. Rheoli Risg / Risk Management

There are no risks on the register linked to sepsis or the deteriorating patient

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications***

5.1 There is no EqIA implicaiton currently identified within this paper

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

Adult Sepsis Screening Tool

The use of this tool should not replace clinical judgment

Version 1.2

Emergency Department or Inpatient Use			
Ward / Area:			
Consultant:			
Date		Time	
Completed by			

1. IDENTIFY THE DETERIORATING PATIENT

NEWS + ≥ 3	Yes ☐
NEWS+ Score	
OR Patient looks acutely unwell	Yes ☐

Patient Details

Y

2. Could this be due to an INFECTION?

Pneumonia	☐
Urinary Tract Infection	☐
Unknown (Likely chest or Urinary source)	☐
Intra-abdominal / Biliary	☐
Cellulitis, Soft tissue, Joint or device infection	☐
Other (Specify……)	☐
Completely Unknown	☐

N

SEPSIS UNLIKELY ☐

Investigate for an alternative diagnosis of the deteriorating patient & escalate as required

Continue to monitor patient
If the patient condition changes or **NEWS+** increases without an alternative diagnosis re-screen the patient

N

Y

3. NEWS ≥6 or is at least ONE of the following present

Respiratory rate ≥ 25 per minute	☐
Oxygen required to keep SpO2 ≥ 92%(88%in COPD)	☐
Heart rate > 130 per minute	☐
Systolic BP ≤ 90 (or drop >40 from normal)	☐
NEW altered mental state	☐
Non-blanching rash, mottled / ashen / cyanotic	☐
<0.5 ml/kg/hr in last 18 hours	☐
Neutropenia or chemotherapy within last 6 weeks	☐

N

4. NEWS 3-5 or at least ONE of the following present:

Respiratory rate 21-24	☐
Heart rate 91-130 bpm or new dysrhythmia	☐
Systolic BP 91-100mmHg	☐
<0.5 ml/kg/hr in last 12-18 hours	☐
New-onset altered mental state	☐
Temperature < 36ºC	☐
Trauma or surgery in last 6 weeks	☐
Impaired immune system	☐
Clinical signs of wound, device or skin infection	☐

If patient has AKI and lactate > 2mmols escalate to SEPSIS PROBABLE

Y

Y

SEPSIS PROBABLE ☐

This is a time-critical condition
Inform senior clinical decision maker
Start SEPSIS 6 Immediately
Administer antibiotics **within 1 hr**

Scan to Download

SEPSIS POSSIBLE ☐

Inform senior clinical decision maker
Consider investigations eg X-ray/CT
Bloods for FBC, U&E, Gluc, LFT, Coag, VBG
Begin at least 1 hourly observations
Make antimicrobial decision **within 3 hrs**

SEPSIS 6		TIME	NAME	COMMENT / REASON NOT COMPLETED
➢ **SENIOR CLINICIAN IN ATTENDANCE**	☐			
➢ **Give Oxygen to ensure sPO2 ≥94%** (88-92% if COPD)	☐			
➢ **Take Blood Cultures** (prior to Antibiotics)	☐			
➢ **Give IV Antibiotics** as per micro guide **(1st dose < 1 hour)**	☐			
➢ **Give Fluid:** 500 mls stat of Hartmann's and review	☐			
➢ **Take blood for Lactate and Hb** (target>70g/l)	☐			
➢ **Start Fluid Balance chart** (consider catheter)	☐			

5. Reassess after Sepsis 6:

Systolic BP<90 mmHg	☐
Reduced level of consciousness	☐
Resps >25 pm	☐
Lactate not improved	☐
Other Clinical Concern	☐

YES

Refer to senior immediately +/- Critical Care (if appropriate):

Consider repeat fluid bolus especially if lactate >2mmols and hypotensive. (Up to 30mls/kg in resuscitation phase)

Time of Review		
Name and Signature		
Referral to Critical Care?	Y	N
Time of Referral:		

Teitl adroddiad: ***Report title:***	Her Majesty's Inspectorate of Prisons (HMIP) Inspection of HMP Berwyn – May 2022			
Adrodd i: ***Report to:***	Quality Safety Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This item is to provide information on the Her Majesty's Inspectorate of Prisons (HMIP) unannounced inspection of HMP Berwyn during May 2022 and to provide assurance in relation to the recommendations identified and highlight good practice identified.			
Argymhellion: ***Recommendations:***	The Board is asked to review and acknowledge the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Gill Harris Deputy CEO /Executive Director Of Integrated Clinical Services			
Awdur yr Adroddiad: ***Report Author:***	Hannah Beer – Quality, Safety & Performance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This items links to all BCUHB Strategic Objectives.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No WP7 Procedure for Equality Impact Assessments reviewed and no policy / process development or decision making is included within this report.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No WP68 Procedure for Socio-economic Impact Assessments reviewed and no policy / process development or decision making is included within this report.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Issues identified within report are included within the Health Board risk register under the following references and titles: HMP16 - Enablement issues by HMPPS impacting on delivery of Health and Wellbeing Services at HMP Berwyn (score 20) HMP17 - Insufficient staffing levels within the Primary Care Team impacting on the delivery of Health and Wellbeing Service at HMP Berwyn (score 20) HMP15 - Significant delay in treatment provision to HMP Dental patients (score 12)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:***	Issues identified within report are included within the Health Board risk register under the following references and titles:

(or links to the Corporate Risk Register)	HMP16 - Enablement issues by HMPPS impacting on delivery of Health and Wellbeing Services at HMP Berwyn (score 20) HMP17 - Insufficient staffing levels within the Primary Care Team impacting on the delivery of Health and Wellbeing Service at HMP Berwyn (score 20) HMP15 - Significant delay in treatment provision to HMP Dental patients (score 12)
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** *Implementation of recommendations*	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Appendix 1 - HMP Berwyn HMIP Action Plan*	

Her Majesty's Inspectorate of Prisons (HMIP) Inspection of HMP Berwyn May 2022

1) What is HMIP?

HM Inspectorate of Prisons for England and Wales is an independent inspectorate led by HM Chief Inspector of Prisons. They provide independent scrutiny of the conditions for and treatment of prisoners and other detainees and report on their findings. They inspect prisons, young offender institutions, secure training centres, immigration removal centres, court custody suites and military detention. The inspections are guided by the idea of 'healthy establishments', in which staff support prisoners and detainees to reduce reoffending and achieve positive outcomes for themselves and the public. The reports include recommendations on how establishments can improve outcomes for prisoners.

The Inspection is split into the following sections with a number of expectations relating to specific areas used to measure compliance against:

- 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 families 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.

Prisons are inspected at least once every five years, although HMIP expect to inspect most establishments every two to three years. The vast majority of inspections are full and unannounced, assessing progress made since previous inspections and undertaking in-depth analysis.

2) HMP Berwyn Inspection

Her Majesty's Inspectorate of Prisons (HMIP) completed an unannounced inspection of HMP Berwyn in May 2022, this was the second inspection since the prison opened in February 2017. The first inspection took place in March 2019.

Health and Wellbeing service delivery is considered within the respect element of the inspection and subsequent report. Inspections of the Health and Wellbeing provision in establishments in Wales are a joint inspection with Health Inspectorate Wales (HIW).

HMP Berwyn received the following outcome during the inspection against each category:

	2022	2019
Safety	2 - Reasonably good	3 - Not sufficiently good
Respect	2 - Reasonably good	2 - Reasonably good
Purposeful activity	3 - Not sufficiently good	3 - Not sufficiently good
Rehabilitation & Release Planning	3 - Not sufficiently good	3 - Not sufficiently good

This report relates to the findings in relation to Health and Wellbeing service delivery only and does not review the wider prison report.

3) Concerns

The inspectors identified 11 area of concern across the prison, four of which they felt were a priority and should be addressed immediately. One related to Health and Wellbeing and is identified below:

Patients waited too long to access routine primary care clinics
Primary care staffing and inconsistent prison officer escort arrangements led to long waits of up to 12 months for many routine clinks.

There was one further concern identified in relation to Health and Wellbeing within the report which was classed as a key concern rather than priority, this was:

Several patients had been taken off antipsychotic and other psychiatric medicines which led to a deterioration in their condition.
This created potential difficulties when psychiatric treatment had to be reconstituted.

4) Notable Practice

The inspection team highlighted seven areas of notable practice across the prison as part of their full report, three of which related to Health and Wellbeing delivery and are detailed below.

The inspection team define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn.

A dietician worked closely with kitchen staff and the healthcare department to support prisoners with acute dietary conditions and with the PE department to support healthy living.

Specialist primary care staff such as physiotherapy, dietician and occupational therapist were working in innovative and flexible ways to meet patient's needs.

Mental health peer champions worked alongside professional staff to offer advice and support to prisoners across all houses. Novel wing-based mental health cafes on every house enabled prisoners to be seen promptly.

5) Summary of Inspection Findings - Health and Wellbeing Service

Overall, the inspection team felt that the Health care support had deteriorated since the previous inspection, however acknowledged the impact of the COVID Pandemic on health service delivery alongside the staff vacancies within the primary care team.

The positive practice and areas for improvement are detailed below within the sub headings the inspection team review service delivery against:

Strategy, Clinical Governance and Partnerships

Good practice:

- Robust governance and oversight arrangements were in place
- Risks were well understood, with controls and mitigations established.
- Incidents were reported and investigated and learning used to inform future practice.
- Acknowledgement of vacancies within the team, however workforce plans in place to address recruitment and utilisation of effective skills mix.
- Health and Wellbeing Centre and clinic rooms on houseblocks were very good and complied with infection control standards.
- Responses to complaints were thorough and leaflets on the process were available bilingually.
- Prisoner led telephone helpline provided valuable advice to prisoners.

Areas for improvement

- Care planning to capture clinical decision making and patient engagement fully.
- Lack of office space and group rooms.
- No suitable space for vulnerable prisoners to wait for appointments

Promoting Health & Wellbeing

Good practice:

- Health and Wellbeing Strategy Group in place which had delivered campaigns including nutrition and oral health.
- Good partnership working during COVID outbreaks.
- An eclectic and skilled health team delivered effective screening programmes.
- Access to a range of immunisations and vaccinations, including provision of sexual health advice and barrier protection.

Primary Care and Inpatient Services

Good practice:

- Wide range of health care specialists in place, the service delivery had reduced since last inspection. Many primary care vacancies, in particular nursing staff. The leadership team prioritised service based on risk and clinical priorities and service reconfigured to use staff innovatively.

- Initial and secondary screening occurred routinely for men arriving at HMP Berwyn.
- Same GP provider delivered in and out of hours service which supported continuity of care.
- Palliative care nurse has established an agreed pathway to support patients at the end of life.
- Availability of on-site x-ray, ultrasound and telephone consultations with secondary care consultants.
- Prisoners were appropriately supported on release and provided with a health summary and supply of medication.

Areas for improvement:

- Patients waiting too long to access most routine appointments *(key concern)*
- Insufficient prison escorts impacted on health and wellbeing appointment access.

Mental Health Care

Good practice:

- New leadership, stable staffing and innovative working had refreshed mental health services and patients were able to access an appropriate level of support.
- All new prisoners receive a full health screen to identify need and all remand prisoners are seen by the mental health team.
- Novel mental health cafes enabled prisoners to be seen promptly.
- Mental Health Peer Champions worked alongside professional staff to provide advice and support.

Areas for improvement:

- Pathways for men with personality disorder or ADHD were less well developed
- Accountability for specialist prescribing had become unclear *(key concern)*
- Delays in transfer for prisoners requiring specialist care and treatment in hospital under the Mental Health Act.

Substance Misuse Treatment

Good practice:

- The team worked effectively with prison staff to support the priorities of the drug strategy.
- First night and early days support was appropriate for prisoners with drug and alcohol problems.
- Clinical decision meeting was held every week to discuss complex cases.
- Peer support was visible and well organised.
- Good access to and engagement with a range of psychosocial programmes.
- Effective use of digital technology to deliver a range of online resources.
- Ethos of recovery was evident.
- Good access to alternative therapies, such as acupuncture.
- Mutual aid from Narcotics Anonymous and Alcoholics Anonymous had been maintained.

- Release planning included training in Naloxone (used to counter the effects of opiate overdose)

Areas for improvement:

- Operational shortfalls in wider Health and Wellbeing team resulted in care needs of men with substance misuse needs not being consistently addressed.
- Care plans were standardised rather than individualised.

Medicines Optimisation and Pharmacy Services

Good practice:

- Medicine optimisation and management procedures were good.
- The prescribing of tradeable medicines was well controlled.
- Patients arriving at HMP Berwyn were reviewed and managed appropriately to ensure the safety and clinical appropriateness of the medication.
- Patients had access to medication review services.
- A wide range of emergency medicines are available.
- Medicines management processes were good in relation to management and storage.

Areas for improvement:

- Medication administration could take more than two hours, which placed pressure on health and wellbeing staff.
- Patients who did not attend for their medication were not always followed up robustly.

Dental Services and Oral Health

Good practice:

- The physical dental environment is excellent.
- Robust oversight and governance of practice and services delivered by a motivated and skilled team.

Areas for improvement:

- Access to routine treatment is a longstanding issue *(key concern)*

6) Next Steps

Following the receipt of the full inspection report, an action plan has been developed to address the recommendations identified by the inspection team. The action plan is reviewed at a number of partnership governance meetings for monitoring and prompt resolution.
The action plan is attached as Appendix 1.

The Health and Wellbeing team are also addressing the areas identified by the inspection team which were suggested areas for improvement, however were not identified as formal recommendations.

7) Full Report

The full report is published on the HMIP website and available on the link below:

HMP Berwyn (justiceinspectorates.gov.uk)

APPENDIX 1 – HMP BERWYN HMIP ACTION PLAN

Concerns	Response Action Taken/Planned	Responsible Owner	Target Date	Progress
Priority concern				
Patients waited too long to access routine primary care clinics. Primary care staffing and inconsistent prison officer escort arrangements led to long waits of up to 12 months for many routine clinics.	Waiting times for all services are reviewed and monitored each month at the Quality, Safety and Performance meetings which includes health and prison membership.	Head of Healthcare & Deputy Governor	Ongoing	Complete *Standard agenda item and report received at monthly operational and quality meetings to review attendance / progress. Evidence available in the form of meeting agenda and minutes.* *Current waiting time:* *Routine face to face GP appointment - 5 weeks* *Urgent face to face GP appointment – same day* *Same day appointments available with nursing team*
	Waiting for routine GP appointments has been addressed with the delivery of a routine GP waiting list initiative adopting a residential house delivery model to reduce non-attendance. Aligned with this is the commencement of residential house GP clinics on Ceiriog to improve efficiency of available GP sessions by reducing non-attendance.	Head of Healthcare & Deputy Governor	August 2022 *(revised date November 2022)*	The Health & Wellbeing service have commenced routine GP appointments on houseblocks, however HMPPS staffing not consistently in place to support patients attendance. HMPPS have completed a review of their staffing profile to support patients in attending Health appointments. This staffing profile has been agreed and will take effect on site from 06/11/22. Review of impact will be conducted from December 2022.
	A full time recruitment officer in post to support timely recruitment to vacant clinical posts.	Head of Healthcare	August 2022	Complete *Staff member has been in post since May 2022*.

	The establishment will re-introduce free movement to support internal appointment attendance during the Core Day as part of the COVID Recovery Plan. This will support access to Health Services and reduce the need to facilitate all movements through Officers.	Deputy Governor	November 2022	*HMPPS action* *HMPPS are finalising the detail of the COVID recovery plan*
	The establishment has reviewed the Activity Profile and provided guidance and support to the Residential Areas surrounding Attendance to Activity and Appointments. This will be further supported by an increase in the officer support resource for Primary Care and GP Services within the new profile.	Deputy Governor	November 2022	As above. HMPPS have completed a review of their staffing profile to support patients in attending Health appointments. This staffing profile has been agreed and will take effect on site from 06/11/22.
	Funding for a routine care dental waiting list initiative has been approved which includes the recruitment of an additional clinical resource to increase capacity for the duration of the initiative. The delivery of this is initiative is dependent upon the recruitment of the additional clinicians.	Head of Healthcare	December 2022	*Funding agreement in place. Recruitment process in place for additional dentist and dental nurse* *The current maximum wait for a routine dental appointment is 1yr 20 weeks, however urgent appointments are seen following triage by the dental team.* *A programme of oral health promotion has also been completed and is regularly refreshed, including the provision of dental products and information to promote oral hygiene to support patients.*
	The Health Provider and the Operational Team monitor Attendance Rates at the Monthly Local Health Delivery Group Meeting and a specific Improvement Sub Group has been set up to run alongside the changes to Movement and Support Resource in order to monitor and drive improvement.	Head of Healthcare & Deputy Governor	December 2022	*Regular meetings held to review processes and implement measures to support attendance.* *Review will take place in December 2022 to consider impact of revised staffing support for health appointments by HMPPS.*

Concerns	Response Action Taken/Planned	Responsible Owner	Target Date	Progress
Key concern				
Several patients had been taken off antipsychotic and other psychiatric medicines which had led to a deterioration in their condition. This created potential difficulties when psychiatric treatment had to be reconstituted.	Weekly Prescribers Forum in place to support all prescribers by providing multi-disciplinary discussion around complex prescribing decisions or prescribing tradable medicines. This includes where there has been evidence of diversion or intoxication when prescribed medicines. Fortnightly forums will specifically focus on mental health medicines.	Head of Healthcare	August 2022	Complete *Prescribers Forum held on a weekly basis* *All prescribers (permanent and sessional at HMP Berwyn) are invited to attend the meeting which is co-ordinated by Lead Pharmacist.*
	When prescribing secondary care initiated mental health medicines, the prescriber will document a comprehensive plan describing the action to be taken by the GP in the event of intoxication or diversion.		August 2022	Complete *Psychiatrists on site at HMP Berwyn, supported by Mental Health Team Manager, ensure that plan is in place and known to staff on site.*
	On arrival at HMP Berwyn should the GP assess concerns regarding the safety or appropriateness of secondary care initiated mental health medicines these will be referred to the mental health team prescriber for early review and clinical decision.		September 2022	Complete *Process in place for GP to highlight to Mental Health Team. Mental Health team have allocated time for prompt daily review if required,.*
	The Health Provider (BCUHB) will develop a Shared Accountability Meeting as a sub group of the Medicines Management Group (MMG) to produce pathways and processes for clear		September 2022	*Meeting established and initial meetings have taken place.* *Work ongoing by Lead Pharmacsist to embed meeting within the service governance processes.*

	lines of accountability for prescribing of antipsychotic and other psychiatric medicines. Membership of this group will include but not limited to Mental Health Directorate Medical Director, GP Provider Medical Director and Lead Pharmacist. The Terms of Reference for this group to be agreed at MMG.			*TOR to be reviewed by MMG in November 22.*
	A clear explanation will be given to the patient by the prescriber explaining reasons for prescribing decisions. Patient information will be available to all patients explaining the rationale behind HMP Berwyn's medicines management strategy.		September 2022	Complete *Revised patient information leaflets on medicine optimisation policy have been developed.* *Shared with patients on arrival to HMP Berwyn by nursing team.* 48xxx Betsi HMP Berwyn Medication 49958 Betsi Berwyn Medication A5.pdf *Rationale shared by prescriber when required, either in person or by letter which is documented on clinical record.*
	An increased psychiatry resource will be introduced to support timely review of secondary care initiated mental health medicines.		January 2023	*Report submitted to HMP Berwyn Health, Wellbeing & Social Care Partnership Board to request increased funding for psychiatry provision which was agreed.* *Head of Healthcare is working with MHLD Medical Director in relation to recruitment.*
	The MMG is in place to oversee governance of prescribing at HMP Berwyn		Ongoing	Complete *Medicines Management Group (MMG) is a regular, monthly meeting within the HMP Berwyn governance structure and*

				is chaired by the Director Of Medicines Management (Integrated Health Community East)

Teitl adroddiad: ***Report title:***	Interim Summary Report (Royal College of General Practitioners) RCGP review of (Betsi Cadwaladr University Health Board) BCUHB Primary Care Development
Adrodd i: ***Report to:***	Quality Safety and Experience
Dyddiad y Cyfarfod: ***Date of Meeting:***	1st November 2022
Crynodeb Gweithredol: ***Executive Summary:***	The Assistant Director of Primary Care commissioned the RCGP to provide a diagnostic sustainability report with an accompanying quality improvement plan for twelve GP practices in North Wales. The practices were a mix of BCUHB managed and GMS (General Medical Services) practices. The practice sustainability reports are confidential to each practice. The RCGP identified specific issues within BCUHB managed practices, which led to an interim report documenting their findings. These are described in their report (appendix 1). The RCGP consider these issues to be outside the control of the individuals employed in the practices. These issues include • Clinical demand and capacity mismatch • High number of patients with respect to WTE (Whole Time Equivalent) GPs • Poor staff morale • Focus on meeting immediate / acute demand with limited time for patients with more chronic and complex needs This report, the outcomes of both the recent primary care sustainability board workshop and the recent primary care vision-setting workshop will help to inform the new primary care programme board and its underlying work streams. A specific deep dive into managed practices is planned as part of this programme. The outcomes of this work will then underpin the planned strategy for primary care and specific outcomes and actions. The RCGP will review this work on a fortnightly basis.
Argymhellion: ***Recommendations:***	The committee is asked to note the findings of the report and the proposed next steps.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons
Awdur yr Adroddiad:	Dr Jim McGuigan Dr Emma Hosking

Report Author:				
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Clinical Services Strategy The Primary Care Strategy is in development and is anticipated to be completed by the beginning of January 2023.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***				
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N/A			

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The risks arising from the report are currently under review
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Potential need to match pay for clinical staff between independent contractors and BCUHB could lead to increased costs for BCUHB. This detail will be worked through following the deep dive into managed practice in November 2022.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Need to improve recruitment and onboarding processes in BCUHB
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) Not applicable currently
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	This is being reviewed following receipt of the report.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. *RCGP Primary Care Development Interim Summary Report to Betsi Cadwaladr University Health Board*	

Guidance:

Quality, Safety and Experience Meeting

1st November 2022

Interim Summary Report of Royal College of General Practitioners (RCGP) review of BCUHB (Betsi Cadwaladr University Health Board) Primary Care Development

1. Cyflwyniad / Cefndir
Introduction/Background

This paper is to inform the QSE of the contents of the interim summary report of the RCGP (Royal College of General Practitioners) review of BCUHB Primary Care Development (appendix 1) and the response of the Office of the Deputy Director for Primary Care.

2. **Corff yr adroddiad /** ***Body of report***

BCUHB commissioned the RCGP to provide a package of support to twelve GP practices across BCUHB. The sustainability assessment and support is a standardised approach offered by the RCGP UK wide.

RCGP support was offered to both GMS practices and BCUHB managed practices across the three health communities. Five GMS practices and six managed practices had completed the scoping exercise at the time of the interim RCGP report to BCUHB.

The RCGP support process is confidential between the practices and the college. The RCGP generates an individual diagnostic report with a quality improvement plan for each practice once the process is complete. The confidentially allows for full engagement with the RCGP, which is considered essential for full candour and the generation of a meaningful individualised practice report. The individualised practice reports are currently outstanding.

Due to issues raised during the scoping exercise, the RCGP has taken the unusual step of issuing an interim report to highlight their findings (appendix 1). The interim report only addresses the findings within the BCUHB managed practices.

The RCGP findings are recorded as a set of themes listed below:

1. Advisers reported their concerns about potential patient safety issues. Whilst no specific examples of harm to patients were identified, there is often significantly more clinical demand than the services have the capacity to deliver.

2. The lack of capacity to meet demand is affecting the morale and well-being of some staff.

3. In some localities, there is severely reduced access for both patients and staff to a GP for several hours.

4. There are high levels of patient numbers per WTE (whole time equivalent) GP.

5. Sometimes staff are only able to manage on-the-day demand, with a limited capacity to provide care for patients with complex long-term conditions, mental health problems or undertake annual reviews.

6. Non-clinical staff are taking on roles and responsibility to manage clinical issues related to patient care.

7. Some practices are switching phones off to try to manage patient demand and workload.

These themes all stem from a lack of available clinical staff (GPs from the RCGP perspective) versus demand, which has led to practice level mitigations and potentially staff working outside their competencies.

The RCGP interim report identified potential solutions to their findings, which are followed by examples of good practice within the managed practices (appendix 1)

Assessment

Staffing managed practices has been a challenge since their inception and is a function of the lower WTE numbers of GPs in North Wales compared to the most areas of the UK. These difficulties have led to several different multi-disciplinary service models in the managed practices that are different to most GMS practices. Most GPs working in Integrated Health Community (IHC) East managed practices are locum GPs. During the period of RGCP engagement, at least two managed practices were having acute staffing issues that the then Area teams were heavily involved in managing.

The RCGP interim report helped to inform part of the discussion at the primary care vision-setting workshop (26/09/2022). Whilst the primary aim of the workshop was to facilitate the development of a primary care strategy, the output of the workshop has also led to the development of a primary care programme board and work streams. Within that programme a series of deep dives into various aspects of primary care are planned. One deep dive will concentrate upon all aspects of BCUHB managed practices. This will allow the development of a delivery plan for managed practices, which will encompass agreed models of care, the development of an accountability process for managed practices, and enhanced recruitment.

Furthermore, following the recent board workshop in September 2022 around primary care sustainability in its widest sense, it was agreed that whilst independent contractors are the preferred model of delivery of primary care medical services, a mixed economy with some managed practices would be retained. This will give the platform to develop both a quality improvement and test bed function within primary care. This steer from the board is a new and clear direction of travel, which will inform the wider primary care strategy.

The RCGP has agreed to maintain fortnightly meetings with Dr Jim McGuigan to review ongoing progress and offer their further insight.

The actions in summary:

1. Development of primary care programme board (commencing November 2022) and primary care work streams using intelligence from relevant deep dives (commencing week 4 October 2022).

2. Rapid development of a primary care strategy and delivery plan with outcome-based objectives, to be completed beginning of January 2023

3. Continued regular RCGP input to review progress until January 2023

4. Staffing levels and competencies across all managed practices will be mapped using the Wessex LMC GP practice staffing framework (appendix 2). At a practice level, management locally will then reference their confidential practice report against this framework to ensure that staff are working within their competencies. The practice's framework data will be used to inform the wider work during the managed practice deep dive.

3. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

There are no budgetary implications associated with this paper at this time.

4. Rheoli Risg / Risk Management

This paper is not linked to any of the current corporate risk register items

5. Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications*

There are no equality and diversity implications at this time but Procedure WP7 will be referenced as the work progresses and EqIA and SEIA compliance will be incorporated as required.

Royal College of General Practitioners

RCGP Primary Care Development
Interim Summary Report to Betsi Cadwaladr University Health Board

Date: 24 June 2022

Contents

Introduction and Key Themes

It is apparent that staff across all practices and within Betsi Cadwaladr University Health Board (HB) are doing their best to manage some challenging issues.

The RCGP advisers have now undertaken a scoping exercise with seven of the 12 practices involved in the initial stage of this project. Each of these 12 practices has had or is scheduled to have a face-to-face visit by the advisers allocated to a practice. For more detailed background information on the project, see Appendix 1.

Some common themes have emerged from both GMS and HB managed practices across the three Integrated Health Communities (IHC); many of these reflect the issues raised by the HB before starting this project (see Appendix 1).

However, there are some issues specifically within the HB managed practices that have the potential to compromise patient safety, impact on the health and well-being of staff, resilience, and sustainability.

Key Themes

The following themes have been identified at HB managed practices:

- Advisers reported their concerns about potential patient safety issues. Whilst no specific examples of harm to patients were identified, there is often significantly more clinical demand than the services have the capacity to deliver,
- The lack of capacity to meet demand is affecting the morale and well-being of some staff
- In some localities, severely reduced access for both patients and staff to a GP for several hours
- High levels of patient numbers per WTE GP
- Staff only able to manage on-the-day demand, with often a limited capacity to provide care for patients with complex long-term conditions, mental health problems or undertake annual reviews
- Non-clinical staff taking on roles and responsibility to manage clinical issues related to patient care
- Some practices switching phones off to try and manage patient demand and workload.

The overarching problem is the lack of available GPs. This is likely to impact on the delivery of safe, effective, and appropriate health care and high levels of stress for clinicians. The concerns are that this could potentially lead to missed diagnoses, clinical errors, a demoralised workforce, staff sickness and/or resignation.

The RCGP were commissioned to provide a diagnostic report to each practice and a QI plan. It has become evident that some of the actions needed to address the issues identified are outside of the control of individuals employed in the practices and in some instances, the HB themselves. The RCGP are committed to continue to support both the staff and practices, however we need to 'reframe' our approach.

The practices we have started to support are all struggling with significant issues around the recruitment and retention of staff and, as a result, are working under significant clinical and

administrative pressures. These challenges appear, in most cases, to be so significant that it would be inappropriate to ask them to do extra work for us that, in all probability, would not benefit the practice in the short term. An example of this is providing detailed analysis of data around clinical performance.

After discussions amongst the RCGP management team, we have decided to shift the focus of our support. It has become apparent that, in most instances, the priority needs to be to support the well-being of the staff, rather than only to provide a detailed analysis of data, processes, and systems. Our advisers will work with them to find solutions to the issues that have been highlighted and if necessary, escalate when required.

Solutions

GP recruitment
The issues of staff recruitment and retention especially in GPs is a priority. We would suggest that there needs to be a UHB strategy to address this key issue.

Information from the Welsh Government in Nov 2020 indicated that 200 new GPs had been recruited and North Wales would benefit from 29 of these new trainees. This programme was supported by HEIW with each trainee given a financial incentive of £20,000 and a one-off payment to cover the cost of their final exams. It would be interesting to know how many of these 29 trainees are still employed in BCUHB, if successful why, if not what needs to change and if repeating a similar scheme would attract more GPs.

Feedback from 'Project Flex' in the West IHC would be valuable, as would reflecting on other innovative projects across the UK and how these could be implemented in Wales.

- https://www.srmc.scot.nhs.uk/wp-content/uploads/2021/04/Notes-on-requirements-to-become-a-GP-in-Scotland-non-UK.pdf
- https://www.recruitmentsupport.scot.nhs.uk/
- https://www.bma.org.uk/bma-media-centre/bma-scotland-urgent-support-required-for-gps

GP & locum salaries capped

It has been reported that there is sometimes a fixed payment for Salaried and locum GPs in managed practices. This is less than GPs could earn working in non-managed practices. It is likely that this puts managed practices at a disadvantage and contributes to their recruitment and retention difficulties. This would benefit from a review.

General staff salaries

There appears to be a discrepancy between staff employed in HB managed and GMS practices in terms of salaries and terms and conditions of employment. This could put managed practices at a disadvantage in terms of retention and recruitment and would benefit from a review.

Recruitment process

There currently appears to be a protracted process in place when staff are appointed to a HB managed practice. This can result in prolonged delays of up to several months in replacing staff with subsequent impact on the existing workforce and workload. This would benefit from an urgent review.

HB as employers

Staff have commented on some of the benefits of being employed by the HB such as access to HR, finance, occupational health, and clinical governance support. Some of the less positive comments from the management and leadership teams in practices are lack of autonomy, inability to make decisions locally and the inability to make even simple changes without going through a series of lengthy bureaucratic processes.

Skills mix

There are innovative pieces of work in some IHCs where the use of the wider Multidisciplinary Team (MDT) team is being utilised effectively. Currently lack of staff appears to be impacting on their implementation and success. This model would benefit from being explored in more detail in terms of effective utilisation of skills, impact, and cost effectiveness. It would also highlight any gaps in skills and knowledge to meet the needs of the future practice population.
Wessex LMCs Practice Healthcheck Diagnostic Tool

The Wessex LMCs Wessex Skills Matrix tool could be adapted to encourage practices to look at skill mix in more depth. This would need to be done in looking at the population health of the locality now and in the future.

Staff working within their competencies

Some non-clinical staff appear to be working outside of their role, capabilities, and competencies. The patients' physical, mental health and well-being are at the forefront of their actions. They may be unaware of the consequences and implications of making such decisions. Non-clinical staff should not be placed in a position where they must make clinical decisions on the management of patient care.

An Away Day with non-clinicians could explore some of the challenges they are facing, provide some context and allow them to share practical solutions.

Staff supervision and support

The increased workload in practices, patient demand and addressing the backlog of care has had a negative impact on the resilience and well-being of staff. In England in March 2021 (post pandemic) the Professional Nurse Advocate (PNA) role was implemented. PNAs receive training to facilitative 'restorative supervision' for colleagues, nurses, and others. This type of leadership role and supervision enable staff to reflect and improve on the care they provide and address their own and colleagues' health and wellbeing.

The East IHC have already appointed two nurses to provide input and support to HB managed practices, the West have a similar role for PMs. The impact and learning from these roles could be shared across all IHCs.

Views of service users

There do not appear to be any formal Patient Participation Groups (PPGs) or Patient and Carer Participation Groups (PCPGs) across the IHCs. We know from elsewhere that the Covid-19 pandemic may have had an impact on establishing or maintaining these groups. The purpose of these groups is to work with the practice team to provide a service user's perspective on matters of policy and practice.

Some research in 2019 in three locations in Wales highlighted the important elements from the perspective of a service user when accessing primary care services. There were several positive comments. Some of the negatives were, concerns around the lack of continuity of care, qualifications of staff other than a GP managing their care and using IT to access appointments and order repeat prescriptions.

Nationally there have been campaigns to try and educate service users on appropriate use of health care e.g., Choose Well, using expertise of pharmacies. A local educational campaign that encourages people to access alternative professionals and services should continue.

The 'Making it Real" document is based around six themes which reflect *"the most important elements of personalised care"*. The "I" statements are seen from an individual's perspective and the 'We" what an organisation should put in place to make sure they are meeting the individual's needs. Practices may find this a helpful document.

Sharing example of innovative practice

The IHCs have already started to implement some innovative strategies in addressing some of the issues already highlighted. For example:

West IHC

- Piloting Project Flex, which consists of two semi-retired GPs working in the region for 16 weeks of the year. Two GPs from Hereford are piloting this project, with the intention of providing feedback in early February 2022. The RCGP have not yet seen this feedback
- Using GP Hub, a remote consultation service based in South Wales, to supplement GP shortages. Patients appear to have had some resistance to this approach as a perceived loss of face-to-face appointments. It would be helpful to have an update on the impact of this service including feedback from patients
- Allocating a PM employed by the HB in each practice who can make some changes. The amount of decision-making responsibility and accountability each PM has appears variable across the practices
- Recruiting GPs to work across sites and are starting to explore nursing roles that do the same

East IHC

- Employing two nurse leads at the HB that provide support and advice to those nurses in the managed practices

Central IHC

- Adopting an MDT approach to deliver care which appears to have had some success. Learning from these experiences could be beneficial to all practices across the three IHCs.

It is hoped that the RCGP can share some of these and other examples of innovation across all the HB managed practices.

Conclusion

The RCGP have witnessed dedicated clinicians and managerial staff struggling to provide safe and effective care due to the conditions in which they are working. The HB need to be fully aware of the gravity of the mismatch between capacity and demand and address the issues urgently in order to give patients in Wales the high-quality care they deserve. This interim report serves to highlight some issues and themes. The RCGP would welcome the opportunity to work closely with the HB to share good practice more widely and look for innovative solutions to these significant concerns.

Appendix 1

Background to the project

The RCGP were commissioned by BCUHB in January 2022 (date of contract signature) to provide support to GP practices across three IHCs: West, Central and South, and East. Practices are spread widely within the IHCs and each IHC appears to operate a different model in the provision of care to its service users and the utilisation of staff.

How were practices selected?

For West and East IHCs, practices were asked to volunteer themselves if they were interested in RCGP support. Practices in the Central IHC were identified for this programme through primary care sustainability matrix, escalation submissions and local knowledge. Health Board (HB) managed practices were contacted first regarding RCGP support.

How were priority practices identified by the Health Board?

IHCs prioritised managed practices to be supported first by the RCGP. Some practices were marked as priority due to the rapidity with which they responded to the expression of interest in RCGP support. IHC leads believe this was indicative that the practice was aware of internal issues that require external support.

The HB shared some common themes, though not all practices in each IHC had the same issues. BCUHB do not expect RCGP to support and encourage managed practices back to a partnership model, their expectation is that the RCGP would support with the issues identified below:

- sustainability
- insufficient or inefficient staffing levels
- poor definition of roles and responsibilities with lack of accountability
- lack of effective use of skills and knowledge both clinical and non-clinical
- recruitment of GPs
- developing efficient processes e.g., access, staffing, managing blood results/referrals/letters/meds management including prescriptions, dealing with patient expectations.
- capacity
- leadership
- turnover of staff
- lack of continuity of clinical staff
- culture
- premises

Practices involved in the project
The RCGP are supporting 12 practices in total across the three IHCs. Two of the 12 are currently being supported as one practice.

IHCs	GMS Practice	HB Managed
East	2	2
Central	2	1 (2)
West	1	3
Total	5	6

General update on the practices

At the time of this interim report the RCGP advisers have now undertaken a scoping exercise with seven of the 12 practices. Each of these 12 practices has had or is scheduled to have a face-to-face visit by the advisers allocated to a practice.

Following an initial telephone call, every practice was sent a MOU to sign and an essential information form to complete; with the permission of the practice, PM and GP all staff were also asked to complete a confidential questionnaire.

During the scoping visit, the RCGP advisers have where possible have had a confidential interview with as many clinical and non-clinical staff as possible.

In addition, the Clinical Leads have had calls via Microsoft Teams with staff in practices across the three IHCs.

RCGP Advisers

GPs, Advanced Clinical Practitioners and PMs were recruited where possible from professionals who had some experience of working within Wales. A minimum of two advisers are allocated to each practice. Any new advisers onboarded to support the programme are paired with an RCGP adviser who had experience of supporting practices outside the HB in either Wales or England.

The RCGP advisers are supported by two Deputy Leads.

Data

There is a plethora of data available in the public domain in England. Scrutiny of this data and making it available to advisers provides some insight and background to the practice on how well it is performing and a comparison with practices in their locality and nationally.

One of the challenges was trying to access this data for Welsh practices in a meaningful format. Staff from all three IHCs provided us with data on most of the practices, named contacts and locations on where specific data could be found. They were also able to clarify which sets of data that practices could access and provide themselves.

Appendix 2

In line with best practice in declaring conflicts of interest that may give rise to a perception of bias, the authors of this interim report were:

Andrew Cooper, Deputy Lead for the RCGP Primary Care Development Programme, and devolved nations lead

Andrew is taking a joint leadership role for the BCUHB commission with responsibility for supporting the RCGP Advisers going into practices. He is co-author of the interim report. He has worked in the NHS in Wales for all his professional life and was a GP in Cardiff for 32 years. He also has a background in medical education and worked for the Wales Deanery, and then HEIW. He is an examiner for the MRCGP.

Helene Irvine, Deputy Lead for the RCGP Primary Care Development Programme, and resources lead

Helene is taking a joint leadership role for the BCUHB commission with responsibility for supporting the RCGP Advisers going into practices and co-author of the interim report. Her background is as an Advanced Nurse Practitioner and most recently as a nurse adviser to Wessex LMCs. She has been a CQC specialist adviser and has wide experience of working in primary care, at both local and national levels and has contributed to several competency documents for the nursing including the national Covid 19 oximetry at home project. She has worked as a Deputy lead for the RCGP for 8 years.

Susanne Caesar, Medical Director of the RCGP Primary Care Development Programme, appointed in April 2022

Susi is normally the overall lead for all RCGP Primary Care Development commissions, providing support to the Deputy Leads responsible for delivery. She was responsible for proof-reading and commenting on the draft interim report.
Having separated in 2013, she is the ex-wife of the current BCUHB Executive Medical Director, Dr Nick Lyons. As such, she declared the potential for a perception of bias to all present and recused herself from any further involvement once the relationship became apparent at the initial meeting to present the interim findings.

Multidisciplinary Framework Costings

Please note, salaries do not include on-costs for these roles

KEY: Cannot undertake this activity | Needs extra training | Expected to be able to undertake this activity | Not cost effective | Competencies and relevance unknown

New PCN Ro

SKILLS & COSTINGS
(based on NHS AfC mid point years of service 2021/22 Pay Scales)

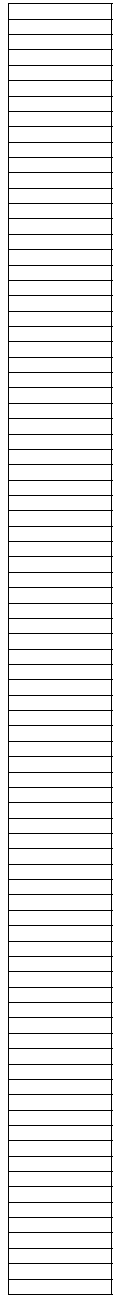
The timings of each activity represent the average from data provided by PMs/GPNs

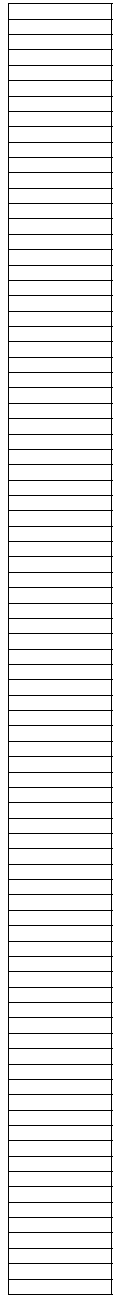
It is acknowledged that much more than a 'specific task/activity' takes place in any consultation

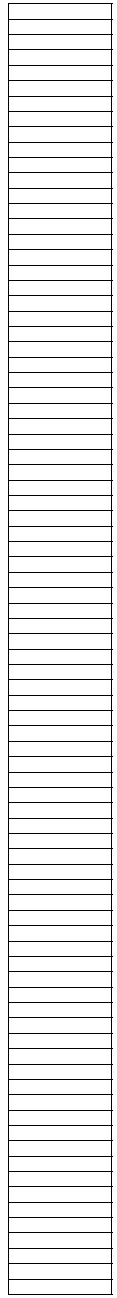
The list below provides a 'snap shot' of the most common activities. It is not a full list.

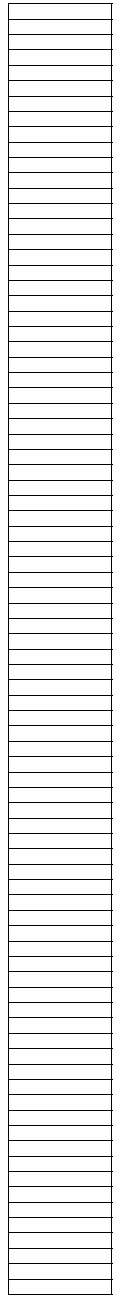
	PLEASE NOTE: Salaries DO NOT include on-costs for these roles	Nursing Apprentice	HCA	Nursing Associate HCA	GPN Level 1	GPN Level 2	GPN Level 3 (NMP)	ANP (NMP)	Consultant AP/NMP (PhD)	GP	GP & HCA (Band 3)	Nurse with Diploma (Band 6/7) & HCA (Band 3)	Care Co-Ordinator	Social Prescriber Link Worker	Healthy & Well Being Coach
	Bands		Band 3	Band 4	Band 5	Band 6	Bands 6-7	Band 8 (A-B)	Band 9			Band 6/7 & 3	Band 4	Up to Band 5	Band 4-5
	Potential Annual Full Time Salary (mid band)	Depends on age / level	£21,776	£24,881	£27,799	£34,171	£42,120	£53,218	£93,734	£93,000	£114,776	£63,996	£22,548	£27,779	£24,881
	Hourly Rates @ 20/21 AFC Scales (mid band)		£11.17	£12.76	£14.26	£17.52	£21.60	£27.29	£48.07	£47.69	£58.86	£32.82	£11.56	£14.25	£12.76
	Rate per Minute (rounded up/down)		£0.19	£0.21	£0.24	£0.29	£0.36	£0.45	£0.80	£0.79	£0.98	£0.55	£0.19	£0.24	£0.21
Prescribing															
Use of PGDs															
Referral Radiology															
Full Clinical Assessment & Decision Making including examination of: Respiratory system, Cardiovascular system, GI & hepatic, Renal & Genito urinary, Neurological, ENT, Eyes, Dermatology, Men's/Women's health															
Full MSK Assessment															
Paediatric clinical assessment															
Palliative & end of life care															
Leadership															
Clinical Teaching															
Research/Audit															
Home Visits incl Travel & Documentation	60			£12.60	£14.40	£17.40	£21.60	£27.00	£48.00	£47.40					
Same Day Access	10					£2.90	£3.60	£4.50	£8.00	£7.90					
ANNUAL REVIEW															
Learning Disabilities Review	30				£7.20	£8.70	£10.80	£13.50	£24.00	£45.00					
Medication Review	10				£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Mental Health Review	10				£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
LIFE STYLE															
Diet - Weight Control & Lifestyle Advice	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85			£2.85	£3.60	3.15
MGMT Of PRESENTATIONS - examples															
Central Chest Pain	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Sepsis & Signs of Deterioration															
Minor Illness Assessment (face to face)	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Triage	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Ear Infections	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Coughs & Colds	10					£2.90	£3.60	£4.50	£8.00	£7.90					
SOB	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Headache / Dizziness	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Medication Queries	10				£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Medication Reviews	10					£2.90	£3.60	£4.50	£8.00	£7.90					
Issuing & Signing Prescriptions															
Signing Repeat Prescriptions															
Sick Notes															
Hospital Referrals															
Ear Irrigation	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Appraisal of Others															
CVD Monitoring/Management	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
CKD	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Mental Health	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Health Promotion	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90			£1.90	£2.40	£2.10
Managing an Acute Asthma Attack															
Mgt. of UTIs	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Rectal Bleeding	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Gynaecological Examinations	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Abdominal Pain	10						£3.60	£4.50	£8.00	£7.90					
Skin/Rashes	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					

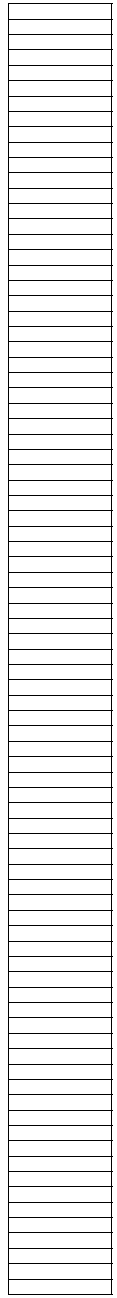
Hypertension Management	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
LTC (Long Term Condition)															
Asthma - New Diagnosis	30					£8.70	£10.80	£13.50	£24.00	£23.70					
Check inhaler technique	10				£2.34	£3.24	£3.57	£4.74	£8.44	£7.90					
Asthma Check/Review	20		£3.80	£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
COPD - New Diagnosis	20				£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
COPD Review	30			£6.30	£7.20	£8.70	£10.80	£13.50	£24.00	£23.70					
Patient @ Risk of Diabetes	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Diabetes - Newly Diagnosed	30				£7.20	£5.80	£10.80	£9.00	£24.00	£23.70					
Diabetic - Check/Review	20		£3.80	£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80	£19.60	£11.00			
Diabetic Pre-assessment - BP/Wt/Bloods	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85	£14.70	£8.25			
Spirometry	40		£7.60	£8.40	£9.60	£11.60	£14.40	£18.00	£32.00	£31.60	£39.20	£32.40			
PROCEDURE															
B12	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Phlebotomy	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Blood Test (read)															
Blood Test (request)															
Catheters - Female	30				£7.20	£8.70	£10.80	£13.50	£24.00	£23.70					
Catheters - Male	30				£7.20	£8.70	£10.80	£13.50	£24.00	£23.70					
Cryotherapy	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£6.80					
Ear Irrigation	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Electrocardiogram (routine)	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Injection Zoladex/Lidocaine	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
INR Test	5		£0.95	£1.05	£1.20	£1.45	£1.80	£2.25	£4.00	£3.95					
Minor Surgery (maybe with & without GP)	30		£5.70	£6.30	£7.20	£8.70	£10.80	£13.50	£24.00	£23.70	£47.34	£15.46			
Swabs (routine)	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Urinalysis	5		£0.95	£1.05	£1.20	£1.45	£1.80	£2.25	£4.00	£3.95					
SCREENING															
Alcohol Screening															
Blood Pressure Check (routine)	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
BP (home)/24hr Monitoring	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Health Check (NHS)	20		£3.80	£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
VACCs / IMMs															
Baby Imms - 1st app't	15			£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Baby Imms - Follow Up	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Flu Vaccination	5		£0.95	£1.05	£1.20	£1.45	£1.80	£2.25	£4.00	£3.95					
Hep A Booster	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Hep B Booster	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Meningitis ACWY	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Nasal Flu	5		£0.95	£1.05	£1.20	£1.45	£1.80	£2.25	£4.00	£3.95					
Pneumovax Clinic	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Shingles Vaccine	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Travel Vaccinations - 1st app't	25			£5.25	£6.00	£7.25	£9.00	£11.25	£20.00	£19.75					
Travel Vaccinations - 2nd app't	20			£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
Whooping Cough - Pregnant Women	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
WOMENS HEALTH															
Coil Check	10				£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Coil Fitting	25		£4.75	£5.25		£7.25	£9.00	£11.25	£20.00	£19.75	£24.50	£13.75			
Coil Removal	10						£3.60	£4.50	£8.00	£7.90	£9.80	£5.50			
Contraception Initiation	15						£5.40	£6.75	£12.00	£11.85					
Contraception Review	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Cx Smear	15			£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Depot Contraception	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Emergency Contraception (prescribe)	10						£3.60	£4.50	£8.00	£7.90					
High Vaginal Swab	10			£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Vaginal Discharge / Irritation	10			£2.06	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Implant Insertion	25		£4.75	£5.25	£6.00	£7.25	£9.00	£11.25	£20.00	£19.75	£37.50	£11.00			
Implant Removal	30		£4.68	£5.43	£5.43	£8.70	£10.80	£13.50	£24.00	£23.70	£45.00	£13.20			
Pessary Change	10					£2.90	£3.60	£4.50	£8.00	£7.90					
WOUND CARE															
Doppler	40		£7.60	£8.40	£9.60	£11.60	£14.40	£18.00	£32.00	£31.60					
Dressings Leg Ulcers - Compressions (per leg)	25		£4.75	£5.25	£6.00	£7.25	£9.00	£11.25	£20.00	£19.75					
Tissue Viability	20		£3.80	£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
Dressings (simple)	15		£2.85	£3.15	£3.60	£4.35	£5.40	£6.75	£12.00	£11.85					
Suture Removal (up to 10)	10		£1.90	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Suture Removal (up to 20)	20		£3.80	£4.20	£4.80	£5.80	£7.20	£9.00	£16.00	£15.80					
Application of Steris trips	10		£1.63	£2.10	£2.40	£2.90	£3.60	£4.50	£8.00	£7.90					
Application of Tissue Adhesive	10		£1.90	£2.10	£0.00	£0.55	£0.76	£4.74	£8.00	£7.90					

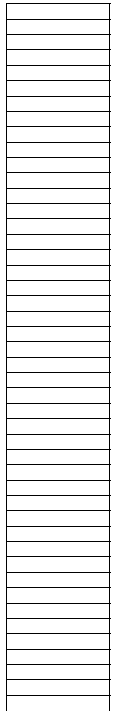












les Eligible for 100% Reimbursement up to a maximum amount.

Refer to the updated GP Contract 2020/21

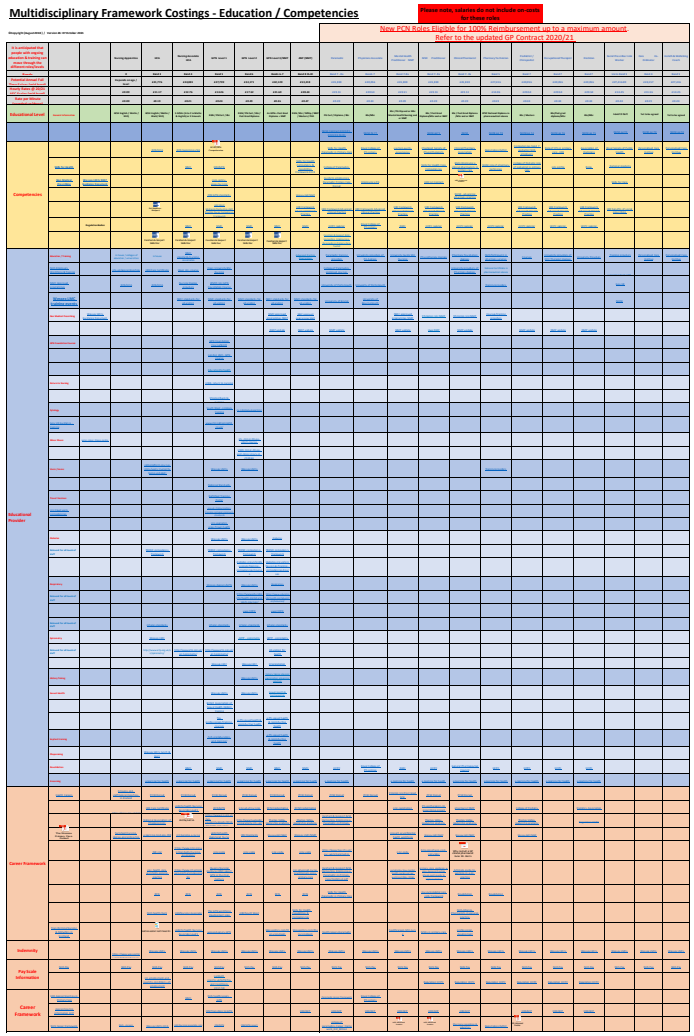
MSK Practitioner	Clinical Pharmacist	Pharmacy Technician	Paramedic	Physicians Associate	Dietician	Occupational Therapist	Podiatrist / Chiropodist	Mental Health Practitioner NMP
Band 7- 8a	Band 7- 8a	Band 5	Band 7 - 8a	Bands 7	Band 7	Band 7	Band 7	Band 7-8a
£45,838	£45,838	£27,416	£45,838	£40,056	£40,056	£40,056	£40,056	£45,838
£23.51	£23.51	£14.06	£23.51	£20.54	£20.54	£20.54	£20.54	£23.51
£0.39	£0.39	£0.23	£0.39	£0.34	£0.34	£0.34	£0.34	£0.39
£23.40	£23.40	£13.80	£23.40	£20.40	£20.40	£20.40	£20.40	£23.40
£3.90	£3.90		£3.90	£3.40				£3.90
	£11.70		£11.70	£10.20		£10.20		£11.70
£3.90	£3.90	£2.30	£3.90	£3.40				£3.90
	£3.90		£3.90	£3.40		£3.40		£3.90
£5.85	£5.85	£3.45	£5.85	£5.10	£5.10	£5.10	£5.10	£5.85
£3.90	£3.90		£3.90	£3.40				£3.90
	£3.90		£3.90	£3.40				
	£3.90		£3.90	£3.40				£3.90
	£3.90		£3.90	£3.40				
	£3.90		£3.90	£3.40				
£3.90	£3.90		£3.90	£3.40				
£3.90	£3.90		£3.90	£3.40				£3.90
£3.90	£3.90	£2.30	£3.90	£3.40	£3.40	£3.40	£3.40	£3.90
£3.90	£3.90	£2.30	£3.90		£3.40	£3.40	£3.40	£3.90
			£5.85	£5.10				
	£5.85		£5.85	£5.10				
	£5.85		£5.85	£5.10				
£3.90	£3.90		£3.90	£3.40		£3.40		£3.90
£3.90	£3.90	£2.30	£3.90	£3.40	£3.40	£3.40	£3.40	£3.90
	£3.90		£3.90	£3.40		£3.40		£3.90
			£3.90	£3.40				
			£3.90	£3.40				
			£3.90	£3.40				
	£3.90		£3.90	£3.40				

	£3.90		£3.90	£3.40				
	£11.70		£11.70	£10.20				
	£3.80	£2.30	£3.90	£3.40				
	£7.80		£7.80	£6.80				
	£7.80		£7.80	£6.80				
	£11.70		£11.70	£10.20				
	£3.90		£3.90	£3.40				
	£11.70		£11.70	£10.20				
	£7.80		£7.80	£6.80				
	£5.85		£5.85	£5.10				
	£15.60		£15.60	£13.60				
	£3.90		£3.90	£3.40				£3.90
	£3.90		£3.90	£3.40				£3.90
	£11.70		£11.70	£10.20				
	£11.70		£11.70	£10.20				
	£3.90		£3.90	£3.40				
	£5.85		£5.85	£5.10				
	£5.85		£5.85	£5.10				
	£3.90		£3.90	£3.40				
	£1.95		£1.95	£1.70				
				£10.20				
	£3.90		£3.90	£3.40			£3.40	
£1.95	£1.95		£1.95	£1.70			£1.70	£1.95
£3.90	£3.90	£2.30	£3.90	£3.40				£3.90
	£5.85		£5.85	£5.10				
	£7.80		£7.80	£6.80				
			£5.85	£5.10				
			£3.90	£3.40				
	£1.95		£1.95	£1.70				£1.95
	£3.90		£3.90	£3.40				
	£3.90		£3.90	£3.40				
	£3.90		£3.90	£3.40				
	£1.95		£1.95	£1.70				
	£3.90		£3.90	£3.40				
	£3.90		£3.90	£3.40				
	£9.75		£9.75	£8.50				
	£7.80		£7.80	£6.80				
	£3.90		£3.90	£3.40				
			£3.90	£3.40				
			£9.75	£8.50				
			£3.90	£3.40				
	£5.85		£5.85					
	£3.90		£3.90	£3.40				
			£5.85	£5.10				
	£3.90		£3.90	£3.40				
	£3.90		£3.90					
			£3.90	£3.40				
			£3.90	£3.40				
			£9.75	£8.50				
			£11.70	£10.20				
			£3.90	£3.40				
£15.60			£15.60	£13.60			£13.60	
			£9.75	£8.50			£8.50	
			£7.80	£6.80			£6.80	
			£5.85	£5.10			£5.10	£5.85
			£3.90	£3.40			£3.40	£3.90
			£7.80	£6.80			£6.80	£7.80
£3.90	£3.90		£3.90	£3.40			£3.40	£3.90
£3.80	£3.90		£3.90	£1.29			£3.40	£3.90

Multidisciplinary Framework Costings - Education / Competencies

Please note, salaries do not include on-costs for these roles

New PCN Roles Eligible for 100% Reimbursement up to a maximum amount
Refer to the updated GP Contract 2020/21



Teitl adroddiad: ***Report title:***	Psychological Interventions (including Psychological Therapies) for Children and Young People			
Adrodd i: ***Report to:***	**Quality, Safety and Experience Committee**			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	Following the paper presented on Psychological Therapies at Quality, Safety and Experience Committee, 3rd May 2022; this paper updates the Committee on the current position in relation to the delivery of Psychological Interventions (including Psychological Therapies) across Children's Services. A baseline mapping exercise has been completed using the Matrics Plant Framework (see Appendix 1) and Implementation Plan (see Appendix 2). The current position, next steps and recommendations are outlined.			
Argymhellion: ***Recommendations:***	The Commitee is asked to note the work undertaken to map the provision of psychological therapies for children in North Wales against the Matrics Plant framework and the actions identified for improvement.			
Arweinydd Gweithredol: ***Executive Lead:***	Gareth Evans, Acting Executive Director Therapies and Health Science			
Awdur yr Adroddiad: ***Report Author:***	Dr Sara Hammond-Rowley			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* x☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* x☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: The mapping exercise highlights the position of Children's psychological therapies in North Wales. Improvement activity is being overseen through the targeted intervention plan for All Ages Mental Health.				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Targeted Intervention Improvement Framework for Mental Health and Children's Services - Implementation of Matrics Plant. • Multiagency No Wrong Door Strategy • Implementing the principles of the NEST framework • T4MHS
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	No legal implications are identified.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No EqIA is included in the forward work programme.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No In the context of addressing health inequalities SEIA is included in the forward work programme.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	No significant risks
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Financial implications are identified within the IMTP and targeted improvement plans
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	• Continued investment in clinical leadership required within each specialty. • Continued investment in Administration and Project Management to support the functions as outlined. • Clinical supervision requirements will increase, impacting on capacity for direct delivery. This needs to be balanced against quality improvement. • Recruitment and retention challenges across all staff groups.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up***	Louise Bell, Regional Assistant Director CAMHS ;Llinos Edwards, Transformation

summary following consultation	Lead, CAMHS; Dr Angela Brennan, Consultant Clinical Psychologist, Fiona Wright, CAMHS Programme Management Business Lead for initial review Gareth Evans, Acting Executive Director of Therapies and Health Science for second review.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 1.4 Risk of a consistent failure to meet performance targets, resulting in an adverse impact on patient experience and quality of care, as well as a loss in public confidence
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:
Implementation of improvement recommendations

a) Continue with the planned work under the Targeted Intervention Transformation and Improvement Programme Project Group, and address the interdependencies across sub programmes to ensure necessary actions are adopted and taken forward without duplication.
b) Define and agree which evidence-based models of psychological intervention will be prioritised and delivered for children and young people across North Wales.
c) Define staffing needs across child specialities for the delivery of specific interventions and ensure a training plan is in place to support effective and sustainable delivery of intervention and intervention specific clinical supervision over time.
d) Establish and utilise systems to support the capture of data including performance, impact and outcomes, including systems which analyse and feedback data to inform on-going service improvement and development.
e) Establish pathways for access to all forms of psychological interventions and therapies and ensure clear co-produced information and guidance is available that meets the needs of children, young people and their families, alongside teams and referrers, to support local implementation.
f) Establish a reliable system to review changes in the evidence base and include guidance on how to create flexibility to adapt to any changes required.
g) Increase the level of audit, service evaluation and research activity in psychological interventions and establish a system to ensure findings and recommendations are used to inform service delivery.

List of Appendices:

Appendix 1. Matrics Plant Guidance (2020).
Appendix 2. Matrics Plant Implementation Plan Template (2021).
Appendix 3: NEST Framework (2021).
Appendix 4: Framework on Embedding a Whole School Approach (2021).

Appendix 5: No Wrong Door (2020).
Appendix 6: No Wrong Door - A Community-based Regional Strategy for Child and Adolescent
Mental Health. RPB (2021).
Appendix 7: Matrics Plant Implementation Baseline October 2022
Appendix 8: Extract MHM Part 1b CAMHS Performance Report September 2022

Quality, Safety and Experience Committee

1st November 2022

Psychological Interventions (including Psychological Therapies) for Children and Young People

1. Cyflwyniad / Introduction

This paper sets out the current position and proposed activity to be undertaken in respect of psychological interventions for children and young people, in response to actions approved at Quality, Safety and Experience Committee, 3rd May 2022 Action 1: Map our current position across all adult (physical and mental health) and Children's Services using the existing Matrics Cymru and Matrics Plant frameworks.

The aim of submission is to update the Committee on the current position, seek views for the proposed recommendations for improvement and provide assurance in respect of progress to date and the forward work plan for psychological interventions for children and young people age 0-18 years.

The current position has been established through completing baseline data collection using the Matrics Plant Implementation Plan. A work plan has been developed as part of the Targeted Intervention Improvement Framework for Mental Health and Children's Services and work is underway. Recommendations are based on identified gaps and good practice is highlighted.

2. Corff yr adroddiad / Body of report

a) Background and Context

i) Matrics Plant - Guidance on the delivery of psychological interventions for children and young people in Wales. Issued December 2020 (Appendix 1).

Matrics Plant was published following the earlier release of Matrics Cymru (2017) which is focused entirely on adult populations. The National Psychological Therapies Management Committee approached children's specialists to invite minor edits, the collective view was that the needs of children and young people require a much broader approach.

Although many of the general themes relating to the delivery of psychological help are the same when delivering to all age-groups e.g. the supervision and training needs of staff, prioritising evidence-based models; the needs of children are different enough to warrant a more inclusive 'whole-system' approach to the conceptualisation and implementation of psychological approaches.

Child Psychology in North Wales worked with Improvement Cymru Public Health Wales and Aneurin Bevan UHB to develop the guidance, which was released December 2020.

ii) Matrics Plant Implementation Plan – A tool to support the implementation of Matrics Plant. Issued September 2021 (Appendix 2).

Improvement Cymru with Aneurin Bevan UHB developed the Implementation Plan tool to support the delivery of Matrics Plant. The template was not intended to be used as a performance measurement tool, but rather to encourage a process to assist in supporting services to translate the spirit and detail of the guidance into measurable actions, and help in providing a framework within which to recognise existing good practice and identify areas for improvement.

It is with this spirit in mind that the teams have been encouraged to review the current psychological interventions on offer to children and young people, and collect baseline information honestly and with open minds in relation to highlighting plans for improvement. Areas of good practice have also been noted.

iii) What is a Whole-System Approach and why is it needed?

Children and young people have little say in how their lives begin or unfold, especially in early childhood. There is increasing evidence to demonstrate that how children are raised and nurtured will have a direct impact on their development, and for many, this will have life-long impact.

Children often communicate their emotional state through their behaviour. This behaviour can be a manifestation of what's going on in their environment, which is usually out of their control. A whole-system approach supports the key principles of working with children within their context and wider systems - this means that one-to-one work directly with a child isn't always the most appropriate or effective approach to providing the help that is needed. This requires careful and skilled assessment to untangle what might be happening when children and young people present to services in order to determine the most appropriate plan. Applying skills in supporting others to help children and young people is a relatively new and unfamiliar approach for many clinicians. This forms part of our work within Early Intervention, Prevention and Mental Health Promotion a sub programme of our Targeted Improvement Programme.

Where direct individual help is needed, a whole system approach fully supports the need for a range of evidence-based interventions and types of therapeutic help for children and young people (sometimes called 'models' or 'modalities'), delivered by staff with the right skills and competencies to be able to do this well; and ensuring that outcomes are routinely monitored. We have been working to support these approaches for many years and will be focusing on further improvement in sub programme of our Targeted Improvement Programme Improving Access to Planned Care.

The NEST/NYTH Framework (Appendix 3).

The NEST Framework (2021) is key to supporting the emotional health and wellbeing of children and young people and the adults who care for them. This framework set out expectations for how we can jointly plan and deliver services for children young people and families in the context of a whole system approach and transformational change. Matrics Plant supports the NEST framework by drawing on the latest evidence base, and ensuring that clinicians interpreting and applying evidence-based interventions are appropriately qualified and experienced and able to apply their knowledge and skills in

context. Delivering Matrics Plant in the context of the NEST framework forms part of all sub programmes of our Targeted Improvement Programme for children and young people.

Whole School Approach (Appendix 4).

The Framework on Embedding a Whole School Approach (2021) is focused on supporting good emotional and mental well-being by fostering nurturing environments that build strong relationships between children, young people, families and schools, and across staff teams within education settings. It also recognises the broader influence of psychologically informed approaches in creating a shift in culture in our shared approach to emotional and mental health. Our contribution to the whole school approach lies in the roll out of the Child and Adolescent Mental Health Schools In-Reach Service, supporting education through the implementation of psychologically informed interventions, also connected with Matrics Plant. This work will be overseen by the national Public Health Wales team and overseen through the Early Intervention, Prevention and Mental Health Promotion sub programme of our Targeted Improvement Programme.

No Wrong Door (Appendix 5 & 6).

The recently formed Children's Sub-group of the Regional Partnership Board (RPB) commissioned work on developing a strategy across North Wales based on the Children's Commissioner's Report 'No Wrong Door' (2020). The No Wrong Door strategy for North Wales (Appendix 7) supports inter-disciplinary and multi-agency work to implement the recommendations within the strategy and work streams are at an early stage. The strategy forms a system-wide approach which is inclusive of delivering appropriate psychological interventions by staff with the necessary competencies. Key stakeholders will be invited to link with the Psychological Interventions Targeted Improvement sub programme to agree shared goals across the whole system, in line with Matrics Plant.

iv) Terminology, Definition and Scope

Psychological therapies are only one component of a range of psychological interventions offered to support the emotional and mental health needs of children and young people. The terminology of 'psychological therapies' is therefore replaced with 'psychological interventions' to more accurately convey the breadth of appropriate evidence-based approaches required to meet the needs of children and young people.

Matrics Plant defines psychological interventions as "…purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing".

Evidence-based psychological interventions encompass a wide range of courses of action including *targeted training* to upskill key members of a child or young person's system; *network consultation* to support the development of a shared framework for understanding and responding to the child or young person's specific presentation; *one off or on-going consultative support* to an individual or specific team; *interventions with main carers / parents* and *interventions directly with the child or young person.* By definition therefore the recipient of an intervention will not always be the child or young person.

Matrics Plant is inclusive of all children regardless of any additional needs, specific circumstances or which service they first present to. In practice this means that access to appropriate psychological interventions for emotional, mental health and wellbeing needs must be based on need. The implementation of Matrics Plant through the Targeted Improvement Programme and the Psychological Therapies Management Committee will therefore include children and young people who also have learning disabilities, neurodevelopmental problems and physical health conditions, as well as those whose primary presenting problem results accessing help directly through Child and Adolescent Mental Health Services (CAMHS).

v) Summary

Psychological interventions for children and young people include a range of approaches delivered in context, sometimes with the child directly and often only with the adults who care for them. This means that a whole-system multi-agency approach is required.

Matrics Plant provides clear guidance on good practice in the delivery of psychological interventions for children and young people, and an implementation plan for self-assessment is provided. This guidance aligns with the goals of a number of current strategies including the Framework on Embedding a Whole School Approach to Emotional and Mental Wellbeing, The No Wrong Door report and North Wales approach and the NEST planning framework.

All children and young people, regardless of which service they first present to, are entitled to appropriate needs led evidence-based and informed support for their emotional health, wellbeing and mental health needs.

b) Current Position

i) Baseline Mapping

Baseline data mapping was completed between July-September 2022. Each area / regional CAMHS lead and Consultant Clinical Psychologists for children with learning disabilities and physical health conditions completed the Matrics Plant Implementation Plan for their service footprint. Baseline information on children with neurodevelopmental concerns is not included at this stage as these services currently focus primarily on assessment.

Services included in the baseline data collection:

a) Community CAMHS ‘Tier 3’ East, Central and West
b) Regional CAMHS at ‘Tier 4’ Kite Community Intensive Outreach Team
c) Regional ‘Tier 4’ North Wales Adolescent Service
d) Child Learning Disability services East, Central and West represented by chair of regional network
e) Child Health Psychology Service East, Central and West represented by the Consultant Clinical Psychologist responsible for clinical leadership within the specialty across north Wales.

Services not included in the baseline data collection:

a) Neurodevelopment Service
b) Forensic Adolescent Consultation Service
c) North Wales Brain Injury Service

d) Complex Needs Service

Methodology
Each service representative (selected within area teams) was invited to take part in a semi structured interview covering all sections of the Matrics Plant Implementation Plan. Two of seven services taking part opted to complete the template on their own, five participated in an interview. Data was recorded and transcribed or submitted directly in the template. Key themes from the full data set have been distilled into one template – see Appendix 8. Examples of good practice and plans for improvement are outlined below.

ii) Examples of Good Practice

There are many examples of good practice relating to specific activities and innovations at a local level that are too numerous to list, these range from responding flexibly and creatively when young people struggle to engage with the service through to setting up coordinated systems and programmes of induction for new staff. The following represent key examples that are relevant across the region.

a) Range of Interventions and Specific Therapies on Offer

There is a wide range of evidence-based models of intervention and therapy offered to children young people and families accessing CAMHS, including Cognitive Behaviour Therapy (standard, trauma informed and for eating disorders); Dialectical Behaviour Therapy (full programme and skills training); Systemic Family Therapy; Psychoanalytic Psychotherapy; Interpersonal Therapy for Adolescents; Family Based Treatment for anorexia nervosa; Eye Movement Desensitisation and Reprocessing; Video Interaction Guidance. In Learning Disability, Positive Behaviour Support is available in most teams, Preschool Autism Communication Training is also available in some. Large scale availability of Friends Resilience, a low intensity manualised intervention for the prevention of anxiety and depression is available bilingually via building capacity in front line services to deliver the model with fidelity. Silver Cloud has recently extended to include modules for parents of young people with anxiety, and the Solihull Approach for parents of young children is widely available. Both are promoted widely.

b) The Psychological Therapies Training Team - in partnership with Bangor University, the North Wales Clinical Psychology Programme and Adult Mental Health

This small team began in 2011-2012 with one 0.4 WTE Child Therapist funded through fixed term grant funding from adult mental health services to test out a model for joint working to develop therapy skills and competencies across the workforce. Since that time, 136 staff across children's and adult services have accessed accredited training in Cognitive Behaviour Therapy at Level 6 or Level 7, including one cohort of Educational Psychologists (Conwy) and one cohort from CAMHS in North Powys. In addition, 37 places were accessed by CAMHS staff in Trauma-Focused Cognitive Behaviour Therapy skills training in 2021, and specialist supervision training workshops have been delivered and will continue with an eye on making sure the infrastructure to support skilled and accredited staff keeps pace.

Service Improvement Funding has allowed us to develop additional 0.5 WTE capacity to add to the Children's Services element of the team, new recruits will enable an expansion in training and accreditation of staff across the children's workforce focusing on Dialectical Behaviour Therapy and Eye Movement Desensitisation and Reprocessing. The team will

also soon house a newly funded whole time post focusing more broadly on the development of core skills across the children's workforce.

c) Staff Skills and Competencies

Psychological interventions are everybody's business across CAMHS whilst in child health, learning disability and neurodevelopment services, psychological interventions tend to be delivered largely by clinical psychologists or specialist therapists. Psychologists and psychological therapists are fully integrated within the teams and deliver direct assessment therapy and supervision of team members as well as clinical leadership and wider systems work to support others who are working with children and young people.

Our goal is to develop sustainable high quality services for children young people and families by investing in skills and competencies in line with national frameworks for working therapeutically with children and young people. With that in mind there are over 50 clinical psychologists delivering psychological interventions for children and young people and clinical supervision of staff, 22 of whom are accredited in specific models of psychological therapy; and an additional 5 are working towards accreditation. There are also 41 accredited Psychological Therapists/Practitioners and an additional 9 working towards accreditation. We are very proud of this achievement and aim to continue to build an evidence-driven culture and support staff to develop high quality accredited skills in therapy delivery and supervision so that our services are effective and sustainable over the long term.

d) Indirect Interventions on offer to the Teams and the Wider System

All teams offer various forms of targeted training for staff joining services and also for the wider system of professionals working with children and young people. As early intervention and preventive approaches increase and develop, early access to consultation with mental health specialists is being embedded through community services including the CAMH Schools In-Reach Service and through practitioners working alongside Primary Care and the wider cluster Communities. System-wide interventions require formulation-driven consultation, training and joint working in line with the models on offer. Accredited training in Trauma-Informed Practice is key to our forward work plan and is already underway via Schools In-Reach and Community working. The Five Ways to Wellbeing Framework contributes to our approach to building capacity in front line services, and using well supported interventions such as Reading Well, children's mental health specialists are supporting increasing numbers of front line services across the statutory and voluntary sector to work effectively with children's mental health and wellbeing and identify quickly those who need specialist help and refer on.

e) Joint working with Local Authorities – Multi-agency Partnership Working

Regular consultation sessions are routinely provided in children's Social Services in west, these are well used and valued by Social Work colleagues. Three teams have been established jointly between CAMHS and Social Care, aimed at children with complex behaviours and social care needs. Specialist CAMHS practitioners and Psychologists are based within teams in central area and in east. Several examples of routine practice include joint working with Local Authority teams.

f) Meeting the Mental Health Needs of Children and Young People with Learning Disabilities

West area CAMHS has established and maintained over the long term three specialist roles to work with children and young people with learning disabilities and mental health needs. In addition, Service Improvement Funding has allowed us to develop a new post

focused on adapting evidence-based approaches for young people who cannot access mainstream psychological intervention services. This role will support all areas in extending their offer of psychological interventions to young people who are at increased risk of developing mental health problems because of their intellectual difficulties.

g) Infancy and the Early Years

East area CAMHS has developed a psychological intervention service for babies and very young children in order to intervene very early in the life of children. Working with parents to identify risks and issues and supporting engagement with their developing children, this service is also closely connected with Early Years Pathfinder work in the east.

h) Involvement and Participation of Children and Young People

Three Patient Participation Officers and one Patient Liaison Officer have been appointed within Children's Services, focusing on emotional and mental health, learning disability, neurodevelopment and liaison at Tier 4. The voice of children and young people is systematically being sought and heard, alongside the development of a Children's Charter. This is an area of good practice relevant to all aspects of the services including psychological interventions and will be accessed in order to establish the views of young people in this regard.

iii) Gaps and Challenges

There are a number of gaps and challenges in delivering psychological interventions across the region, the most notable are:

a) Performance Management and Key Performance Indicators

Data on psychological interventions and specialist psychological therapies is not currently collected across Children's Services. All access and delivery information relating to psychological interventions delivered directly to children and young people are subsumed into one intervention measure, collected in response to part 1b of the Mental Health Measure. No data is reported about children and young people accessing psychological interventions via services outside CAMHS e.g. child health psychology, children's learning disability services. Data on indirect whole-systems working is not collected at all. Work is planned to address performance and outcome data through several sub programmes of our Targeted Intervention Improvement Programme.

Based on CAMHS Intervention Target 1b under the Mental Health Measure September 2022, a total of 568 children and young people across BCUHB are waiting for intervention, 480 of whom have waited over 28 days. The longest wait at the end of September 2022 was 49 weeks (East), closely followed by 47 weeks (West) and 30 weeks (Central). Further details can be found in Appendix 8.

The NHS Wales Delivery Unit will be reviewing psychological therapies for children and young people April – September 2023. This assurance review aims to understand the consistency and variation in the psychological interventions/therapies offer to children and young people in Wales, and to clarify data included and excluded against the performance targets, including the relationship to the Mental Health Measure Part 1b (intervention) target. It is acknowledged that the current performance reporting framework does not represent a complete picture of demand, activity, capacity or waiting lists within teams, and that target compliance can mask issues within a service. The methodology will first be used and tested with the same aim in adult services between September 2022 and March

2023, following which the application of the same methodology will be used to review and explore the provision of psychological therapies in services for children and young people, in line with Matrics Plant.

Additional gaps and challenges include:

a) Workforce, recruitment, training and retention of staff in clinical roles, with particular challenges in recruiting and retaining psychiatry and psychology.
b) Partial administration and recording of routine outcome measures coupled with a lack of routine feedback for teams to use findings from outcomes data to improve clinical practice and promote service improvement. It is difficult to motivate staff to continue collecting outcome measures in the absence of a routine feedback process to inform reflective practice.
c) Inconsistent pathways for accessing psychological interventions across areas. This stems at least in part from local variation in custom and practice and the influence of individual interest which may not always prioritise the interventions that are known to have most impact. Clear definition, information and guidance needed for all psychological interventions and associated pathways.
d) Lack of access to evidence-informed psychological interventions for marginalised groups in particular children and young people with learning disabilities. Societal attitudes and values contribute to this, as does a lack of defined targets for these groups; resulting in children with significant need being further marginalised and unable to access the help they are entitled to.
e) Lack of access to evidence-based psychological interventions through the Welsh language. This is a long standing problem impacting on all aspects of the service including psychological interventions and remains a significant challenge.
f) Absence of a reliable system to review the evidence-base, keep up to date with changes and implement adjustments to psychological interventions accordingly. Each service is partially compliant but an absence of an agreed methodology for reviewing the evidence and making necessary changes within context means there is no available information to demonstrate that required changes in practice have occurred.
g) Limited or no direct involvement in research, audit and evaluation. This presents a challenge in balancing the capacity for delivering interventions with the need to improve quality and engage staff in developing an evidence-driven culture.

b) Plan for Improvement: Targeted Intervention Transformation and Improvement

Psychological Interventions is one of the priorities in the WG BCUHB Targeted Intervention Framework and a plan is in place to address areas for improvement in Children's Services via the development of a Maturity Matrix and Project Plan. The overarching aim is the deliver Matrics Plant across North Wales. Achievements to date include:

i. Appointment of 0.1 WTE clinical leadership capacity and Project Manager to support the clinical lead in setting out the plan and achieving agreed milestones.
ii. A Project Group is established to deliver the Psychological Interventions work plan and implement and monitor recommendations within IHCs under Sub-Programme 2: Improving Access to Planned Care.
iii. Objectives are in place to address the gaps and challenges highlighted above.
iv. Cycle of business has been proposed with milestones are in progress.

v. Recruit to vacant posts. This includes two additional funded Heads of Child Psychology and Psychological Interventions to support the implementation of Matrics Plant within the IHCs. These roles will also support the development of Psychologically-Informed organisations at the local level and across BCUHB.

As pathways are developed, Equality Impact Assessment will be carried out to ensure fair and equal access to appropriate evidence-based and informed psychological interventions for all children and young people. The Project Group will clarify the need for a Socio-Economic Impact Assessment in the context of our role in addressing health inequalities.

c) Next Steps and Recommendations

Continue with the planned work under the Targeted Intervention Transformation and Improvement Programme Project Group, and address the interdependencies across sub programmes to ensure necessary actions are adopted and taken forward without duplication:

i. Define and agree which evidence-based models of psychological intervention will be prioritised and delivered for children and young people across North Wales.
ii. Define staffing needs across child specialities for the delivery of specific interventions and ensure a training plan is in place to support effective and sustainable delivery of intervention and intervention specific clinical supervision over time.
iii. Establish and utilise systems to support the capture of data including performance, impact and outcomes, including systems which analyse and feedback data to inform on-going service improvement and development.
iv. Establish pathways for access to all forms of psychological interventions and therapies and ensure clear co-produced information and guidance is available that meets the needs of children, young people and their families, alongside teams and referrers, to support local implementation.
v. Establish a reliable system to review changes in the evidence base and include guidance on how to create flexibility to adapt to any changes required.
vi. Increase the level of audit, service evaluation and research activity in psychological interventions and establish a system to ensure findings and recommendations are used to inform service delivery.

Key themes in delivering of the recommendations include working closely with Bangor University in developing a Master's Programme in Cognitive Behaviour Therapy, and engaging fully with Adult Mental Health Services in building an all-age strategy for the Psychological Therapies Training Team. Together this will extend the reach of and access to accredited Cognitive Behaviour Therapy modules and increase the numbers of accredited staff thus increasing capacity for sustainable delivery of main models of psychological intervention over time. An overarching aim is to create an encouraging and enabling work place that is inclusive of all professions in developing an evidence-driven culture and improving skills and competencies so that children and young people are able to access high quality help that is appropriate to their needs.

3. Goblygiadau Cyllidebol / Ariannol / Budgetary / Financial Implications

New posts have been funded through the Mental Health Improvement and Service Improvement Funding. Additional development will be linked to IMTP Plan and Improvement Plans within Targeted Intervention and Service Improvement Funding.

4. Rheoli Risg / Risk Management

There is no significant specific risk relating to psychological therapies. There is a risk that CAMHS will not meeting waiting time target for intervention by financial year end.

5. Goblygiadau Cydraddoldeb ac Amrywiaeth / Equality and Diversity Implications

n/a

GWELLIANT CYMRU IMPROVEMENT CYMRU

GIG CYMRU NHS WALES

Matrics Plant

Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales

Commissioned by Improvement Cymru on behalf of the Together for Children and Young People Programme and the National Psychological Therapies Management Committee

Contents

Glossary

Context – the settings around children and young people, the things they are a part of and which have an influence on how they grow up. This includes systems in which the child or young person has day to day relationships such as family, school, peer group, community, as well as systems which influence those, such as culture, religion, politics and social media.

System – similar to context, but thought about in terms of the ways in which each part or member interacts with other members including the child or young person.

Trauma – an event that is very frightening and which has significant negative impact on how the person to whom it happened views themselves, the world and other people.

Relational – thinking about things in terms of the person's relationships with other people.

Developmental – thinking about things in terms of the person's cognitive, social, emotional and physical development.

Values based practice – basing the way in which you do your job on the values that are important to you as a professional, to the profession in which you are qualified and to the organisation in which you work.

Evidence based practice – basing the way in which you do your job on the findings of published research.

Practice based evidence – evidence generated through the systematic evaluation of the outcomes of any aspect of clinical practice, including therapeutic relationships.

Theory based practice – innovative psychological intervention based on sound theoretical principles that may not yet have generated significant published evidence.

Therapeutic relationship – the relationship between a psychological professional and the person they are helping.

Systemic case conceptualisation – a way of trying to understand what is going on for someone that includes thinking about the role of relationships, systems and contexts.

Developmental trauma - things that happened, or should have happened and didn't, whilst the child or young person is growing up and which have a significant negative impact on their social and emotional development including attachment, often including emotional regulation, the way in which they see and relate to themselves, the world and other people in it.

Family – this can mean very different things to different people at different times. In this document, family can mean the people with whom a child or young person lives with and who may or may not be related to them, as well as people to whom they are related.

Distress – sustained, rather than transient, emotional pain which may present through words or actions and may include an increase or decrease in certain behavioural patterns.

Embedded – where a psychological practitioner's time is allocated to a specific team or service, which may be within or outside the health service and where that practitioner's time is available to that service without requiring a referral.

Practitioner – a person who is in a professional role in relation to children and families and where part, most, or all of that role involves at the very least noticing the emotional wellbeing and mental health needs of the child or family.

Psychological services – services where the core business is providing intervention to improve the emotional wellbeing or mental health of children and families.

Psychologically minded services – services whose core business includes interacting with children and families where there are often high levels of distress and which therefore need to hold psychological principles at the forefront of what they do. These services may or may not offer specific intervention to improve emotional wellbeing or mental health of children and families, but the services they offer will have an impact on emotional wellbeing and mental health.

Psychological intervention – a purposeful course of action underpinned by psychological theory and driven by a psychological formulation with the intention of improving the child's emotional wellbeing or mental health.

Psychological therapy – a psychological intervention derived from a specific psychological theory and formulated into a model or treatment protocol which may be verbal or non-verbal.

Specialist psychological therapy – a psychological therapy which draws on multi theoretical frameworks to create and deliver bespoke interventions which may be verbal or non-verbal.

Role appropriate – a level of psychological understanding that is appropriate to the reach and remit of the role and service.

Introduction and Context

Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children[1], young people and their families. This requires an evidence-based theoretical framework to guide the provision of a range of interventions, in addition to the delivery of direct therapy specific interventions. Matrics Plant does not recommend specific models of service - accepting that models may vary and change over time. It does however have a number of organising principles for services which recognise that children and young people:

- Live in their own specific circumstances
- Will have their own developmental needs
- Will have differing levels of control over their lives and/or the ability to seek support
- Should receive appropriate and proportionate psychological services based on distress/need rather than always requiring a mental health or other diagnosis
- May be best helped by services working with the people that the child or young person spends time with as well as offering individual work with them when this is needed.

Services should be designed to ensure that they are able to meet the needs of the child or young person at the earliest appropriate opportunity as well as at the earliest possible stage in their development. This would include ensuring that suitably qualified practitioners are available to provide psychological interventions across the full range described in this document; including targeted training, consultation to networks or individuals, intervention with main carers/parents and intervention directly with the child or young person. This may be in addition to ensuring that services and support are available to the child or young person, their parent(s) or main carer(s) as well as health, social care, education and third sector staff within the child or young person's system and who may be responsible for delivery of all or part of a psychological intervention.

Unless otherwise indicated, it will usually be in the best interests of the child, young person and family for the practitioners already involved to remain involved. This maximises a sense of stability and safety, value, worth and belonging for the child, young person and family.

These principles are inclusive of all children and young people from 0-17. This does not exclude children and young people on the basis of neurodevelopmental profile, physical health needs, disability, legal status, living arrangements, method of communication, preferred language or any other characteristic. It is acknowledged that the needs, context and influences for each child or young person will be different based on their own particular profile, age and developmental stage.

1 When this document refers to children and young people, it refers to all those aged 0 to 17 years

Matrics Plant has been developed under the auspices of the Together for Children and Young People Programme Board and overseen by the National Psychological Therapies Management Committee (NPTMC) that developed Matrics Cymru[2]. The consultation draft was also reviewed by the National Youth Stakeholder Forum.

A process for reviewing the evidence tables, which are currently published as addenda to Matrics Cymru, is being developed. Evidence tables in respect of children and young people will be included. These will be developed to encompass interventions in a variety of settings and services and include but not be limited to, child health, children with additional needs, looked after children, children with learning disabilities and neurodevelopmental needs. In the interim, practitioners are referred to the Scottish Matrix[3] and National Institute for Clinical Excellence[4].

As with Matrics Cymru, it is anticipated a national plan will be developed to support health boards and their partners in the delivery of Matrics Plant.

Matrics Cymru was published in September 2017, following extensive work and collaboration between service user and carer representatives and representatives from the seven health boards in Wales, Welsh Government, the National Psychological Therapies Management Committee and Public Health Wales. Matrics Cymru as a framework for practice, has as its focus, the provision of psychological therapy within mental health services for adults and older adults, including those with a learning disability.

Service structure and the focus of work within psychological and psychologically minded services for children, young people and families differs sufficiently from the model outlined in Matrics Cymru to require adapted guidance. Many of the recommendations set out in Matrics Cymru can apply where the intervention indicated following assessment and formulation is direct therapeutic work with the referred child or young person. This is not always the dominant service model in services for children, young people and families, where intervention with the child or young person's parent(s) or carer(s), teachers, or wider systems is a common practice for enhancing psychological wellbeing in a child or young person. Many intervention services for this population are provided through partner agencies.

For the purposes of this document, psychological interventions are defined in the following way:

Psychological interventions are purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

2 http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Matrics%20Cymru%20%28CM%20design%20-%20DRAFT%2015%29.pdf

3 https://www.nes.scot.nhs.uk/media/420chmra/matrix_-_children_youngpeopletablesfinal_2015.pdf

4 For example, for possible depression: https://www.nice.org.uk/guidance/ng134/chapter/Recommendations

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child or young person.

Whilst the formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who service users are, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of a psychological intervention.

Matrics Cymru consists of seven sections. In considering applicability to services for children, young people and families, the wider system around the individual has been included and many aspects of these mutually complementary frameworks are relevant across the age span and can be considered where relevant. Breadth of approach is extended for section 1 (Psychological Therapy Services Model – this has been reframed A Psychologically Minded Whole Service Approach for Children, Young People and Families) and 2 (Psychological Therapy – reframed Psychological Interventions) with a more inclusive approach and substantial new content. Similarly, greater breadth in how services and interventions can be delivered is reflected in section 3 (Psychological Therapists – reframed Practitioners Providing Psychologically Minded Interventions), with wider content developed.

The guidance in sections 4 (Supervision), 5 (Training) and 6 (Audit and Data Collection) of Matrics Cymru are generally applicable across all services with a few additional considerations and as such, a short addenda for children and young people has been developed.

Reviewing the evidence in relation to psychological interventions in services for children, young people and families fell outside the scope of this initial piece of work and as such, general guidance has been provided. This is provided in section 7.

Section 1: A Psychologically Minded Whole Service Approach

The stepped care model for mental health is described in the Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services[5]. In work with children, young people and families, there will be some interventions and services that will cross different tiers of provision and some interventions/services which do not neatly fit within this framework. Stepped/tiered care services adopt an incremental approach to service provision, best described as pyramidal in structure, with high volume, low intensity interventions being provided at the base of the pyramid to people with the least severe difficulties. Subsequent steps are usually defined by increasing levels of case severity and increasingly intensive forms of treatment rather than levels of contextual complexity.

This model of service organisation fits well where the primary model is direct work with the referred individual, where the referred individual is help seeking on their own behalf, has the agency to make changes in their environment or routines and where that individual has the resources and ability to independently attend appointments. For children and young people, it is often the case that they are referred due to the concerns of others, have less agency to make changes in their environment or routines and often need parental support with transport to appointments.

Children and young people usually exist within a context which they have limited power to change. This is described in Bronfenbrenner's Ecological Model of Child Development (Bronfenbrenner 1979)[6], which illustrates the layers of influence that impact on a child's development and wellbeing. Practitioners working with children, young people and families should intervene in the part or parts of the system that will create the most meaningful and lasting improvement[7].

Children and young people are continually developing and learning, often at a rapid pace. Subject to their cognitive, social, emotional and physical development children have the potential to:

- adapt and develop different ways of relating[8]
- survive or thrive in response to their developmental opportunities, relationships and environment.

5 http://www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf

6 https://books.google.co.uk/books?hl=en&lr=&id=OCmbzWka6xUC&oi=fnd&pg=PA3&dq=Bronfenbrenner%E2%80%99s+Ecological+Model+of+Child+Development+(Bronfenbrenner+1979)+,&ots=yyQ0Q4SSf-b&sig=P6QLhTS5CIaJ04R0OQ002eONwdc#v=onepage&q=Bronfenbrenner%E2%80%99s%20Ecological%20Model%20of%20Child%20Development%20(Bronfenbrenner%201979)%20%2C&f=false

7 https://www.bps.org.uk/sites/bps.org.uk/files/Blogs/Files/The%20Child%20%26%20Family%20Clinical%20Psychology%20Review%20-%20Summer%202015.pdf

8 The impact of the first 1000 days on infant mental health should be considered particularly in the context of perinatal mental health

All practitioners working with children, young people and families should be able to understand and respond to expressions of distress and within a relational, contextual and developmental framework[9]. They should look to build resilience in children and young people and families with a clear focus on hope and recovery. The United Nations Convention on the Rights of the Child[10] should be given central consideration.

It is important for all practitioners working with children and young people to understand that they may communicate their difficulties or distress in a wide range of ways due to individual, gender or developmental differences. Expressions of distress do not necessarily indicate that something is 'wrong' with the child or young person, but may indicate that something is not right/unhelpful or historically has not been right/unhelpful within one or more of the child's of young person's contexts or relationships. Services addressing the emotional wellbeing and mental health of children, young people and families should be able to assess, formulate and deliver meaningful interventions within this framework.

Each service working with children, young people and families will usually undertake a proportionate assessment of emotional wellbeing and mental health need and develop a formulation with the child, family, or service as appropriate. This supports an understanding of the factors that are contributing to the maintenance of the presenting issue. Factors internal to the child may be also highly relevant, including their social, emotional and physical development, temperament and personality, physical or learning disability and long term or severe medical conditions.

These internal factors will both be affected by and affecting, current and historic experiences, environment and developmental opportunities. Understanding the impact and interplay of these internal and external factors will assist in reaching a working understanding of the development and maintenance of the presenting difficulties, which in turn can lead to a sound understanding of what and with whom the most effective psychological intervention will be.

Adverse Childhood Experience reports[11] have highlighted the importance of life experiences and environment on children's and young people's development. Developmental trauma and toxic stress[12] may have a direct and long term effect on both a child's and young person's sense of self and their physiology.

9 https://www.bps.org.uk/sites/bps.org.uk/files/Blogs/Files/The%20Child%20%26%20Family%20Clinical%20Psychology%20Review%20-%20Summer%202015.pdf

10 https://www.unicef.org/child-rights-convention/convention-text

11 http://www.wales.nhs.uk/sitesplus/888/page/88524

12 Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years. https://developingchild.harvard.edu/science/key-concepts/toxic-stress/

A sound understanding of these alongside appropriate trauma informed competencies and compassionate alliances is essential in responding to the needs of children and young people[13].

There are many children, young people and families who are best supported in settings within their own communities, by people with whom they already have relationships (Making Sense Report recommendation 1)[14]. There are others who would benefit from more specialist support, who may, for a number of reasons, not take it up. In these cases, it may be more helpful to support the people who are already present in the system to provide psychologically informed support.

Practitioners working with children, young people and families usually have access to and engagement from many elements of a child's or young person's developmental context – parents or carers are usually keen to see change and practitioners such as those working in education, youth service, local authority, third sector etc. are often available and able to be involved in creating more favourable developmental and relational conditions for the identified child or young person.

This can be especially relevant where the presenting concerns are expressed by adults in the child or young person's system rather than by the child or young person themselves. It is essential that the expertise and support that exists within the tiered system is available to practitioners in embedded services in the form of easy to access consultation, advice and role appropriate supervision, as well as skilled psychological and other practitioners being embedded within these systems.

Psychologically minded services for children, young people and families should therefore:

- Be able to engage children and young people in a way that supports their level of ability and communication
- Be able to offer interventions with children, young people and families' immediate and wider contexts and systems as well as with the identified child or young person
- Be trauma, attachment and ACE (Adverse Childhood Experiences) informed with appropriate competencies and skills
- Engage proactively with health, local authority, education[15], third sector and youth organisations in order to create conditions to foster positive child development
- Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments

13 (e.g. The Scottish Psychological Trauma and Adversity Training Plan 2018) (https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/).

14 https://www.hafal.org/wp-content/uploads/2018/07/A-report-by-young-people-on-their-well-being-and-mental-health.pdf

15 Whole school approach - https://gov.wales/written-statement-joint-ministerial-task-and-finish-group-whole-school-approach-mental-health-and

- Help children, young people, their families and the systems around them to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework
- Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered
- Contribute to strengthening the evidence base, drawing on and developing practice based evidence and evidence informed models.

And in direct psychological work with the child, young person or family be able to:

- Offer a service in Welsh
- Deliver evidence-based care via appropriately qualified, supported and supervised staff
- Provide an appropriate choice of evidence-based interventions
- Operate within a framework of values-based practice which places children's needs as central
- Communicate effectively according to the developmental needs of the child – this may include non-verbal interventions such as through play, music, art or drama
- Deliver measureable outcomes improving and/or associated with psychological health and wellbeing
- Help children, young people and families to achieve personally meaningful progress
- Evaluate and respond to feedback from children, young people and families about the appropriateness of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy.

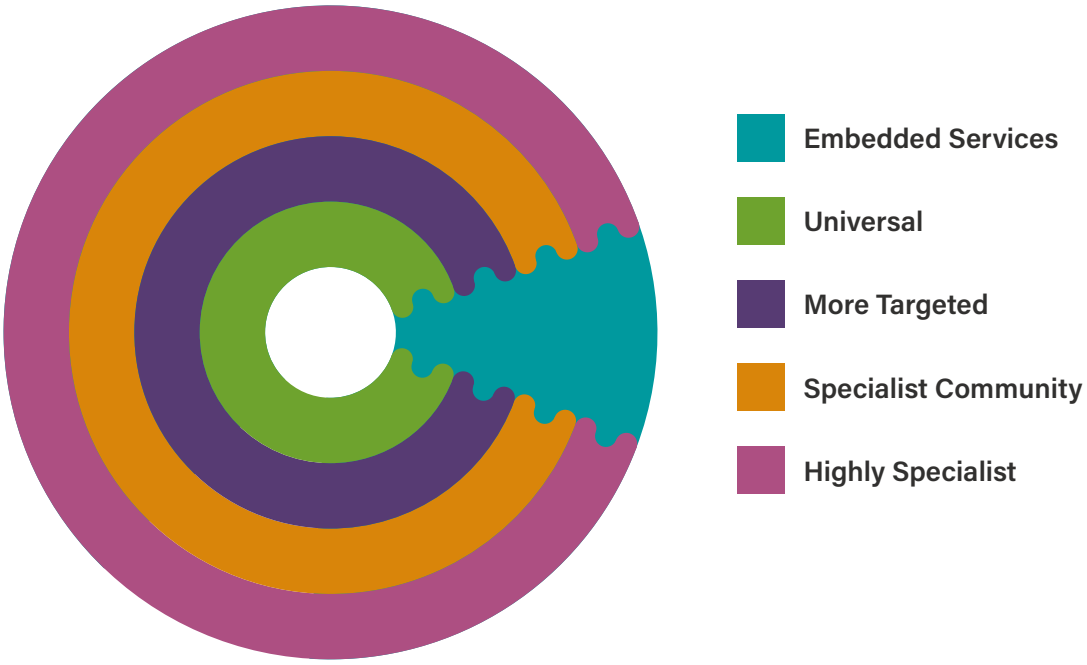
In practice, this means having practitioners within the workforce who:

- Are able to deliver a service in Welsh
- Are trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work
- Are delivering interventions which make sense in respect of the presenting needs and are supported by the best possible evidence
- Are operating within a well-governed system which offers regular high quality, psychological supervision (model-specific where appropriate) support and relevant Continuing Professional Development (CPD)
- Are monitoring the quality of the therapeutic relationship, recognising that this is an essential factor in achieving a successful outcome
- Have a role appropriate understanding of social, emotional, psychological, cognitive and physical development and the impact of acute, chronic or life limiting physical health problems on emotional wellbeing and mental health
- Have a role appropriate understanding of systemic case conceptualisation

- Have the ability to communicate[16] effectively with children, young people, their carers and practitioners in their contexts, the systems and to maintain a compassionate approach
- Have an awareness of the impact of attachment, developmental trauma and ACEs with role appropriate competencies
- Have role appropriate training to appropriate standards with the competences required and the support necessary to deliver psychological interventions effectively within the service context in which they work
- Contribute to innovative and reflective practice.

Types of Service

The Joint Commissioning Panel for Mental Health (2013)[17] outlines the tiered structure of Child and Adolescent Mental Health Services (CAMHS), differentiating the four tiers based on how a child or young person accesses the service. Services which sit outside the traditional tiered framework are more difficult to stratify, since although some services will have a specific remit for mild or very severe complexity, severity and level of emotional distress, others are able to respond flexibly across the broad range of presentations that are met within community settings. Five types of services are described here. It is anticipated these will be available in all health boards across Wales as services mature and develop in line with a developing national plan. It is not the intention that children, young people and families should only ever be supported by one of these types of services. It is essential for seamless working that different aspects of these services be available as necessary to jointly support a child, young person, or family when appropriate.



16 Specific attention should be paid to Welsh language and any reasonable adjustments that need to be made in order to deliver an equitable service.

17 https://www.jcpmh.info/good-services/camhs/

Embedded services take many forms. One of the key characteristics of this approach is the organising principle around intervening with the system first, providing a service aligned to the context rather than solely the individual child or young person. Outcomes for children, young people and families are typically improved when good communication and collaboration occurs between systems and agencies and this approach is therefore robustly advocated. In particular, it is suggested the recommendations of No Wrong Door: bringing services together to meet children's needs (2020)[18] can helpfully support this way of working. Where different agencies work together, it is essential that appropriate service level arrangements and protocols are in place.

Key features are:

- Access to the service is based on distress/need rather than always requiring a mental health or other diagnosis
- Proactive engagement with existing systems/services and psychologically skilled practitioners being embedded within services. These practitioners are able to offer interventions flexibly and according to need, without requiring a qualifying referral to a mental health service
- Services which may seek to prevent development or escalation of difficulties, as well as to promote psychological understanding and ways of working throughout community settings and services. This promotion and prevention may be both early in the life of the difficulty, as well as early in the life of the child or young person
- Services which may work closely, often being co-located and embedded within communities, social care and education services to support practitioners already involved with families to develop clear psychologically informed formulations and to support delivery of well supported psychologically informed interventions
- Services which may be multi-agency, multi-disciplinary services and able to deliver a high level of intensive and flexible psychological interventions and support for children and young people about whom there is the highest level of concern.

Nature and focus of the Intervention

These services can be organised in different ways. Often, practitioners with psychological expertise will be embedded within, or proactively engaging with, supportive services across the health, education and social care sector.

Psychological consultation, support and training would be organised around the service and its context as well as the specific needs of any identified child or young person.

18 https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/

For example:

- A service aiming to promote understanding of complex trauma and attachment need could engage through training and ongoing team psychological consultation with teams who work with children and young people presenting with these needs (such as social work teams, specialist educational settings, family court systems etc.), supporting the development of a deeper understanding of the impact of these experiences and ways in which their services could most helpfully meet these needs
- Psychological practitioners embedded within early years or family intervention teams supporting a contextual, normative and developmental understanding of the children and young people the team works with and offering proactive, preventative programmes of work
- Psychological practitioners working with teams around children and young people in the care of the local authority. The resilience of the system can be supported by engaging with the many practitioners (health, education, social care, foster or residential carers) through psychologically informed training, psychological consultation and formulation. The needs of the individual children and young people, as well as specific needs of their carers can be met through direct psychologically informed work, where many presenting difficulties are more often linked to complex developmental trauma than mental health difficulties and so referral thresholds for traditionally oriented services may not fit. A service model which allows psychological practitioners to be alongside and available flexibly can often meet the needs of this population more appropriately than a refer-treat-discharge model
- Psychological practitioners embedded within paediatric physical health teams supporting a psychological understanding of the impact of an acute, chronic or life limiting physical health condition and the treatment regime, who are able to offer intervention directly with the child, young person, or family as well as consultative support to the team.

Universal services such as early years services and all primary care agencies including general medical practice, midwifery, school nursing, health visiting and schools. These services aim to promote mental wellbeing, recognise when a child or young person may have developmental or mental health problems that this level of service cannot meet and know what to do when this is the case. Universal services may be provided by a range of agencies both inside and outside the health service.

Nature and focus of the Intervention

Community based provision for children and young people and their families, provided by a range of practitioners. These services will often be supporting the child, young person, or family for reasons other than mental health need. Psychological/specialist consultation and support to the systems around the child, young person and family could include training around specific presentations and helpful responses, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs.

For example:

- Involvement of families would usually focus on group or individual psychoeducation and advice about how to respond to the child or young person
- Direct work with the child or young person could take the form of general skills building/ preventative group work, individual or group work.

More targeted services such as youth offending teams, primary care mental health services, school and youth counselling. This includes support for children and young people with less severe mental health problems. These are services where there is usually a single practitioner involved in supporting the child, young person or family, though that practitioner will usually be part of a team. Staff may work with the child or young person directly, or indirectly by supporting practitioners working in universal services and include school counsellors and voluntary sector youth counselling services.

Nature and focus of the Intervention

Community based provision for children and young people, involving health, education or social care practitioners, sometimes including parent/carer involvement. Psychological/specialist consultation and support to the systems around the child, young person and family could include training around specific presentations or needs and helpful responses, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs, or supporting the design and delivery of an intervention carried out by staff already working with the family.

For example:

- Involvement of families would usually focus on psychoeducation and/or supporting delivery of psychological therapy approaches with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and could be focused on development of key skills such as emotional regulation.

Specialist Community Teams – the nature and provision of these vary across Wales. They are multi-disciplinary teams of practitioners providing a range of interventions to children, young people and families, including teams with specific remits, such as:

- Child and Adolescent Mental Health Services
- CAMHS learning disability teams or Child Learning Disability Teams
- Neurodevelopmental Teams
- Child Health Psychology
- Community forensic CAMHS (FACTS)
- Adolescent substance misuse Teams

- Crisis/home treatment teams preventing admission to hospital or supporting discharge from hospital
- Liaison teams providing CAMHS input to children and young people in acute care systems
- The types of specialist community teams and their focus/organisation will vary across Wales according to local service organisation and may not include all types of teams mentioned above, or may include other specialist teams.

Nature and focus of the Intervention

Outpatient provision for young people with complex difficulties and young people who pose a risk to themselves or others, guided by psychological formulation which can involve a team of mental health and multi-agency practitioners and usually includes parent/carer involvement. Often more than one professional will be involved in supporting the child, young person or family. Where needed, this is usually supported by some level of out of hours crisis support availability.

Psychological/specialist consultation and support to the systems around the child, young person and family could include training around how to respond to a young person's specific needs within a context where other practitioners have a relationship with that young person, e.g. educational settings. It could also include consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs. Working alongside and in collaboration with staff in the social care and education sectors where there is a mental health or risk component to the child or young person's needs is also often helpful.

For example:

- Work with families could be formalised family therapy approaches, or involvement of families in supporting highly specialist psychological intervention with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and be focused on either development of key skills such as emotional regulation, or specialist psychological therapies.

Highly specialist services such as day and inpatient services, very specialised outpatient services and increasingly, services such as crisis/home treatment services which provide an alternative to admission. These are generally services for a small number of children and young people who are deemed to be at greatest risk of rapidly declining mental health, or from serious self-harm who need a period of intensive input and are often provided on a regional or supra-regional basis. There are also a small number of very highly specialised services including, but not limited to, medium secure adolescent units, services for those with gender dysphoria and highly specialist obsessive compulsive services.

Nature and focus of Intervention

Day and inpatient provision for highly complex and/or young people who pose a high risk to themselves or others; involving a team of mental health practitioners working together to support the child or young person, usually including parent/carer involvement.

Psychological/specialist consultation and support to the systems around the child, young person and family could include training around how to respond to a young person's specific needs within a context where other practitioners have a relationship with that young person, e.g. educational settings, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs.

- Work with families could be specialist family therapy approaches, or involvement of families in supporting specialist psychological therapy approaches with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and be focused on either development of key skills such as emotional regulation, or specialist psychological therapies.

Section 2: Psychological Interventions

Psychological interventions are purposeful courses of action typically driven by a formulation, which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child's or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child or young person.

Whilst formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who service users are, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of an intervention.

Psychological interventions encompass a wide range of practice. Interventions described in this document refer to psychologically informed and/or psychological therapy interventions. Intervention goals and the type of intervention should be based on the areas of life or developmental skills that are identified during assessment and formulation as priorities and which are most likely to create the conditions for improvement in psychological wellbeing. Psychological interventions may or may not be linked to a particular diagnosis and diagnosis is not a requirement for access to a psychological interventions. When providing psychological interventions, where services work together, outcomes for children, young people and families are more likely to be efficient and effective[19].

19 https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/

Psychological interventions with children, young people, their families and systems, have an increasing evidence base demonstrating both clinical effectiveness and economic benefit[20]. However the language, cultural and presenting needs of children, young people, their families – systems are often complex and multiple and do not fit well into traditional research models, leading to a relative lack of direct clinically applicable evidence. As such, much work with this population is dependent on practice based evidence as well as gold standard evidence[21] and often innovative theory based practice[22].

There is emerging and well-grounded practice based evidence that interventions other than directly with the child or young person can achieve good and lasting outcomes[23]. Family and group interventions are already well researched as effective[24].

Where the presenting needs fit within diagnostic criteria[25], the published evidence base is growing and there are well supported interventions, as well as some promising interventions which are widely used. A formulation shared by all parties involved is frequently the process from which an appropriate intervention should be developed.

Psychological Formulation

Psychological formulation can be used in addition to, or instead of, a diagnostic process in order to offer the best possible care and support for improving psychological wellbeing in a child or young person. The psychological formulation details the matters that have come together to create the presenting need as well as what might be maintaining the situation. It recognises strengths and challenges. Psychological formulation should be carried out as a collaborative process, whether that is with an organisation or team around a theme[26], or practitioners working with the child, young person or family, or directly with the child, young person or family in relation to the presenting needs. Psychological formulation informs decisions around care and choice of intervention for the child, young person and family such as where intervention is likely to have most impact (e.g. system, family, parent/carer and/or individual) and what interventions are likely to be helpful. It will also identify factors which may facilitate or hinder progress and helps goals to be collaboratively agreed. A shared psychological formulation is key to the engagement of all parties in any courses of action necessary for progress towards shared goals.

20 https://www.ncbi.nlm.nih.gov/pubmed/11473907

21 See NICE Guidance

22 https://fhcappg.org.uk/wp-content/uploads/2019/01/practice-based-evidence-report-300119.pdf

23 http://centaur.reading.ac.uk/75842/ and https://www.jaacap.org/article/S0890-8567(19)30173-X/fulltext

24 https://onlinelibrary.wiley.com/doi/pdf/10.1111/1467-6427.12032#:~:text=Systemic%20interventions%20are%20effective%20in,children%20(Myers%2C%202011).&text=Systematic%20narrative%20reviews%20concur%20that,is%20family%2Dbased%20and%20structured.

25 See NICE Guidance

26 E.g. Things to consider when working with those that may be presenting with challenging behaviour

Psychological formulation should be proportionate to the level at which a service is being provided and draw upon an understanding of psychological theory, as well as knowledge of intrinsic factors such as developmental level, genetic, biological and health needs. As such, whilst psychological formulation is a skill, the application of that skill depends upon a role and service appropriate depth of relevant knowledge and expertise.

Psychological formulations are not intended to be static and will often develop over the course of an intervention as more information becomes available or as the outcomes of different aspects of an intervention become known[27].

This document considers four main psychological formulation driven courses of action, which may be offered individually or simultaneously:

- Intervention directly with child or young person
- Intervention with main carers/parents
- Intervention with wider systems/consultation
- Targeted training.

Intervention directly with child or young person

Often, it is identified through assessment and psychological formulation that an intervention directly with the child or young person is indicated either as the main or only intervention, or in combination with interventions targeting other parts of the child or young person's system. Interventions directly with children or young people can occur across the spectrum of need, delivered by health, social care, education, or third sector agencies and can take the form of group or bespoke individual interventions. The intervention itself could be befriending/mentoring, support with community engagement, psychoeducation, development of strategies to be tried in day to day life, or a formal therapeutic intervention.

Individual interventions at any level can include skills development such as emotional literacy, emotional regulation, social skills or a psychological therapy. Examples can be found at Annex 1. Where the intervention is an individual formal therapeutic intervention, the competence frameworks for each therapy modality should be followed, whilst holding in mind the importance of child development and context. Both the Scottish Matrix Evidence[28] tables and National Institute for Health and Care Excellence (NICE)[29] guidelines should be used as a reference guide to competencies required where these are not yet set out in Matrics Cymru.

27 http://www.sisdca.it/public/pdf/DCP-Guidelines-for-Formulation-2011.pdf

28 https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/

29 https://www.nice.org.uk/

Intervention with main carers/parents

Children's and young people's relationships are central in terms of their development, their ability to respond to adversity and the way they see themselves. It is within relationships that children and young people come to understand their emotions and develop strategies to manage them. Children and young people's relationships play a significant role in maintaining and changing presentations of emotional distress. Parents and carers will have their own unique set of experiences/needs and consideration should be borne in mind when developing any interventions[30].

The assessment and formulation process considers the role of these closest relationships and identifies opportunities for intervention. Interventions with main carers/parents can occur across the spectrum of need, delivered by health, social care, education, or third sector agencies and can take the form of group or bespoke individual intervention. The intervention itself could include psychoeducation, involvement in therapeutic strategies to be tried in day to day life, or formal family focused therapy. Examples can be found at Annex 1.

Intervention with wider systems/consultation

Psychologically informed consultation is an intervention that can be offered to adults who are part of the child's or young person's life as a stand-alone and/or ongoing intervention or as part of an intervention. The format will usually be a meeting during which a consultant[31] or consultants enable a consultee or group of consultees to collaboratively explore a concern or dilemma. This may lead to the development of a shared formulation, often leading to actions. The role of consultant requires the utilisation of appropriate highly specialist experience and knowledge of psychological theory and practice to support the consultee or consultees to take forward recommendations and actions from the consultation. This can be provided flexibly to an individual, group, team, service or network around a child or young person and their family.

Psychological consultation can support earlier intervention by practitioners already involved with the child or young person and can support those systems to "hold on" and maintain existing relationships. Children's and young people's systems, including friendship groups, school life and local community life have an impact on the possibility and sustainability of positive outcomes following intervention. Engagement with these systems alongside other interventions through consultation and joint working can add to the efficacy of interventions.

30 It is understood that where carers or parents have experienced ACE's and have acute or chronic difficulties such as physical or mental health difficulties, cognitive or learning disabilities, substance misuse or dependency, have relational problems or experience trauma (e.g. domestic violence), in addition to financial and housing issues, their parenting capacity may be impacted. In such circumstances, a multiagency approach is essential to support the immediate system around the child in addition to any psychological intervention.

31 This is usually a professional with relevant training, knowledge and experience linked to psychological models and interventions.

Psychological consultation can also support the adults and networks in the child's or young person's life to better understand and respond to their needs. This enables the context in which the child or young person is developing to be adjusted to create conditions in which the child or young person can achieve better developmental outcomes. Psychological consultation can be considered to be both a preventative intervention and an intervention offered following assessment and formulation and can be offered alongside other interventions or as an intervention in its own right. Psychological consultation increases the skill, knowledge and confidence of the consultees to respond to similar needs in future and can maximise the availability of professional expertise. Examples can be found at Annex 1.

Targeted Training

Targeted training is an intervention that can be offered to the adults who are part of the child's or young person's life to enable them to better understand and respond to the child's or young person's needs. It can be useful as a stand-alone intervention and/or alongside other interventions such as direct work with a child or young person and their family. Supporting adults in this way allows the context in which the child or young person is developing to be adjusted to create conditions in which the child or young person can achieve better developmental outcomes.

It also supports the systems around a child, young person and family to remain involved, supporting the maintenance of existing relationships. Targeted training can be considered to be both a preventative intervention (e.g. open access sessions) and an intervention offered following assessment and formulation (e.g. needs identified after an individual or systems assessment and formulation). Example of targeted training can be found at Annex 1.

Section 3: Practitioners Providing Psychologically Minded Interventions

Historically, there has been a focus on defining competence and skill in relation to specific therapeutic approaches.This document seeks to be inclusive of practitioners engaged in psychological interventions more broadly, as well as those engaged in specific therapeutic work.

When working with children, young people and families, formulation is pivotal to understanding and responding and whilst considerations around the therapeutic alliance remain central, it is important to note that when direct work is carried out, it is often not, or not only, the child or young person with whom a therapeutic alliance is created. Where the work is focused within the child's or young person's system, the relationship with the practitioners or parents needs careful consideration. Established models (e.g. Roth and Pilling[32]) have focused on competencies required for individual therapeutic work within mental health services. The landscape of provision for children and young people's emotional wellbeing and mental health is broader than this, encompassing not only mental health services, but also the wider health sector, education, social care and third sector provision. As such, a framework of levels of psychological understanding and practice when engaged in work around children's emotional wellbeing and mental health that can be applicable across sectors and settings is proposed.

The workforce addressing mental health and emotional wellbeing for children, young people and families is located in the health service (both in mental health services and in other parts of the health service), local authority services including education and social care, as well as in the third sector. As such, the definition of a practitioner providing psychologically minded interventions for children, young people and their families can be as broad as a person interacting in a professional capacity with a child, young person or their systems.

Within this wider definition, there is a broad range of competency. At the most generalist end of the spectrum, all practitioners working with children, young people and families should have an awareness of child development (psychological, emotional, cognitive and physical), the impact of developmental trauma, family development and transition, and the systems around a child or young person; as well as the skills to identify psychological needs and give advice/support. At the more highly specialist end of the spectrum, practitioners will have the relevant experience and qualifications to provide appropriate psychologically minded interventions and support others to do so. This will include specific training at or above Masters Level.

32 https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-11

Levels of Psychological Understanding and Practice

Level	Staff Group	Assessment	Intervention	Core Skills	Knowledge
1	All practitioners working with children and young people	Identify psychological needs	Information giving, empathic communication, emotional support	Awareness of systems around child or young person	Awareness of child development (psychological, emotional, cognitive and physical) Impact of developmental trauma Family development and transitions
2	Practitioners with additional responsibility for emotional wellbeing	As above and Screen for psychological needs	As above and Problem solving and informal counselling	As above and Ability to engage with systems around and with the child or young person	As above and Ability to respond in a role-appropriate manner to needs identified in respect of child development (psychological, emotional, cognitive and physical) Impact of developmental trauma Family development and transitions

3	Practitioners with specific training in psychological approaches[33]	As above and Assess psychological needs and devise formulation and intervention	As above and Delivery and monitoring of formal/specific psychological interventions	As above and Ability to consult to and with systems and practitioners around the child or young person in order to guide, lead, or jointly deliver intervention	As above and Ability to incorporate into formulation and intervention and support systems around the child or young person to more fully understand
4	Practitioners with highly specialist training in psychological approaches[34]	As above and Assess complex psychological needs and develop shared formulation and/or intervention	As above and Multi-theoretical frameworks used to create and deliver unique interventions	As above and Ability to consult to and with systems and practitioners around the child or young person in order to guide, lead, or jointly deliver interventions where the presenting needs are highly complex	As above and Ability to lead the development of a complex shared formulation and intervention across multidisciplinary and multiagency contexts

33 See Annex 3

34 See Annex 3

Section 4: Supervision of Psychologically Minded Interventions and Psychological Therapy

There are clear modality specific requirements for appropriate clinical supervision where the intervention being carried out by practitioners working with children, young people and families is formal psychological therapy and there are clear minimum standards in relation to supervision for many professions. It is essential that any practitioner delivering a formal psychological intervention or therapy has access to appropriate clinical supervision to ensure it is being delivered to an appropriate standard[35]. Clinical supervision should be regular and ongoing and take account of modality and profession specific minimum standards.

In addition to the skills and training requirements set out therein, it will be necessary for anyone providing supervision for a practitioner working with children, young people and families to have a good knowledge and understanding of child development (physical, emotional, social and cognitive), systems around the child or young person including family development and transitions. Practitioners should have role appropriate level of skills and awareness regarding trauma informed practice and the impact of developmental trauma[36].

Where the intervention being carried out by practitioners working with children, young people and families is other than formal psychological therapy, the requirements for model specific clinical supervision is less pertinent, but the knowledge outlined above and an understanding of the system in which the professional is working, the resources available to them, a compassionate and relationally informed approach are essential. The nature and focus of this supervision should fit for the particular scenario and staff group and could include reflective practice and case discussion as well as personal reflection.

In all cases, one of the focuses of supervision will be supporting, educating and enabling the supervisee in understanding the presenting needs in the context of relationships and development and to support the practitioner to deliver the most appropriate intervention competently and safely.

Where an intervention is being led or delivered by a professional working outside of a core mental health service, careful consideration needs to be given as to how supervision can be provided and accessed. It is likely that multiagency agreements and protocols will need to be developed and practitioners employed within core mental health services will have a lead responsibility in this. The model of having highly skilled psychological practitioners embedded within other services also addresses this need.

35 The standards used for supervision in Wales will be those identified in the University College London competence framework which were commissioned by Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland) (NES).

36 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6088388/

Of equal importance at every level of service provision and every level of expertise, is the availability of appropriately skilled and knowledgeable support, supervision and consultation – each service must be appropriately supported.

Levels of Supervision, Support and Psychological Consultation

Level	Staff Group	Requirements for support, supervision, consultation
1	All practitioners working with children and young people such as teachers and youth workers	Access to a practitioner with appropriate skill and knowledge to support identification of psychological needs and to support the process of information giving, empathic communication and general psychological support
2	Practitioners with additional responsibility for emotional wellbeing such as wellbeing leads	Access to a practitioner with appropriate skill and knowledge to support screening for psychological needs and to support the processes of problem solving, informal counselling and engagement with the systems around the child or young person
3	Psychological practitioners such as those with relevant qualifications or experience	Access to a practitioner with appropriate skill, knowledge, qualifications and training to support the assessment of psychological needs and the development of formulation, intervention plans and to support the process of consulting to and with systems around the child or young person in order to guide, lead or jointly deliver intervention Where delivering formal psychological therapies, access to appropriate expert clinical supervision
4	Highly specialist psychological practitioners such as those with a relevant post-graduate qualification	Access to a practitioner with appropriate skill, knowledge, qualifications and training to support the assessment of complex psychological needs, development of shared and jointly held complex multi-theoretical formulations and unique intervention plans and to support the process of consulting to and with systems around the child or young person in order to guide, lead or jointly deliver intervention where presenting needs are highly complex Where delivering formal psychological therapies, access to an accredited supervisor or supervisor accredited in the field

For practitioners providing services outside core or commissioned NHS services, the above levels of support should be considered as good practice and it would be good practice for staff working in core or commissioned NHS services to consider how to proactively support these practitioners in order to create safe, robust, skilled and knowledgeable multidisciplinary and multiagency approaches to improving emotional wellbeing and mental health in children and young people.

Section 5: Training

There are clear frameworks in relation to specific therapeutic modalities and within overarching frameworks (e.g. Matrics Cymru; Scottish Matrix)[37]. The UCL/NES Competence Framework for Child and Adolescent Mental Health Services further sets out universal core requirements.

In addition, it is important that all practitioners both within and outside NHS services working with children, young people, their families and systems have training in:

- Typical and atypical child development (social, emotional, cognitive and physical; to include attachment)
- Understanding of adverse childhood experiences, developmental trauma and the impact on a child's development and functioning
- Understanding of factors that promote resilience
- Understanding and working with systems around a child or young person.

Opportunities should be provided in house to ensure that all NHS staff working with children, young people and their families have a role appropriate level of knowledge and skill within these areas. Where a service is being provided outside of a core mental health service, careful consideration needs to be given as to how this knowledge can be developed and assured. It is likely that multiagency agreements and protocols will need to be developed and practitioners employed within core mental health services will have a lead responsibility in this. The model of having highly skilled psychological practitioners embedded within other services also provides an opportunity for appropriate skill development.

37 See Annex 2

Section 6: Audit and Data Collection

The principles outlined in Matrics Cymru and the Working Together Toward Common Goals: Outcome Measurement in Wales paper[38] can be considered to apply. In addition, it is important to consider the contexts in which the child or young person exists and how outcome data will be collected, where the psychological intervention is not direct therapy and where the psychological intervention is provided within the system rather than with the child or young person directly.

Where the intervention takes the form of direct psychological intervention, whether individual, family or group, appropriate outcome measures should be collected from the child or young person (where their development allows) and from their parent(s) or carer(s) subject to age and consent.

Outcome measures currently recommended by Welsh Government are SDQ (Strengths and Difficulties Questionnaire), SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale) CGAS (Children's Global Assessment Scale), GBOs (Goal Based Outcomes), Social Services and Wellbeing Care and Support Plan 10 point scale and CHI-ESQ (Children's Experience of Service Questionnaire).

Where the intervention takes the form of consultation or targeted training, outcome measures should evaluate whether the need identified has been met by the intervention – this may be increased confidence, skill, system resilience or understanding leading to better outcomes for the child or young person. Careful thought and multiagency co-operation will be required where interventions are led or delivered by practitioners employed outside of mental health and emotional wellbeing services. The published evidence in relation to emotional wellbeing and mental health services for children and young people is significantly less expansive than that for adults of working age. As such, where possible and appropriate, outcome data should be collated, embedded into practice to support service improvement and learning and shared across services through communities of practice to support innovation and learning where appropriate and possible. Children and Young People's Improving Access to Psychological Therapies programme have published a resource booklet[39], Child Outcomes Research Consortium also provides access to a wide range of resources, as do the Evidence Base Practice Unit[40].

38 http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/2019-08-20%20OUTCOME%20PAPER%20-%20Final.pdf

39 http://www.burdenbasket.co.uk/media/files/CYPIAPT-ResourcePack_1_4.pdf

40 https://www.corc.uk.net/outcome-experience-measures/ and https://www.ucl.ac.uk/evidence-based-practice-unit/publications-resources/resources-professionals

Section 7: Evidence Base

The 2017 Adult Matrics Cymru Guidance document and Evidence Tables[41] outlines current available evidence base and practice based evidence, for a wide range of mental health and other difficulties experienced by adults. The evidence tables' document outlines the rationale for evidence-based practice and practice based evidence. It states:

Psychological services play a particularly important role in mental health services for children and young people. Although this remains an under-researched area compared to mental health overall, much of the evidence of "what works for whom" in relation to children and young people comes from the adult or generic psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to "generic" CAMHS clinical practice and within services for children and young people, given the need for clinicians to develop skills in communicating effectively, for example, with younger children or with families. It is noted that the use of diagnostic, rather than developmental frameworks for describing children's experiences of difficulty and distress within their complex context of care and to index effective practice through these means, may not be appropriate or helpful in psychological services for children and young people.

Currently, services and practitioners should refer to relevant evidence including the Scottish Matrix 2015 evidence tables and existing NICE guidance. It is noted that these documents although current are now more than five years old. A process is being developed in partnership with the NPTMC to update and publish further tables. These documents may also inform the commissioning of appropriate psychological therapy services alongside the key principles and standards outlined in the current document.

Underpinned by theoretical models and understanding of developmental processes, a wide range of art, play based and creative therapeutic interventions are delivered to children and young people in Wales. It is acknowledged that there is a limited evidence base for certain children or young people (e.g. those with a learning disability and those who are looked after), whereby adaptions of pre-existing interventions are necessary.

The Scottish Matrix[42] is a helpful resource in that it reviews the available evidence base for delivering psychological interventions for children of all ages (including attachment and infant mental health), those who have neurodevelopmental conditions (e.g. Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder) or behavioural difficulties, common mental health presentations, self-harm and interpersonal problems, substance misuse, trauma, neuropsychological conditions (e.g. acquired brain injury and epilepsy) and interventions linked to paediatric psychology (e.g. adherence, chronic pain and adjustment to

41 http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/evidence-tables_final.pdf

42 https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/

chronic illness).
It also reviews the available evidence for children who have experienced certain circumstances (e.g. children at risk of going into care, looked after, adopted and refugee children).

A process for the future review of evidence tables will extend the current inclusion criteria of the Scottish Matrix and also include peer review case studies and qualitative research. The process will include the range of interventions discussed in this document. The development of a repository for practice based evidence, as well as leadership for collaborative sharing of practice and outcomes, could be helpful in driving forward innovative effective practice across Wales and would be congruent with the Parliamentary review[43].

43 https://gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf and which supports clinical leadership in informing Once for Wales approaches regarding the accessibility and implementation of models of practice for which there is good evidence of effectiveness.

Annex 1: Examples

Targeted training

Following assessment and formulation, it is identified that staff in school could respond more helpfully to a child or young person with severe and complex mental health need, and this would reduce the amount of missed education days and support recovery. School staff could be supported by training from Specialist CAMHS practitioners to understand and respond safely, helpfully and in line with assessed needs to a young person with severe and complex mental health needs.

Often parents feel they do not know how best to respond to ongoing high levels of emotional distress in their children and as a result, respond in a variety of ways and experience significant distress themselves. Open access to psychoeducational sessions could be provided to enable parents to understand and respond helpfully to their child when presenting with emotional distress. Following assessment and formulation, it could be that accessing psychoeducation could form part of an intervention plan.

Relationships are central to how children and young people develop, learn and manage their emotional experiences. Children and young people who have experienced developmental trauma including attachment disruptions often need additional focus on quality of relationship in order to manage and often their internal stress is manifested behaviourally. Whole teams can be supported through training to understand the impact of complex developmental trauma and attachment needs and become more able to adapt their team's approaches to work to be attachment and trauma informed, benefitting every child and young person and creating conditions in which children and young people with additional sensitivities in this area can begin to thrive.

Consultation

A member of school staff is finding that all reward and sanction strategies are ineffective in shaping behaviour that is difficult within a classroom context and seeks consultation in order to understand the presentation from within a psychologically informed framework. This leads to an attachment informed shared understanding and a school action strategy that prioritises relationships and arousal regulation over more traditionally accepted behavioural strategies.

A child has been referred to services due to concerns around angry outbursts. It is clear from shared multiagency knowledge that there has been significant involvement of family support services and that the family struggles financially. A network consultation bringing all relevant parties together to develop a shared understanding of how the child's presenting needs have come to be and are being maintained could lead to a multiagency response involving parenting support, outreach youth work and practical support to allow the child to attend age appropriate extra-curricular activities. The impact of this could be monitored through follow up network consultations, with the shared formulation and action plan being adapted accordingly.

Ready, referral free availability of an expert consultant embedded within a team working with a population of children or young people where these needs are present allows ongoing consultation in relation to appropriate strategies and approaches which may prevent the escalation of presenting need and create more favourable conditions for positive development.

Intervention with main carers/parents

A child has been referred to services due to high levels of anxiety impacting significantly on their daily functioning including attendance at school. Assessment and formulation identifies that the way in which the family understand and respond to the child's anxiety is contributing to the perpetuation of the difficulties. Intervention with parents could include psychoeducation around physiological, cognitive and behavioural aspects of anxiety as well as supporting the parents, either individually or in a group format, to understand and apply principles of Cognitive Behavioural Therapy within the home and the child's environment.

A child has been referred to services due to increasing levels of oppositional behaviour, emotional dysregulation and risk taking. Assessment and formulation identifies that, due to adverse experiences for the child and parents, the parent-child relationship is punitive and conflictual rather than supportive. Intervention with parents could include psychoeducation around the impact of adverse childhood experiences and support to alter the way in which they respond to the child (e.g. Non Violent Resistance, Circle of Security, Dyadic Developmental Psychotherapy and Theraplay).

Relationships are central to how children develop, learn and manage their emotional experiences. Where an emotional wellbeing or mental health need has been identified, it is helpful for the key adults with whom the child interacts on a daily basis to be able to respond from a therapeutically informed position. This can allow in the moment management or therapeutic strategies to be deployed with greater frequency and real world generalisability than can be achieved with outpatient appointments. If the skills are embedded within the family, they can be used repeatedly in the future should difficulties re-arise.

Intervention directly with child or young person

A child has been referred to services due to high levels of emotional distress or mental health difficulties. Assessment and formulation identifies that the child has some patterns of belief and/or thinking and/or feeling and/or behaving that are contributing to the perpetuation of the difficulties. Intervention directly with the child could include specific therapy modality informed work, or specialist work to support change in these patterns in order to improve emotional wellbeing and mental health. The choice of therapeutic intervention should be informed both by the existing evidence base and formulation identifying the areas of greatest need and the child's developmental needs and individual agency.

Annex 2: Training

Training and skills development are key to:

- The delivery of psychological therapy and supervision
- Increasing the capacity of the current and any new workforce to deliver effective interventions at both the required quality and volume.

Values base and recovery focus

All staff working in mental health services will be operating from the values base as described in the 10 Essential Shared Capabilities. The 10 essential shared capabilities were originally developed and published by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and the NHS University in 2004. It is important to note that these organisations worked closely with service users and carers to ensure that they reflected their priorities. It is intended that they will enable service users and carers to have increased awareness of what to expect from staff and services.

The 10 essential shared capabilities

1. Working in partnership	6. Identifying people's needs and strengths
2. Respecting diversity	7. Providing service user-centred care
3. Practising ethically	8. Making a difference
4. Challenging inequality	9. Promoting safety and positive risk taking
5. Promoting recovery	10. Personal development and learning

Over time there may be other values based standards that will require the training of staff. In addition to training in values based care and recovery, all mental health staff should have a basic level of psychological 'awareness' and 'literacy.' This should include:

- Training in a psychological model within which they can construct a basic psychological formulation of service user's difficulties
- Training in listening and communication skills
- Training in basic counselling skills
- Training in self-awareness and the role of the therapeutic relationship.

Psychological therapy services also need to ensure they comply with the terms of the Welsh Language Act 1993 and the Welsh Language Measure (2011).

Psychological interventions and therapy

Psychological therapies interventions can be subdivided in line with the tiers in a stepped-care model as below:

- Low intensity treatments
- High intensity therapy
- High intensity specialist therapy
- Highly specialist therapy and interventions.

The mapping of levels of training against the tiers of the matched/stepped-care system is shown in Section 3, Table 3, "Minimum training to deliver different levels of therapy in Wales". Competence to practice within a specific psychological therapy model e.g. Cognitive behavioural therapy (CBT), systemic therapy should also be consulted (see Page 36 and 37).

In June 2017, there were no all Wales training schemes that deliver training for the 10 essential shared capabilities, or for the workforce delivering low intensity interventions. It is therefore important that local training schemes are structured around the relevant competence frameworks identified in Matrics Cymru and that those delivering the training have the appropriate level of expertise.

The standard of competence required to deliver high intensity specialist psychological therapy has been set intentionally high at Diploma level, in order to ensure fidelity to the evidence base. However, it is recognised that some staff currently delivering high intensity psychological therapy will require additional training to meet this standard. In addition to direct practice based training, staff will also need training in accountability processes and procedures, including legal obligations, how to manage complaints, second opinions and investigation of errors or potential errors.

The effectiveness of therapy, supervision and the state of the therapy relationship are profoundly affected by the accuracy and reliability of record keeping. Partial and inaccurate records can mean lost opportunities, missed risks, misunderstandings and misrepresentations of the service user. Staff need to know how to check the accuracy of their records with service users, use electronic recording devices to improve accuracy and what they can or cannot change in records and the process they need to follow to change it. It is essential that any opinion is identified as an opinion and all the facts leading to that opinion are given, so that subsequent clinicians can assess the situation for themselves and errors can be better identified and addressed.

Local PTMCs should develop and oversee a training strategy for each health board area. The NPTMC should carry out an option appraisal for developing all Wales training in these areas.

Annex 3: Levels of Psychological Understanding and Practice

Intensity of intervention	Client group / level of severity	Treatment delivered	Competence / training routes
Low intensity:	Common mental health problems – stress/ anxiety/depression **Severity:** Mild/ moderate, with little complexity and limited effect on functioning	Low intensity evidence-based interventions e.g. ▪ Supported self-help ▪ Solution-focused/ problem solving ▪ Structured anxiety/ depression management groups ▪ Self-help coaching ▪ Telephone CBT (TCBT) High volume courses: For example: ▪ Mindfulness ▪ Acceptance and commitment ▪ Stress control	**Level of competence:** Must meet the 'Skills for Health' low intensity competences and the standards referenced within the Matrics Cymru Staff with additional training plus intensive, ongoing clinical supervision
High intensity:	Common mental health problems or those whose difficulties are beneath the threshold of secondary care **Severity:** Moderate/ severe with significant complexity and effect on functioning	Standardised psychological therapy delivered to 'protocol' Treatment duration as specified in NICE guidelines (usually up to 16 sessions) Specialised supervision	**Level of competence:** As a minimum training that meets the Centre for Workforce Intelligence (CWFI) definition for a psychological therapist Must meet the 'Skills for Health' high intensity competence

High intensity specialist:	Moderate/severe mental health problems with significant effect on functioning Specialist areas For example: Schizophrenia, Personality disorder, Bi-polar disorder, eating disorders, substance misuse etc. **Severity:** Moderate/ severe with significant complexity and effect on functioning	Standardised psychological therapy delivered to 'protocol' Treatment duration as specified in NICE guidelines (usually up to 16 sessions) Specialised supervision	**Level of competence:** Must meet the 'Skills for Health' high intensity competence Diploma level therapy training, plus further training in application of advanced therapy techniques to specialist area Further knowledge and skills may be acquired through formal training or through specialist supervision
Highly specialist:	Complex, enduring mental health problems with a high likelihood of co-morbidity and beyond the scope of standardised treatments **Severity:** Highly complex	Highly specialist, individually tailored interventions, drawing creatively on the theoretical knowledge base of the discipline of Doctoral Level Psychology and Consultants in Medical Psychotherapy Normally lasting 16 sessions and above As per NICE guidelines Specialist supervision at all levels Providing advice, consultation and training to multi-disciplinary colleagues	**Level of competence:** Specialist knowledge of a range of theoretical and therapeutic models. Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systemic and neuropsychological processes. This will include: ▪ Doctorate in Clinical or Counselling Psychology, Consultant Medical Psychotherapist, individual clinicians with highly developed special skills and expertise, normally including involvement in research and equivalence to doctoral qualification. Identified by health board PTMC as having the requisite knowledge and skills. Qualifications and practice consistent with National Standards

Matrics Plant Implementation Plan

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Commissioned by Improvement Cymru on behalf of the National Psychological Therapies Management Committee.

September 2021

Introduction

This plan has been designed to support the implementation of Matrics Plant: Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales[1]. It is anticipated that it will assist health boards and partners in ensuring that both the spirit and detail of Matrics Plant are transferred into action. It has not been designed as a performance management tool but rather a process to recognise existing practice and plan for improvement, if needed. It offers the opportunity for health boards and partners to consider the needs of all children, irrespective of diagnosis or neurodevelopmental profile; identifying examples of good practice and action needed to address gaps in current provision.

Both Matrics Plant and this implementation plan should be considered in relation to children's human rights under the United Nations Convention on the Rights of the Child[2] and in particular, every child's right to express their opinion freely about all matters affecting them and the principles of participation as set out in the national participation standards[3]. The Children's Commissioner for Wales has produced materials to support the implementation of the Convention in your work[4]. They also sit within the overall policy context in Wales which includes the Whole School Approach[5] and the NEST Framework[6].

Ensuring services are equitable to all those in need of them will be central to provision of effective psychological interventions. Reasonable adjustments for those with protected characteristics, including refugee and asylum seeking children, the ongoing development of services available in the Welsh language and more broadly culturally competent services will be essential.

1 https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/psychological-therapies/resources-psychological-therapies/matrics-plant/

2 https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

3 https://gov.wales/sites/default/files/publications/2018-02/Bilingual-Participation-Standards-poster2016.pdf

4 https://www.childcomwales.org.uk/the-right-way-a-childrens-rights-approach/a-childrens-rights-approach-in-wales/

5 https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-well-being

6 https://collaborative.nhs.wales/networks/wales-mental-health-network/together-for-children-and-young-people-2/the-nest-framework/

A Note about Evidence Tables

A process for reviewing the evidence tables, which are currently published as addenda to Matrics Cymru, is underway and new evidence tables will be published over the coming months. Evidence tables in respect of children and young people will be included in this work. These will be developed to encompass interventions in a variety of settings and services and include, but not be limited to, child health, children with additional needs, looked after children, children with learning disabilities and neurodevelopmental needs. In the interim, practitioners are referred to the Scottish Matrix[7] (which includes infant mental health) and National Institute for Health and Care Excellence[8].

Psychological Interventions

Within Matrics Plant, Psychological Interventions are defined as:

" ...purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing".

As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Interventions with main carers/parents
- Interventions directly with child or young person.

Whilst the formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who accesses our services, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of a psychological intervention.

7 https://www.nes.scot.nhs.uk/media/420chmra/matrix_-_children_youngpeopletablesfinal_2015.pdf

8 For example, possible depression: https://www.nice.org.uk/guidance/ng134/chapter/Recommendations

Purpose

This plan is intended to assist health boards and their partners in the delivery of Matrics Plant. Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children, young people and their families.

This requires an evidence-based theoretical framework to guide the provision of a range of interventions, in addition to the delivery of direct therapy specific interventions. Matrics Plant does not recommend specific models of service - accepting that models may vary according to local need and resource and change over time. It does, however, have a number of organising principles for services which recognise that children and young people:

- Live in their own specific circumstances
- Will have their own developmental needs
- Will have differing levels of control over their lives and/or the ability to seek support
- Should receive appropriate and proportionate psychological services based on distress/need rather than always requiring a mental health or other diagnosis
- May be best helped by services working with the people that the child or young person spends time with as well as offering individual work with them when this is needed.

Psychologically minded services for children, young people and families should therefore:

- Be able to engage children and young people in a way that supports their level of ability and communication
- Be able to offer interventions with children, young people and families' immediate and wider contexts/systems as well as with the identified child or young person
- Be trauma, attachment and ACE (Adverse Childhood Experiences) informed with appropriate competencies and skills
- Engage proactively with health, local authority, education, third sector and youth organisations in order to create conditions to foster positive child development
- Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments
- Help children, young people, their families and the systems around them to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework
- Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered
- Contribute to strengthening the evidence base, drawing on and developing practice-based evidence and evidence informed models.

And in direct psychological work with the child, young person or family be able to:

- Offer a service in Welsh
- Deliver evidence-based care via appropriately qualified, supported and supervised staff
- Provide an appropriate choice of evidence-based interventions
- Operate within a framework of values-based practice which places children's needs as central
- Communicate effectively according to the developmental needs of the child – this may include non-verbal interventions such as through play, music, art or drama
- Deliver measureable outcomes improving and/or associated with psychological health and wellbeing
- Help children, young people and families to achieve personally meaningful progress
- Evaluate and respond to feedback from children, young people and families about the appropriateness of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy.

In practice, this means having practitioners within the workforce who:

- Are able to deliver a service in Welsh
- Are trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work
- Are delivering interventions which make sense in respect of the presenting needs and are supported by the best possible evidence
- Are operating within a well-governed system which offers regular high quality, psychological supervision (model-specific, where appropriate) support and relevant Continuing Professional Development (CPD)
- Are monitoring the quality of the therapeutic relationship, recognising that this is an essential factor in achieving a successful outcome
- Have a role appropriate understanding of social, emotional, psychological, cognitive and physical development and the impact of acute, chronic or life limiting physical health problems on emotional wellbeing and mental health
- Have a role appropriate understanding of systemic case conceptualisation
- Have the ability to communicate effectively with children, young people, their carers and practitioners in their contexts, the systems and to maintain a compassionate approach

- Have an awareness of the impact of attachment, developmental trauma and ACEs with role appropriate competencies
- Have role appropriate training to appropriate standards with the competences required and the support necessary to deliver psychological interventions effectively within the service context in which they work
- Contribute to innovative and reflective practice.

A Note about Examples of Evidence

This plan sets out key questions in relation to the points above, gives examples of the type of evidence that may be provided, asks health boards to identify their local evidence and invites health boards to outline a plan for improvement, where needed. For some of these areas, local services will already be well developed and health boards will be able to demonstrate this through reports, data and appropriate up to date policies etc. This will give scope to identify and improve the less well-developed aspects of services.

Examples of the types of evidence that might be provided are included in the tables. These are examples only and not dimensions against which evidence must be provided. Health boards should not be constrained by these and may have other innovative approaches to achieve the required outcomes.

Section 1: Be able to offer interventions with children, young people and families'[9] immediate and wider contexts and systems as well as with the identified child or young person

Key questions	Health board evidence	Plan for improvement if needed
Are the following types of services[10] available? ▪ Targeted training ▪ Network consultation ▪ A range of consultative support ▪ Direct intervention with parents/carers ▪ Direct interventions with children and young people		
Is there an appropriate range of evidence-based 1:1 or group direct psychological interventions available at varying levels of intensity linked to current evidence tables?		
Are a range of psychological interventions involving parents/carers routinely available and linked to evidence tables?		
What is the capacity/provision for interventions for the system around the child?		

Examples of evidence could include: A menu of psychological interventions' is available and accessible for service users, families, staff and stakeholders; Agreed guidelines about when each type of intervention would be appropriate; A menu of quality assured targeted training modules available to meet common needs; An operational process for arranging, recording and following up on network consultation and consultative support including its impact on the child, young person, or family's wellbeing and goals; A menu of direct psychological interventions' is available and accessible for service users, families, staff and stakeholders; A menu of psychological interventions with parents/carers is available and accessible for service users, families, staff and stakeholders; Job plans/job descriptions/person specifications etc.

9 When this document refers to children and young people, it refers to all those aged 0 to 17 years. Family can mean very different things to different people at different times. In this document, family can mean the people with whom a child or young person lives with and who may or may not be related to them, as well as people to whom they are related.

10 Descriptions of these services can be found in Matrics Plant: https://phw.nhs.wales/services-and-teams/improvement-cymru/news-and-publications/publications/matrics-plant/

Section 2: Deliver measureable outcomes improving and/or associated with psychological health and wellbeing

Help children, young people and families to achieve personally meaningful progress

Evaluate and respond to feedback from children, young people and families about the appropriateness, accessibility and acceptability of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy

Key questions	Health board evidence	Plan for improvement if needed
How are the services offered reviewed and developed in relation to current and emerging evidence base?		
How are children and young people enabled to seek advocacy support, as needed, to promote and empower their participation in setting goals and aspirations they seek for themselves?		
How are outcome measures[11] routinely used to: ▪ Ensure goals are personally meaningful? ▪ Evaluate service user satisfaction? ▪ Demonstrate and support improvement in mental health and emotional wellbeing?		

Examples of evidence could include: Regular, documented review of interventions offered by service in relation to new and emerging evidence tables, gaps identified and training/development plan generated; Staff survey feedback; Service user feedback; Policy regarding monitoring of engagement, attendance and participation etc. to ensure that this indirect feedback as to acceptability, accessibility and appropriateness is used to improve services; Evidence of changes made where service user satisfaction has indicated they are necessary etc.

11 https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/outcome-measures/framework/

Section 3: Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments

Help children, young people and their families to understand the emotional and psychological needs of the child or young person within this framework

Be able to engage children and young people in a way that supports their level of ability and communication[12]

Be trauma, attachment and ACE informed with appropriate competencies and skills

Key questions	Health board evidence	Plan for improvement if needed
Do staff have a role-appropriate working knowledge and understanding of the impact of the following on emotional wellbeing and communication: ▪ Child development (physical, cognitive, emotional, social including neurodevelopmental differences)? ▪ Current attachment theory? ▪ Up to date knowledge of ACEs? ▪ The impact of developmental trauma? ▪ Learning disability?		
Is there a process for determining what training or CPD will be necessary to enable staff to deliver appropriate psychological interventions in relation to the above?		

12 The importance of children and young people, especially those with mental health needs or a learning disability, being able to communicate in Welsh (or other first language of choice) is recognised as fundamental to their ability to express their thoughts and needs

How are services made accessible for children, young people and families who have mental health needs and may struggle to engage with traditional clinic-based services due to, for example, developmental trauma, presenting need, neurodiversity, learning disability?		

Examples of evidence could include: Database/record of staff training; Database/record of staff competency; Review at annual staff appraisals (e.g. PDR, PADR etc.); Training plans including programme of staff development opportunities and knowledge updates, could include special interest groups; Policy around follow up for families who have struggled to engage; Allowances are made within capacity planning for establishment of rapport and relationship with these children, young people and families; A range of engagement methods are available, ranging from text messaging through to face to face.

Section 4: Engage proactively with health, local authority, education[13], third sector and youth organisations in order to create conditions to foster positive child development

Help the systems around children, young people and their families to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework

Key questions	Health board evidence	Plan for improvement if needed
What are the pathways/processes for relevant systems and organisations to access expert psychological/psychologically informed support in order to assist them to improve the appropriateness, accessibility and acceptability of their services?		
What are the links/pathways for staff working with children, young people and families more broadly within the health board (e.g. health visitors, school nurses) and outside the health boards (e.g. local authority staff, family support workers) to access expert mental health advice/consultation/training?		
Where staff working with children, young people and families within and outside the health board are delivering psychologically informed interventions, how can they access psychologically informed supervision/support?		
What is the capacity/provision for joint and multiagency working in order to provide the most effective psychological intervention?		

Example of evidence could include: Clearly identified points of contact for these staff within psychological intervention services; Clear, published and publicised pathway for accessing and providing this type of support; Proactive, published and publicised training offering is available to these staff; Agreed mechanism/procedure to capture non-direct intervention as meaningful clinical activity; Local partnership agreements; Job plans/job descriptions/person specifications etc.

13 https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-well-being

Section 5: Staff will receive the appropriate level of supervision – this should include mental health staff, other health board staff and staff in other agencies, as appropriate

Key questions	Health board evidence	Plan for improvement if needed
Is there provision for role-appropriate supervision of practitioners engaged in psychological interventions?		
What are the links/pathways for staff working with children, young people and families more broadly within the **health board** (e.g. health visitors, school nurses) and **outside the health board** to access appropriately skilled supervision and support?		

Examples of evidence could include: Local supervision policies and compliance with these are monitored; There is an index of supervisors, to include capacity and the psychological therapy model(s) offered; Supervisory capacity will meet the needs of all staff; Job plans include time for regular clinical supervision and this is monitored at least quarterly; Jointly developed and agreed framework/policy for the provision of psychological intervention supervision/support etc.

Section 6: Contribute to strengthening the evidence base, drawing on and developing practice-based evidence and evidence informed models

Key questions	Health board evidence	Plan for improvement if needed
How are practitioners within the service involved in research?		
How are practitioners supported to remain up to date with the current evidence base?		
How are the analyses of outcome measures audits shared appropriately, internally and/or externally in order to support the evidence base in relation to most effective outcomes?		

Examples of evidence could include: Evidence of support for research activity; Links to local academic institutions; Research publications of staff; Evidence of sharing outcomes of audits appropriately etc.

Section 7: Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered

Key questions	Health board evidence	Plan for improvement if needed
How are the opinions of children, young people and families used to inform, co-produce and develop the service and the range of indirect interventions offered?		
How are children, young people and families fully involved in co-production of care plans and/or intervention goals?		
How much informed choice do children, young people and families have around which psychological intervention is provided (both in terms of the type of intervention and the way in which it is delivered?		

Examples of evidence could include: Services have conducted a review of youth and mental health organisations locally through which young peoples' views on current/future psychological intervention services can be accessed and have robust pathways to access and feedback these views to inform service development; Policies and procedures reflect current views of children and young people as published in relevant reports (e.g. Young Minds) and from local intelligence; Sample audit of assessments, care plans, or other relevant goal setting documentation for children and young people demonstrate informed engagement in goal setting; There is clear and accessible information proactively provided (perhaps in the form of a leaflet) which outlines for children, young people and families the range of psychological interventions available, the benefits of each and why services may recommend a particular approach (e.g. parent work rather than direct work with child); Where appropriate and available, children, young people and their families have a choice of evidence-based psychological interventions; *Where a choice is not available due to a lack of trained staff or other service constraints, this is recorded and plans are in place to reach a position of being able to offer this choice meaningfully etc.

Section 8: Equity and Accessibility

Key questions	Health board evidence	Plan for improvement if needed
Are there a range of psychological intervention services available to meet the needs of children, young people and families irrespective of diagnosis?		
How is it ensured that all services and documentation are available in the Welsh language?		
What are the mechanisms in place where the child, young person or family prefer or need to access services in a language other than Welsh or English?		
What reasonable adjustments exist to ensure services are accessible to people with protected characteristics and marginalised populations[14]?		
How is equity of service access ensured across the geographical area?		

14 http://www.legislation.gov.uk/ukpga/2010/15/contents
https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equalityduty-wales
https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-248

Are services provided in accessible locations?		
Are services available digitally[15] where appropriate?		
How are children, young people and families supported to access digital services where there are barriers?		

Examples of evidence could include: Overview of services available to meet the psychological wellbeing needs of children, young people and families; Clear pathway to ensure children and young people can access appropriate psychological intervention (may not be with the service to which they have been initially referred); Record of practitioners who are able to deliver a service fluently in Welsh; Translators used have an appropriate level of psychological fluency; All bespoke written material available in Welsh without delays; All standardised written material available in Welsh; Evidence of compliance with current legislation on disabled access; Building and rooms appropriate for the developmental stage and age of the child or young person; Leaflets/reading materials appropriate for a range of developmental stages and ages and in an appropriate range of languages; Appropriate facilities and locations including waiting areas, access, clear signage to and within the building, confidential and safe consultation rooms etc.; Consideration of children, young people and their family's individual circumstances including rurality, access to transport and cultural context.

15 E.g. video conferencing via telephone or text

NEST FRAMEWORK
What You Need To Know

Background

- The Together for Children and Young People (2) Early Help and Enhanced Support (EHES) Workstream is focused on facilitating a 'step-change' in how we support babies, children, young people, parents, carers and their wider families with their mental health and wellbeing.

- It aims to broaden the conversation away from just thinking that help is the domain of specialist services. These services are important, but there is much more that can be done to provide support.

- The purpose is to make expertise and advice quicker to access; and to give the grown-ups closest to children of all ages the skills and confidence to understand what they can do to help.

- When extra help is needed, it aims to take a 'no wrong door' approach so that families get the right help at the right time and in a way that is right for them.

- We have listened to young people, parents, carers and staff who work in schools and children's services all across Wales. These have included teachers, social workers, nurses, doctors, therapists and youth workers.

- The National Youth Stakeholder Group (facilitated by Children in Wales) and Parents Voices in Wales have been especially helpful in making sure we keep focused on what is most important to children, young people, parents and carers.

- It has also been important to link with services for adults too, and with housing, police, ambulance, sports and leisure services.

- Families, schools and communities are so important in preventing mental health difficulties, but also in helping when children and young people struggle most. That is why we talk about **Early Help and Enhanced Support**. This is not just about prevention; it is also about intervention including for those of greatest concern.

- The more people we talked to, the more we realised how much interest there was in doing things differently. Lots of people across many services wanted to get involved which has been very exciting. We have learnt so much from listening to everyone's views.

- We also talked to policy makers in Welsh Government, Partnership Boards and Health Boards across Wales.

- It is especially positive that Ministers across Education, Health and Social Care are taking an equal interest in this work as this leads to joined up planning. We refer to this as a **whole system approach**.

- The aim is to bring everyone together across all agencies, services and departments to focus on the same goal – helping children of all ages in ways that support their mental health and wellbeing at every opportunity.

- Through talking and listening and understanding what is needed we have developed a framework called **NEST**. This was chosen for the following reasons:

    - The importance of a safe and nurturing base or **NEST** for everyone's mental health and wellbeing.

- That all babies, children and young people get the support they need growing up to help them 'aim high' and 'fly the NEST' when they are ready - but they can return to it if they need to.

- That everyone's **NEST** is different, filled with the people, places and activities that are most important to them.

- That many of us, and at different points in our life, will need extra support with our **NEST**, additional layers working together to help our mental health and wellbeing.

It is these layers of support, coming from the people in our day to day lives that often help us the most.

There is research to support this and we have chosen the term 'everyday magic' to describe the power it has to make a difference.

The acronym **Nurturing**, **Empowering**, **Safe** and **Trusted** were the preferred core qualities our **NESTs** need to have, chosen by stakeholders during our co-production sessions.

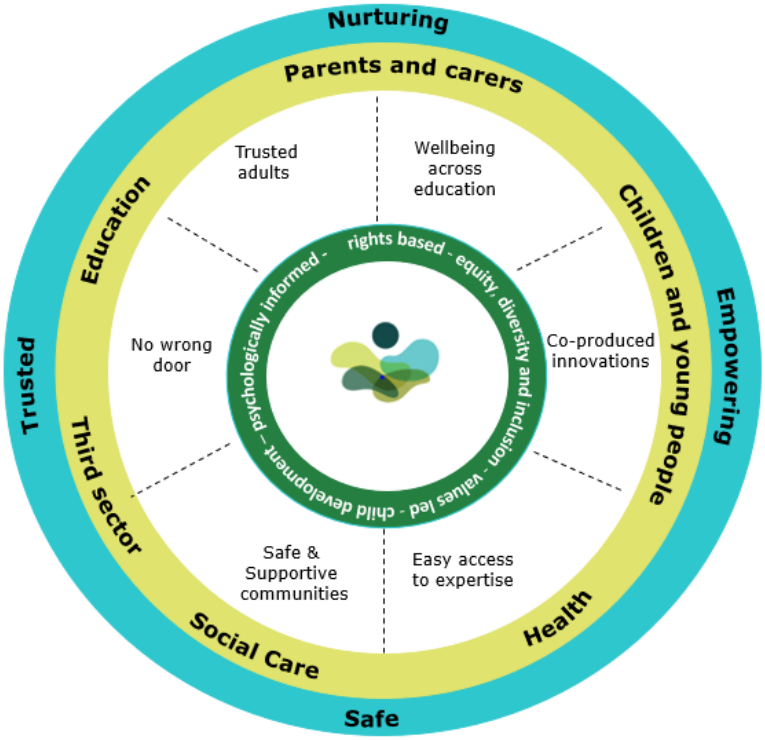
We consulted with a range of people who speak Welsh as their first language regarding the acronym. Rather than a direct translation of NEST, their preference was to develop an acronym for NYTH, see below.

N	rhoi Nerth (Give strength / empower)	N	Nurturing (Taken care of and cherished)
Y	Ymddiried (Trust)	E	Empowering (Feeling strong and listened to)
T	Tyfu'n ddiogel (Growing safely)	S	Safe (Protected and able to be yourself)
H	Hybu (Encourage)	T	Trusted (Reliable and there for you)

What is the NEST Framework?

The **NEST** Framework is a planning tool for Regional Partnership Boards. It aims to ensure **a whole system approach** for developing mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales.

The framework (below) is made up of several sections. The digital version can be developed to link to documents and practice examples as policy and services evolve.



Here is a brief description of each section and why they are important. But the MOST important thing is that they all work together to create a **whole system approach**. All of these things are vital to our mental health and wellbeing, and we can't focus on one thing without taking the others into account. The **NEST** Framework helps us keep an overview on how everything and everyone works together to achieve the best outcome.

Rights Based Approach

A rights based approach is fundamental to all our mental health and wellbeing. Every professional, childcare setting and service needs to understand the importance of this, demonstrating how they put it into practice. Are the children and young people in their care aware of their rights? How does this get enacted day to day?

Equity, Diversity and Inclusion

To feel included and that you belong and have the same chances as everyone else is also fundamental to our mental health and wellbeing. So many difficulties start with feeling left out, or different, or invisible, or like you don't count as much as someone else.

It is why some issues like race, ethnicity, culture, religion, gender identity, sexual orientation, physical health and disability, neurodiversity, additional learning needs, learning disability, adversity and poverty can put you more at risk of struggling with your mental health. This has to change if we are serious about addressing mental health difficulties. The **NEST** Framework has this as an important priority for all professionals and services to actively address. It balances this with the importance of not defining anyone by these characteristics, but seeing the whole unique person, and focusing on what is most important to them.

Values Led

All organisations work in different ways and are designed to do different things. This can lead to differences about what to prioritise and focus on. The **NEST** Framework asks everyone to stop and think about what matters most, and what they should all focus on together to support children of all ages with their mental health and wellbeing. When we did this exercise with a large group of stakeholders from across Wales, these were the values they felt were most important:

Child Development

All babies, children and young people are unique and develop in different ways. This includes their physical and emotional development as well as how they learn. The **NEST** Framework asks that this is given more attention than the current approach that often has age as its main focus.

Psychologically Informed

We are learning all the time from psychology and related fields about what brings the best out in us as humans. The **NEST** Framework anticipates all services should have access to expertise to enable them to keep up to date with the latest research. Examples like Attachment Theory (how we learn about relationships as babies and children from the grown-ups around us) and trauma informed approaches (how we respond when we are exposed to traumatic experiences for prolonged periods of time), are new and emerging learning that we all need to know about and integrate into how we work.

Trusted Adults

This is the most important section of the **NEST** Framework. It is about the vital role that the proximal grown-ups have in helping babies, children, and young people, with their mental health and wellbeing. Having someone close by who they can turn to when feeling sad, or who understands that anger might be about something deeper that is

worrying them is so important. Trusted adults can help babies, children, and young people to learn to manage their feelings by listening and empathising, by helping find words for difficult emotions, by showing ways of managing difficulties, and by helping to sort problems out. Co-regulation, where strong emotions are contained by someone trusted, is fundamental to self-regulation and is a vital building block in psychological development.

Trusted adults who feel supported to provide this, alongside being able to focus on an individual's strengths, encourage them to not give up, and celebrate their achievements, no matter how small, provide the 'everyday magic' that is so important to positive mental health and wellbeing. We all need experiences of this; but children of all ages who don't experience enough of it in their lives for all sorts of reasons, need it even more. Trusted adults help prevent mental health difficulties **and** they help to address them if they develop.

Wellbeing Across Education

From crèches, to nursery, to school, to sixth form and on to college, education settings are a big part of the lives of babies, children, and young people. It is vital that they have a good understanding of mental health and wellbeing and take every opportunity to support it in every way they can. Welsh Government really understands this and have developed a range of policies and initiatives to put mental health and wellbeing at the centre of education. These developments also recognise that this is as important for teachers and support staff as it is for parents and carers too. The **NEST** Framework emphasises the significance of this, and of all services working together to support it.

Co-produced Innovation

The **NEST** Framework has been co-produced which means taking on board everyone's ideas, especially those of the young people and the families it is here to serve. There are so many different points of view that sometimes decisions have to be made about what stays and what gets left out, but the end result is better for having gone on that journey. The **NEST** Framework values this in all services aimed at helping with mental health summed up by the phrase "nothing about you without you". It means services stay focused on what matters most to children, young people and their families, and keep on improving. Peer support, where people get help from others who have gone through similar things is also important; as well as using technology to keep things up to date and open to everyone.

Easy Access to Expertise

One of the biggest changes the **NEST** Framework aims to achieve is to make expert help and advice more available. From helplines, to information, to a regular visit from a specialist to a school or youth service, to multi-agency teams with mental health professionals embedded in them, there are many ways of achieving this. The most important thing is that the grown-ups in children's lives know where to go for help and can get it quickly if they need it. This makes them more likely to feel confident to work through difficulties with young people, instead of feeling out of their depth and passing them on to someone else for help. We call this 'holding on' instead of 'referring on' and the aim is to stop families being passed from service to service, and telling their story lots of times, and never quite feeling that they are in the 'right' place. Of course, sometimes specialists are needed to take a bigger role, but always with the aim of supporting those closest to children and young people first. This recognises that 'everyday magic' can be very powerful therapeutically.

Safe and Supportive Communities

Babies, children, young people, parents, carers and their wider families need safe places to live, to play, socialise and exercise, along with access to healthy food, sports, arts and leisure activities. Work is an important part of this, and access to jobs that pay well is crucial to well-functioning families. The **NEST** Framework recognises that these things are very important to mental health and wellbeing, and when they are not available then children of all ages and their families are likely to struggle. These are problems that can't be 'fixed' in clinics and their importance often gets under-estimated when we think about improving mental health services. The **NEST** Framework aims to shift this balance, emphasising that these are often the MOST important things in keeping us well and achieving our full potential.

No Wrong Door

Sometimes, of course, extra help is needed. This is a really important part of the **NEST** Framework and is all about families getting the right help at the right time and in a way that is right for them. All services that have a role in mental health and wellbeing need to come together to work out how best to meet the need. These services can be from health, education, social services or the third sector. All have something to offer depending on a family's circumstances. The more services come together to listen to what families need, the more they can adapt how they work together to fill the gaps. Services offering extra help might focus on particular groups of children and young people, or on particular issues. **No wrong door** helps work out what is working well in an area and what new services are needed. It also stops the big frustration of waiting on a list to find it's not the right service after all.

Working Together

The aim of the **NEST** Framework is to highlight the most important things that support the mental health and wellbeing of babies, children, young people, parents, carers and their wider families, ensuring that all services work together to make them a priority. It emphasises that every relationship and every service needs to be **N**urturing, **E**mpowering **S**afe and **T**rusted if we are to build the foundations for positive mental health and wellbeing. These qualities are even more important for those who are struggling most, which is why it is about prevention AND intervention. They are also as important for the professionals. We all need to take care of our mental health and wellbeing.

What is your **NEST** like? What would need to happen to make it more **N**urturing, **E**mpowering, **S**afe and **T**rusted?

These are the questions we need to be asking if we are to support the mental health and wellbeing of our communities together.

For Further Information, contact:
Helen.Ranson@wales.nhs.uk

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Llywodraeth Cymru
Welsh Government

Framework on embedding a whole-school approach to emotional and mental well-being

Guidance

Guidance document no: 269/2021
Date of issue: March 2021

Framework on embedding a whole-school approach to emotional and mental well-being

Audience

This Framework is aimed at the needs of school-age learners and the workforce supporting their learning and well-being needs. However, much of the content is also applicable in other settings that deliver education where children and young people require well-being support to fully engage in their learning and to develop. There are a range of intended audiences and partners involved in delivering this Framework, set out on page 11.

Overview

The Framework is intended to support schools, including pupil referral units (PRUs) and education settings in reviewing their own well-being landscape and in developing plans to address their weaknesses and build on their strengths. It recognises that the school alone cannot meet all the needs of a complex population of children and young people, and sets out the role of regional bodies, the NHS and others such as the third sector, in supporting the school. It is meant to support and complement the new national Curriculum for Wales and in particular the Health and Well-being Area of Learning and Experience.

Action required

Schools and local authorities are required to have regard to this Framework when developing action plans, strategies and other policies that impact on the well-being of learners, staff and others working within the school environment.

In addition, local authorities should have regard to this Framework when organising or delivering educated other than at school (EOTAS) provision.

Further information

Enquiries about this document should be directed to:
Health and Well-being in Schools
Support for Learners Division
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

e-mail: mentalhealth.schools@gov.wales

@WG_Education

Facebook/EducationWales

Additional copies

This document can be accessed from the Welsh Government's website at gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-well-being

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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1. Ministerial foreword

If 2020 has taught us anything, it is the importance of maintaining our emotional and mental well-being. None of us could have foreseen the way COVID-19 would affect our lives and even the most resilient of us will have struggled and experienced poor well-being at times.

These are normal emotions and reactions to uncertainty and anxiety about the impact COVID-19 could have on our own health and the health of family and friends; concerns about its impact on our future, as we witness society change in ways in which we could never have thought possible; worries about having to endure enforced separation from family and friends for long periods; and sadly, for some of us, having to endure the impact of loss and bereavement as a result of the virus.

Thankfully, as we start 2021 with the rollout of the COVID-19 vaccines, there is hope that at some point in the near future our lives will return to normal. However, it will not be the same and the emotional scars and impact of COVID-19 are likely to remain with us for some time. This will require additional effort from all of us to support and improve the emotional well-being of the individual and the nation. If we can take positives from the last year let it be that the spotlight is now firmly focused on emotional and mental well-being and, in particular, the well-being of children and young people and the role of schools in supporting and building positive well-being.

Our children and young people already have so much to cope with, whether it be the stresses of growing up in an uncertain world, added pressures such as family circumstances, poverty, physical and mental impairment, housing, access to transport and facilities which many of us take for granted, or their physical environment. All of these can influence children and young people's emotional and mental well-being.

As a result of our cross-governmental strategy *Together for Mental Health* (2012) we have made good progress in addressing many of the negative factors in recent years and education is playing its part, in particular through development of our new curriculum. The development of 'healthy confident individuals' is one of the four purposes of the new curriculum and the Health and Well-being Area of Learning and Experience is about developing the capacity of learners to navigate life's opportunities and challenges.

The Welsh Parliament's Children, Young People and Education Committee acknowledges the progress that has been made in its *Mind over matter: Two years on*[1] (2020) report. This Framework is central to that progress and supports schools, local authorities (LAs) and partners in developing consistent and equitable whole-school approaches to well-being. It builds on the many examples of good practice already occurring across Wales and it is not a standalone document. It is complemented by the work of the Together for Children and Young People

[1] https://senedd.wales/laid%20documents/cr-ld13568/cr-ld13568-e.pdf

Programme (T4CYP(2)); together, they support the ‘whole system’ approach to children’s well-being.

This Framework was consulted on between July and September 2020 and 142 responses were received. We want to thank the many respondents from across the spectrum of Welsh life, including the many individual children and young people, parents/carers, teachers and clinicians who responded. You have helped shape the future of well-being provision for children and young people for the better.

Kirsty Williams
Minister for Education

Eluned Morgan
Minister for Mental Health, Well-being and the Welsh Language

2. Executive summary

This Framework is issued as statutory guidance to governing bodies of maintained nursery, primary, secondary, middle, pupil referral units (PRUs), and special schools and local authorities in Wales. It is also intended for use by the range of partners who work in and with schools to support the emotional and mental well-being of learners and staff. While written primarily for schools much of the content and the focus on well-being is equally applicable in other settings such as childcare settings that deliver the Foundation Phase, further education (FE) and higher education (HE).

It aims to address the emotional and mental well-being needs of **all** children and young people, as well as school staff, as part of the whole-school community. It also recognises that the school alone cannot meet all the needs of what is a complex population of young people, whose needs will vary as they progress through infancy to adolescence and early adulthood. It is not about medicalising well-being; rather it is about taking account of the continuum of need. Primarily it is about building resilience and ensuring preventative action. However, there is also a need to recognise the signs and address poor well-being when it arises and to ensure effective support for schools and the learner when a learner experiences more severe distress. School staff well-being is also central to the Framework, recognising the link between learner well-being and the well-being of the adults they have frequent contact with. Effective learning is most likely to occur in an environment where all are engaged.

The whole-school approach seeks to support good emotional and mental well-being by promoting a positive cultural environment in schools, where children and young people form positive relationships with staff and other learners, and relationships are strengthened:

- between teaching staff
- with the school senior leadership team and wider school staff
- with parents and carers
- with other professionals working with the school
- with the wider community that surrounds the school.

It is about embedding good well-being through teaching as well as all the other aspects of school life. It is an ethos that:

- values inclusion, where everybody works together, contributing their individual skills and resources to the collective good
- creates a supportive environment where young people are encouraged to fulfil their personal and academic potential, where they thrive, learn and emotionally develop, supported by teachers who operate in a culture that equally values their own well-being.

The Framework places a number of actions and requirements on schools and partners, including the following.

- All partners/stakeholders involved in the delivery of this Framework should be open and responsive to each other and be clear on their roles and responsibilities in meeting the emotional and mental well-being needs of children.
- Within the school, delivering the approach involves collaborative and sustainable effort involving all members of the school community; it is the responsibility of the governing body, senior management team, teaching and support staff. Schools, led by the governing body and headteacher, need to make a strong statement that well-being supports academic attainment and wider benefits to community and society, both in the here and now as well as in the future. This should be recognised in schools' developmental plans and relevant documentation. Developing children and young people who have an understanding of their own well-being is an important outcome in itself.
- Partners/stakeholders should involve and engage children and young people to understand this Framework. Children and young people should have a route to tell partners/stakeholders what they think about the arrangements being put in place and what is important to them within the Framework.
- While delivering this Framework is everybody's business, school governing bodies and headteachers, particularly in larger schools, should appoint a named person to lead implementation and act as coordinator to engage with other staff, learners, parents/carers and external agencies. This individual may already have experience of such work in relation to coordinating the Welsh Network of Health School Schemes (WNHSS) activity, or leading pastoral care, for example.
- This Framework is not intended to be overly bureaucratic (effective implementation and delivery may bring benefits, for instance in teachers feeling more supported in the classroom). Wherever possible, existing delivery mechanisms should be used for delivery of this Framework.
- In delivering children's and young people's universal and targeted interventions, or any interventions aimed at improving teacher knowledge and understanding of their own and children's well-being, the school's senior leadership team will ensure that only those interventions with a sound or innovative and developing evidence base are delivered.
- Schools (the whole academic and support staff, led by the senior leadership team) should implement and integrate this Framework, making links with their curriculum.
- Linked to the school improvement planning cycle, the school's senior leadership team will undertake a review of learners' emotional and mental well-being needs and implement a plan to address issues and build on areas of strength.
- The school's senior leadership team should engage partners and their learners to keep activity against this Framework under review and in line with the Children and Young People's National Participation Standards[2] and National Principles for Public Engagement in Wales[3].
- Local authorities should have regard to this Framework when organising or delivering educated other than at school (EOTAS) provision.
- This Framework will be kept under review and evaluated to ensure it is fit for purpose. The first such review will occur during late 2022, taking account of the

[2] gov.wales/children-and-young-peoples-national-participation-standards
[3] www.participationcymru.org.uk/principles

learning arising from having implemented the Framework for a full academic year (2021–22).

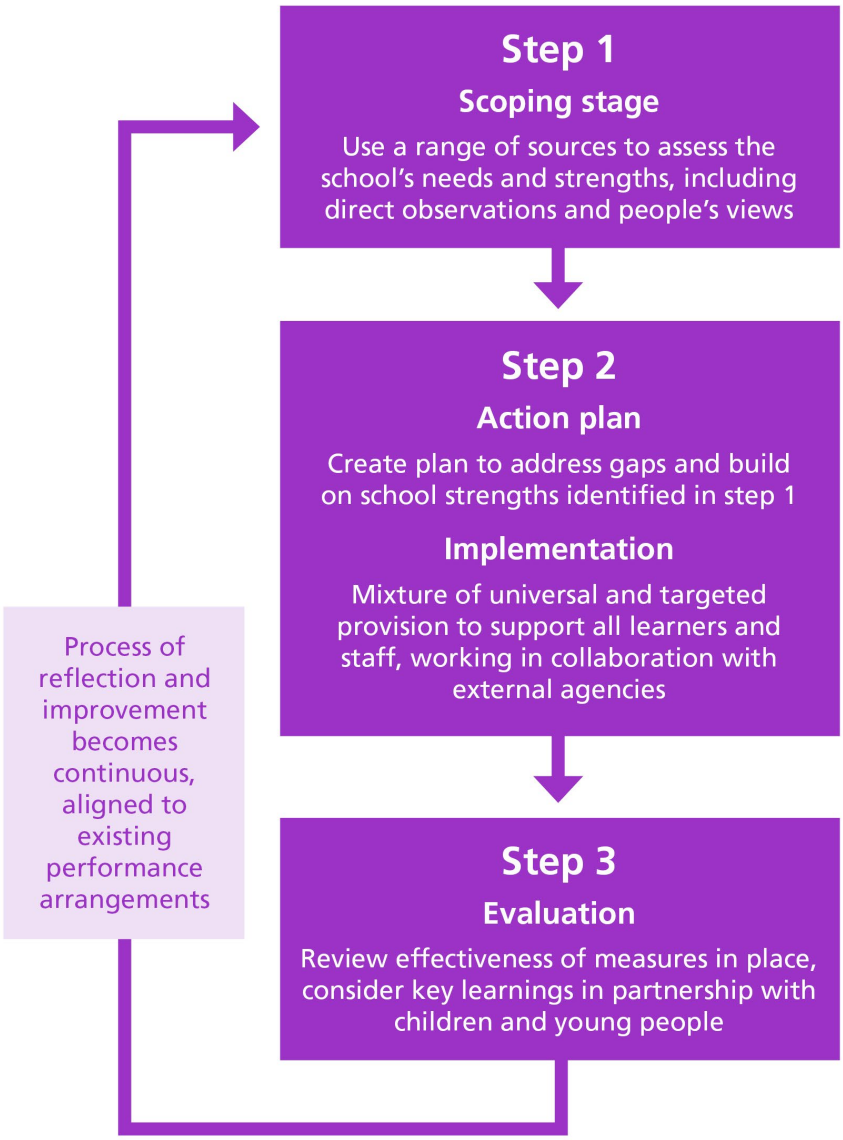
Core values

The Framework is based on the core values of belonging, efficacy and having your voice heard:

	Belonging	Efficacy	Voice
School senior leadership team	How does your school contribute to a sense of belonging?	Do I role model the behaviour I want to see at all levels of the school and build relationships based on respect, trust and fairness?	Do I make space for conversations, giving and receiving constructive feedback, acting on the views of others to help us be at our best more of the time?
All staff	Am I aware of the well-being needs of my learners and colleagues?	Do I understand my own well-being needs and the impact my well-being has on those around me?	Do I have the time to listen to the young people in my care and advocate for them when needed?
Learners	Do I feel safe, valued, treated with respect, connected and supported while at school?	Do I have self-esteem, aspirations, self-confidence and empathy? Am I able to form and maintain trusting relationships with peers? Do I know there are adults I can trust and talk to when I need to?	Do I feel supported to speak my mind, safe in the knowledge that my views are given due consideration?
Parents/ carers/ family	What contribution can I make to both my child and my child's peers' well-being, both in and outside school?	Am I able to positively influence my child in a healthy and success-promoting manner and maintain beneficial ties to the school to support and promote wider community benefits?	Do I feel confident and able to raise and discuss issues and know how to navigate a system that works with me to find appropriate support when needed?

Delivering the whole-school approach

It provides a defined process for schools to develop and embed their own whole-school approaches which is consistent, equitable for learners and staff and which is not intended to be overly bureaucratic, rather working in common with existing school improvement processes. It is about emphasising the good things that we should all be doing as a matter of course.



The Framework enables schools to scope their need, mapping their strengths and weaknesses, using the range of data they have available to them, including internal and external sources and benchmarking data from schools within their own region. They will be supported by dedicated implementation leads, funded by the Welsh Government and embedded within the WNHSS. The implementation leads are developing an assessment tool to support the process; it will inform the school's action plan, build on successes and seek to address gaps. The intention is that this becomes part of continuous improvement, embedded within the school ethos.

The action plan will take account of:

- the whole-school ethos
- the whole-school curriculum and in particular the Health and Well-being Area of Learning and Experience
- staff well-being
- the whole-school school environment
- the whole-school provision of information, awareness raising and advocacy

- the whole-school provision of universal and targeted support
- the whole-school provision for children and young people with specific needs
- the whole-school provision for vulnerable children and young people
- transition between education settings (i.e. home to school, primary to secondary and school to FE/HE, training or employment)
- leadership and staff training.

It also considers:

- how the school works with partners, including the role of youth work
- the whole system roles and responsibilities
- relationships with external services, including the work of the T4CYP(2).

In developing this Framework we are not starting with a blank sheet of paper and there are many examples of good practice across Wales upon which to draw. The Framework includes many case studies of good practice, as well as two examples provided by MIND and The Exchange, in partnership with Swansea LA, of implementing whole-school approaches to help inform activity.

Whole system approach

In reality, the whole-school approach is part of a much wider whole-system approach to meeting the well-being needs of children and young people. In this respect it is integral and codependent on the work of the NHS-led T4CYP(2).

T4CYP(2) is a Welsh Government priority with cross-cabinet commitment. It aims to improve the emotional well-being and mental health services/support for children and young people, through coproduction with those with lived experience, their families, communities, NHS health boards, local authorities and the third sector. T4CYP(2) has three areas of focus:

- early help and enhanced support (EHES)
- neurodevelopmental services
- Regional Partnership Boards (RPBs).

Evaluation

School senior leadership teams should evaluate the effectiveness of their plan as part of wider school improvement to ensure it is meeting their requirements, involving all parts of the school population of learners and staff in the evaluation. Learners, in particular, should not be considered as passive recipients only, rather they should be seen as valued contributors. As such, they should be involved at the very outset of and throughout the school's establishment and implementation of its whole-school approach. Estyn's *Healthy and happy* (Estyn, 2019) highlights the importance that staff and leaders place on listening to learners, not just on having systems in place for pupil representation.

Governance and accountability

The Framework also includes our proposals for governance and accountability, reflecting how schools should ensure adherence to the Framework and how consistency will be ensured at the regional and national levels.

3. Intended audience

A range of audiences and partners will be involved in delivering this Framework, including:

- all maintained school senior leadership teams (headteachers, teachers-in-charge of PRUs, deputy heads and departmental heads) and wider school staff (teaching, administrative, etc.)
- governing bodies of maintained nursery, primary, secondary, middle and special schools
- local authority directorates of education and regional consortia
- local health board primary and secondary care services
- local authority children's and social services
- local authority young carers' services
- parents/carers plus the wider school community
- youth services, youth workers, youth offending teams and youth work organisations (both voluntary and LA)
- youth offending institutes and secure children's homes
- local authority Families First leads
- childcare settings, especially those that deliver the Foundation Phase
- playworkers and play organisations
- third sector organisations delivering both early education and education support services
- children and young people within maintained schools
- children and young people in EOTAS and PRUs
- independent schools
- advocacy providers
- while not specifically intended for FE and HE, the issues in this document are of equal value in those education settings and complement existing guidance such as the Public Health Wales *Healthy and Sustainable Colleges and Universities Framework*[4].

This document contains both statutory guidance and non-statutory advice.

The whole of this document is issued as statutory guidance to:

- governing bodies of maintained nursery, primary, secondary, middle and special schools, as well as of PRUs
- local authorities in Wales

and provides non-statutory advice to other persons, including health professionals, or bodies who may have a role in helping to support the mental health and emotional well-being of learners in maintained schools and other education settings.

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4 www.wales.nhs.uk/sitesplus/documents/888/PHW%20HEFE%20Framework%20bilingual%20October2019.pdf

Local authorities and governing bodies **must** have regard to this statutory guidance when carrying out their duties in promoting the welfare of children who are learners at the education setting, including meeting their mental and emotional well-being needs. The guidance also applies to activities taking place off-site as part of normal educational activities.

Other bodies **should** have regard to this guidance.

What legislation is this guidance issued under?

Section 175 of the Education Act 2002[5] places a duty on local authorities and governing bodies to make arrangements to ensure their functions are exercised with a view to safeguarding and promoting the welfare of children in school or another place of learning. This includes supporting the mental health and emotional well-being of learners.

In meeting the duties under section 175 of the Education Act 2002, local authorities and governing bodies **must** have regard to guidance issued by the Welsh Ministers under this section.

Section 21(5) of the Education Act 2002 places a duty on governing bodies to promote the well-being of learners at the school as far as related to the matters mentioned in section 25(2) of the Children Act 2004, which includes physical and mental health and emotional well-being, education, training and recreation, and social well-being.

The non-statutory advice contained within this document is issued in exercise of the Welsh Ministers' duty to promote the education of the people of Wales and their power in relation to the promotion or improvement of the economic, social and environmental well-being of Wales.

[5] www.legislation.gov.uk/ukpga/2002/32/section/175

4. Background

4.1 The whole-school approach, and a blended learning approach

The coronavirus (COVID-19) pandemic has resulted in an unprecedented situation where, in order to respond to, and where possible mitigate, the public health emergency, significant, complex and often difficult decisions have had to be taken, often within very compressed timescales. Over the course of the last year our understanding of the virus and its longer-term impacts, including the well-being impacts, has continued to develop.

The Welsh Government published and has continued to keep under review the Operational guidance for schools and education settings: Guidance on learning in schools and education settings: coronavirus[6]. This guidance and proposals are in line with the whole-school approach, which in turn supports the well-being response to COVID-19. Whatever the short-, medium- and long-term outcome of the pandemic, there has been a considerable amount of learning that can be adapted to support schools and learners.

All children and young people should have access to support for their well-being at school, and also at home when necessary. If a blended learning approach is to become more common, or the preferred option for some learners with specific needs, then it is even more important that maintaining relationships and being able to talk about issues should be possible even when at home. This brings challenges for some, in particular children and young people with additional learning needs (ALN) who face:

- a lack of contact with their teachers and friends who are important attachment figures
- changes to routine
- anxiety about returning to school
- having to adapt to new rules.

This is not only true for learners, but also staff, who may be suffering poor well-being themselves as a result of having to work from home.

However, while a blended learning approach brings difficulties, there are also benefits. Some groups of learners will have benefitted greatly from a blended learning approach, such as those who fall into the category of ‘frequent school absences’ or those with
long-term sickness. With appropriate support and protocols in place, developing blended approaches for some learners with specific needs could be useful for the long-term. Support and resources for blended learning are available on Hwb[7].

[6] gov.wales/guidance-learning-schools-and-settings-coronavirus-html
[7] hwb.gov.wales/distance-learning

4.2 Purpose

This Framework aims to address the emotional and mental well-being needs of **all** children and young people, as well as school staff as part of the whole-school community. It also recognises that the school alone cannot meet all the needs of what is a complex population of young people, whose needs will vary as they progress through infancy to adolescence and early adulthood.

Supporting the well-being of children and young people is everybody's business and we all have a role to play in working with schools to ensure children and young people are able to fulfil their potential. It is not meant to be bureaucratic, building on existing activity and good practice wherever possible, with Estyn's *Healthy and happy* report[8] showing approximately half of Welsh schools are already engaging in whole-school approaches to some degree. For these schools the Framework will support the process of reviewing and improving work that has already occurred. For schools that have yet to embark on the journey, this Framework will support them in developing a culture that supports the well-being of children and young people.

The Framework also recognises that learner well-being is impacted by their surroundings and the adults they have contact with, in particular the teachers and other school staff, whose well-being needs require attention as much as their learners. It recognises that effective learning can only occur in an environment where all are engaged and when children are in an emotional state where they are receptive to learning.

This Framework provides direction and a template to develop and embed consistent policy and practice within schools and the wider community, underpinned by robust processes, procedures, administrative and governance arrangements to ensure continuity and equity for all. It is underpinned by:

- our commitment to children's rights, and specifically Articles 12 and 29 of the United Nations Convention on the Rights of the Child (UNCRC)[9]. Article 12 states that children have a right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account. Article 29 states that a child or young person's education should develop each child's personality and talents to the full. It should encourage children to respect their parents, and their own and other cultures. The Children's Commissioner has published a guide for schools *The Right Way: A Children's Rights Approach for Education in Wales*[10], which should inform schools' work when embedding a rights-based approach.
- *Education in Wales: Our national mission*[11] Enabling objective 3 ('Strong and inclusive schools committed to excellence, equity and well-being') recognises that all learners must be supported to be emotionally and physically ready to learn in safe and supportive environments. Every school will implement its new curriculum

[8] www.estyn.gov.wales/thematic-report/healthy-and-happy-school-impact-pupils-health-and-wellbeing
[9] www.unicef.org.uk/what-we-do/un-convention-child-rights/
[10] www.childcomwales.org.uk/resources/childrens-rights-approach/childrens-rights-approach-education-wales/
[11] gov.wales/our-national-mission-0

from 2022 for learners up to and including Year 7. Secondary schools will then roll out their curriculum on a year-on-year basis. Every school's curriculum will need to place health and well-being at its heart; together with changes in assessment, evaluation and accountability arrangements, it will drive future behaviour, and ensure mental health is given parity with physical health and emotional well-being and attainment.

It is further underpinned by the Welsh Government's commitments to children and young people's well-being, set out in a range of legislation and strategy. The key legislative and strategic drivers are outlined in Annex 2.

4.3 Key actions/requirements

- All partners/stakeholders involved in the delivery of this Framework should be open and responsive to each other and be clear on their roles and responsibilities in meeting the emotional and mental well-being needs of children and young people.
- Within the school, delivering the whole-school approach involves collaborative and sustainable effort involving all members of the school community; it is the responsibility of the governing body, senior management team, teaching and support staff. Schools, led by the governing body and headteacher, need to make a strong statement that well-being supports academic attainment and wider benefits to community and society, both in the here and now as well as in the future. This should be recognised in their school development plan. Developing children and young people who have an understanding of their own well-being is an important outcome in itself.
- Partners/stakeholders should involve and engage children and young people to understand this Framework. Children and young people should have a route to tell partners/stakeholders what they think about the arrangements being put in place and what is important to them within the Framework.
- While delivering this Framework is everybody's business, school governing bodies and headteachers, particularly in larger schools, should appoint a named person to lead implementation, act as coordinator and engage with other staff, learners, parents/carers and external agencies. This individual may already have experience of such work in relation to coordinating WNHSS activity, or leading pastoral care, for example.
- This Framework is not intended to be overly bureaucratic (effective implementation and delivery may bring benefits, for instance, in teachers feeling more supported in the classroom). Wherever possible, existing delivery mechanisms should be used for delivery of this Framework.
- In delivering children's and young people's universal and targeted interventions, or any interventions aimed at improving teacher knowledge and understanding of their own
  and children's well-being, the school's senior leadership team will ensure that only those interventions with a sound or innovative and developing evidence base are delivered. In this respect, the Welsh Government will develop a repository of resources and evidence-based interventions as well as staff continuous professional development resources for adoption by schools to complement this Framework.

- Schools (the whole academic and support staff, led by the senior leadership team) should implement and integrate this Framework with their curriculum, especially with learning in the Health and Well-being Area of Learning and Experience, to maximise the opportunities they both present and recognise the link between the two.
- Linked to the school improvement planning cycle, the school's senior leadership team will undertake a review of their emotional and mental well-being needs and implement a plan to address issues and build on areas of strength.
- The school's senior leadership team should engage partners and their learners to keep activity against this Framework under review and in line with the Children and Young People's National Participation Standards[12] and National Principles for Public Engagement in Wales[13].
- This Framework will be kept under review and evaluated to ensure it is fit for purpose. The first such review will occur during late 2022, taking account of the learning arising from having implemented the Framework for a full academic year (2021–22). More generally, the Welsh Government has commissioned Cardiff University to consider the short-, medium- and long-term evidence to help inform evaluation.

4.4 Context

This Framework is underpinned by a rights-based approach that aims to achieve a positive transformation of power by strengthening the capacity of duty bearers and empowering the rights holders. The UNCRC is a legally binding international agreement, embedded by the Welsh Government in legislation, setting out the civil, political, economic, social and cultural rights of every child, regardless of their race, religion or abilities. In particular:

- Article 6, which recognises that all children and young people have the right to survive and the right to develop
- Article 12, which states that children have a right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account
- Article 24, which says that healthcare for children and young people should be as good as possible, but also goes further than this by saying children and young people have the right to be both physically and mentally fulfilled
- Article 29, which says that a child or young person's education should help their mind, body and talents be the best they can. It should also build their respect for other people and the world around them. In particular, they should learn to respect their rights and the rights of others.

The World Health Organisation defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It further defines mental health as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work

[12] gov.wales/children-and-young-peoples-national-participation-standards
[13] www.participationcymru.org.uk/principles

productively and fruitfully, and is able to make a contribution to her or his community'[14]. Mental well-being includes our emotional, psychological and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others and make choices. In relation to schools the World Health Organisation defines a health-promoting school as one that constantly strengthens its capacity as a healthy setting for living, learning and working[15].

Approximately 1 in 10 children between the ages of 5 and 16 have a mental health problem and many more have behavioural issues. Approximately 50 per cent of people with enduring mental health problems will have symptoms by the time they are 14, and many at a much younger age[16]. However, this belies the scale of poor mental well-being among children and young people and most of the emotional issues young people and school staff will encounter are not clinical in nature and do not require specialist interventions. Rather, it is about supporting the young person, building their resilience and fostering a sense that there is someone they can trust.

Developing these trusting relationships is central to the whole-school approach. Developing positive relationships between a teacher and learner is a fundamental aspect of quality learning and teaching. The effects of teacher–learner relationships have been researched extensively, and point to how positive relationships can have good social and academic outcomes. Being taught by highly trained, highly motivated, trauma-informed teachers who are aware of the impact they have on the young person's overall development, inside and outside the classroom, is central to promoting emotional and mental well-being.

The whole-school approach recognises the complexity of managing school emotional well-being, e.g. teaching young people to:

- understand their own emotions and how they can adapt and cope with the challenges they will face
- manage low-level short-term challenges such as exam stress
- manage some extremely challenging and complex situations such as parental ill health, substance misuse, caring responsibilities, life events and unexpected events.

It is important that schools can provide a place where adults, children and young people work together to overcome challenges. Children and young people will experience many different relationships throughout their formative years, whether they be short-lived friendships, ones that have been built on trust over a number of years, or ones that will continue to grow throughout their adult lives. School life can and should be challenging and for a child or young person having at least one strong relationship, someone they trust, someone who is more experienced and who they feel has their interests at heart is paramount to not just their academic achievement, but also their social development.

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[14] www.who.int/features/factfiles/mental_health/en/
[15] www.who.int/health-topics/health-promoting-schools#tab=tab_1
[16] gov.wales/together-mental-health-our-mental-health-strategy

The whole-school approach seeks to support good emotional and mental well-being by strengthening the relationship(s) between:

- teacher and learner
- teaching staff
- the school senior leadership team and wider school staff
- the school and parents and carers
- the school and other professionals working with the school
- the school and the wider community that surrounds the school.

With the school as the hub and centre of community life there is much strong work upon which to build the whole-school approach – no teacher enters the profession because they do not care about children and young people. This approach builds resilience[17] among young people; it focuses on prevention and early intervention when required. When more targeted approaches are needed to tackle existing or developing poor emotional and mental well-being, then services work together in a timely fashion to provide appropriate interventions.

The whole-school approach is about:

- embedding good well-being through teaching as well as all the other aspects of school life
- an ethos that values inclusion, where everybody works together, contributing their individual skills and resources to the collective good
- creating a supporting environment where young people are encouraged to fulfil their personal and academic potential, where they thrive, learn and emotionally develop, supported by teachers who operate in a culture that also values teachers' own well-being
- incorporating and building on existing good practice in the field such as the WNHSS[18]
- incorporating the work of others such as Child and Adolescent Mental Health Services (CAMHS), which has traditionally offered assessment, treatment and interventions, and which should now be viewing the child and their needs more holistically.

Considerable work has also taken place in recent years in relation to the impact of adverse childhood experiences (ACEs), which has been built on in education by the ACE Support Hub[19], which has equipped teachers and other school staff with the tools to identify and address the impact of ACEs. In particular, Public Health Wales explores the impact of adults on children and young people in the 2018 report on ACEs[20]. The report highlights that 'having at least one trusted, stable and supportive

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[17] www.wales.nhs.uk/sitesplus/documents/888/ACE%20%26%20Resilience%20Report%20%28Eng_final2%29.pdf

[18] www.publichealthnetwork.cymru/en/social-determinants/education/welsh-network-of-healthy-school-schemes-wnhss/

[19] www.aceawarewales.com/about

[20] www.wales.nhs.uk/sitesplus/documents/888/ACE%20&%20Resilience%20Report%20(Eng_final2).pdf

relationship with an adult is emerging as one of the most important aspects of childhood resilience'. This is reinforced through ACE Support Hub training in education settings, which forms a foundation upon which to build whole-school approaches.

Well-being is also about recognising neurodiversity, a fairly new term that recognises the fact that our brains (neuro-) naturally vary from person to person (are diverse). It moves away from medical words such as 'disorder', 'disability' and 'difficulty'. Instead of just looking at what someone struggles with, it encourages us to think about them as a whole. What are they good at? What do they need support with? Neurodiversity means talking people and pathways, not labels and silos and considers the person in the context of their lives, past and present.

4.5 Importance of good emotional and mental health and emotional well-being

Numerous studies show that education and mental well-being are closely linked and promoting the health and well-being of learners within schools can positively impact learner cooperation, commitment, learning and engagement[21]. This means having a school culture, ethos and environment that nurtures learners' health and well-being can improve learners' educational outcomes. Equally, the relationship between physical and mental health cannot be understated – physical health problems significantly increase the risk of poor mental well-being, and vice versa[22].

Good emotional and mental well-being allows children and young people to develop the resilience to cope better with the challenges they face, and grow into well-rounded, healthy adults. Things that can help keep children and young people of all ages mentally and emotionally well and resilient include:

- being listened to, feeling valued, respected and known as individuals
- being in good physical health, eating a balanced diet and getting regular exercise
- having time and the freedom to play, indoors and outdoors
- being part of a family that gets along well most of the time
- going to a school that looks after the well-being of all its learners
- taking part in local activities for young people.

Other factors are also important, including:

- feeling loved, trusted, understood, valued and safe
- being motivated and interested in life and having opportunities to enjoy themselves
- being hopeful and optimistic

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21 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

22 www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-mental-physical-health

- being able to learn and having opportunities to succeed
- accepting who they are and recognising what they are good at
- having a sense of belonging in their family, school and community
- feeling they have some control over their own life
- having the strength to cope when something is wrong or challenging (resilience) and the ability to solve problems.

There are certain risk factors that make some children and young people more likely to experience problems than other children. These factors do not occur in isolation and an individual may experience several at any given time; they carry varying degrees of risk, can be short- or long-term, and some are more common than others. They include (the following is not an exhaustive list):

- having a long-term physical illness or disability
- having a parent/carer who has had mental health problems, problems with alcohol, substance misuse or is/has been within the criminal justice system. In addition to affecting the young person's own well-being, this could also lead to stigma and discrimination
- experiencing the death of someone close to them
- having parents/carers who are in conflict
- having been bullied
- having been physically or sexually abused
- living in poverty
- being homeless
- experiencing domestic violence and neglect
- experiencing discrimination, perhaps because of their race, sexuality, gender or religion
- having an additional learning need
- acting as a carer for a relative, taking on adult responsibilities
- having long-standing educational difficulties as a result of being in care or on the edge of care
- being subject to many changes, trauma or ACEs
- experiencing loneliness and isolation
- experience of care.

The Welsh Government publishes information annually on the number of children and young people presenting to independent counselling services[23]. On average, the service sees around 11,500 children and young people each year and figures have not fluctuated significantly in several years. The top presenting issues have consistently related to family, anxiety, stress and anger, reflecting a trend in well-being among these young people. Many of these issues are not clinical in nature and did not require clinical interventions, with very few of the young people requiring any onward referral to more specialist services. Children and young people face many of the challenges adults face on a day-to-day basis. However, unlike adults who often have the experience and resilience to overcome their challenges, children and young people often lack the experience, maturity and ability to place their challenges in

[23] statswales.gov.wales/Catalogue/Education-and-Skills/Schools-and-Teachers/Counselling-for-Children-and-Young-People

context. They are also unable to directly control certain aspects of their lives or to cope well when things go wrong. Minor issues can seem like potentially life-changing events for young people. Therefore, having a trusted adult who they can talk to and who could provide an appropriate empathetic response and place their problems into context will be enough in many cases.

4.6 Review and implementation

The Welsh Government is considering how best to measure the short-, medium- and long-term progress in this field and has started by commissioning Cardiff University to undertake an evaluability assessment. This will:

- develop an evidence-based theory of change that articulates how inputs will result in the intended impacts of the whole-school approach
- ensure key stakeholders (including children and young people) contribute to the evaluability assessment
- determine the extent to which the implementation and impact of the whole-school approach can be effectively evaluated
- identify the research and data-gathering activities required for effective evaluation.

This is a long-term piece of work that will consider the full breadth of whole-school-related policy.

We will also consider separate arrangements to measure the specific appropriateness and impact of the implementation and application of this Framework and supporting activity. This will ensure schools and their partners are adhering to the Framework, that it is being consistently implemented across Wales, and that it is fit for purpose. To ensure this we will work with partners to specifically review implementation of the Framework during autumn/winter 2022; this will ensure we are able to consider activity that spans one full academic year (2021–22).

5. Introduction and application

5.1 Overarching principles

- All children in Wales have rights under the UNCRC to be safe, to be treated with equality and non-discrimination, to be supported to develop their physical and mental health, to express their thoughts and feelings, to be involved in decisions made about them, to receive extra support if they are disabled, and to receive an education that enables them to fulfil their potential.
- A whole-school approach should be viewed as central to the success of learning about health and well-being and the four purposes of the new curriculum.
- The responsibility for all school staff to take a whole-school approach to the promotion of good mental health and emotional well-being is universal and integral to a successful school environment. However, each school is different and will face different challenges, so there is no one-size-fits-all approach. The school's senior leadership team will use this Framework to help assess where they need to do more and adopt practice that meets their specific needs.
- A whole-school approach to emotional and mental well-being is achievable through effective leadership, positive culture and co-productive implementation in partnership with all school stakeholders, ranging from governors and heads to learners, from teaching and support staff to auxiliary staff such as cleaners, caretakers and canteen staff.
- A whole-school approach that puts the child at the centre of decisions made about them needs partnership and involvement with families, the community, other statutory bodies and the third sector. Activity within the school is part of a wider whole-system approach to emotional and mental well-being. School staff can therefore be expected to do only what is within their competence and resource.
- A whole-school approach promotes equity for all, reducing variation and using evidence-based practices consistently and transparently, in terms of both use of data for planning and any interventions.

5.2 Values

The whole-school approach is based on the core values of belonging, efficacy and having your voice heard. These dictate the school ethos and the behaviours expected of the whole school population, applying equally to all, not just the learner. Considering the well-being of the school in the context of the core values will help the senior leadership team determine if they are on the right path and meeting their well-being goals. The questions/statements under each heading (belonging, efficacy, voice) are not to be answered solely by the individual concerned, but in partnership with others. For instance, a school senior leadership team may feel that they 'make space for conversations, giving and receiving constructive feedback, acting on the views of others to help us be at our best more of the time', but the experience of teachers, staff and learners in the school may be different. It should form the basis for an honest and open discussion and evaluation. It should not be seen by schools as a 'tick box exercise'; rather it should help schools to consider health and well-being in their own local context, thinking about both the positives and the areas for improvement, and considering how best to develop and express them through policy and practice.

	Belonging	Efficacy	Voice
School senior leadership team	How does your school contribute to a sense of belonging?	Do I role model the behaviour I want to see at all levels of the school and build relationships based on respect, trust and fairness?	Do I make space for conversations, giving and receiving constructive feedback, acting on the views of others to help us be at our best more of the time?
All staff	Am I aware of the well-being needs of my learners and colleagues?	Do I understand my own well-being needs and the impact my well-being has on those around me?	Do I have the time to listen to the young people in my care and advocate for them when needed?
Learners	Do I feel safe, valued, treated with respect, connected and supported while at school?	Do I have self-esteem, aspirations, self-confidence and empathy? Am I able to form and maintain trusting relationships with peers? Do I know there are adults I can trust and talk to when I need to?	Do I feel supported to speak my mind safe in the knowledge that my views are given due consideration?
Parents/ carers/ family	What contribution can I make to both my child and my child's peers' well-being, both in and outside school?	Am I able to positively influence my child in a healthy and success-promoting manner and maintain beneficial ties to the school to support and promote wider community benefits?	Do I feel confident and able to raise and discuss issues and know how to navigate a system that works with me to find appropriate support when needed?

5.3 Local and regional support

The whole school population needs to be supported in developing their whole-school approach; additionally, as our national mission states, local authorities and regional consortia have an important role to play in co-constructing policies, coordinating services, mapping provision and delivering professional development opportunities with other key stakeholders.

Specifically, local authorities can support implementation of the whole-school and system approach by:

- providing guidance on promoting an emotional and mental well-being-friendly environment, including advice on early intervention and prevention and good practice models
- mapping services and provision that support mental health and emotional well-being within a local authority footprint
- providing, in collaboration, clarity on relationships and protocols with other agencies, particularly health, social care and the police, and acting as a source of support for schools with concerns and issues over implementation
- ensuring in reference to key partner agencies that resources, financial and otherwise, are strategically managed to maximise their impact on learners' mental health and emotional well-being needs
- supporting the school's senior leadership team to evaluate their learning environments and practice in the context of mental health and emotional well-being as well as to fully include learners in this process
- working with other key agencies to monitor local practice and provision, including the evaluation quantitative and qualitative information relating to emotional health and well-being
- representing schools' interests at a local level through relevant strategic boards such as public services boards (PSBs) or RPBs to ensure that all key stakeholders and partner agencies are aware of and work together to address issues and provide a whole-system approach
- supporting the commissioning of statutory and third sector providers of emotional well-being support and advice to work with schools (individually and on a cluster basis), ensuring robust evidence-based interventions are available to support implementation of a school's curriculum; and support learner and staff well-being
- facilitating access to the broad range of expertise within the local authority and its partners, including services like educational psychologists, youth workers, school-based counsellors, Healthy Schools practitioners, advisory teachers, safeguarding teams, behaviour support services and social workers
- developing and commissioning a range of support at different levels, such as preventative, universal or targeted services for all young people
- interpreting data to inform practice such as the School Health Research Network (SHRN)[24] data and vulnerability tools
- identifying those learners in need of targeted intervention, including through successful approaches like the *Youth engagement and progression framework*, ensuring the interventions are those most appropriate to the learner
- supporting school leaders by promoting collaboration between schools, with schools benefiting from a system of sharing practices, experiences and resources
- supporting the whole school community (and not just learners)
- demonstrating good practice themselves, leading by example by establishing a statement of well-being and reflecting and assessing their own workplace well-being needs.

Specifically, regional consortia can be commissioned by local authorities to support implementation of the whole-school and system approach by:

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[24] The School Health Research Network: www.shrn.org.uk/

- supporting school and education setting-based staff's professional development in relation to health and well-being and supporting curriculum development
- supporting consistent professional learning and continuous improvement opportunities not only for teachers, but all layers of school and education setting staff, minimising duplication of effort and achieving economies of scale
- supporting governing bodies to understand their role and responsibilities in relation to learners' health and well-being
- providing expertise for schools on mental health and well-being, including sharing best practice and coordination of training
- providing necessary challenge and support in meeting schools' mental health and well-being goals.

5.4 Application in EOTAS and PRUs

EOTAS is education provision other than at school funded and organised or delivered by local authorities. EOTAS is designed to meet the specific needs of pupils who, for whatever reason, cannot attend a mainstream or special school. Local authorities have a duty to ensure EOTAS learners have a suitable education or, where a learner attends a PRU, receives a balanced and broadly based curriculum.

There are diverse reasons why learners do not attend a mainstream school and are in receipt of EOTAS. These include having an illness (physical and mental), refusing to attend school (school phobic), having challenging behaviour associated with social, emotional and behavioural difficulties (SEBD), and being or at risk of being excluded from school. For some children in EOTAS, the structure of the mainstream school does not enable them to receive their education in a way best suited to their individual needs.

EOTAS learners are some of our most vulnerable children and young people. A significant number have special educational needs and can come from challenging backgrounds. As a result of the difficulties they have experienced attending mainstream education, EOTAS learners have often missed extended periods of education and have gaps in their learning, can have low self-esteem and lack confidence, and many have low aspirations for their future. However, we know from evidence that EOTAS provision has a positive impact on the well-being of learners. Research published by Welsh Government in 2013[25], found that learners felt EOTAS had a positive effect on their self-esteem, as well as on their relationships with their school, teachers and families.

Local authorities should have regard to this Framework when organising or delivering EOTAS provision.

[25] https://dera.ioe.ac.uk/18415/1/130624-evaluation-education-provision-children-young-people-educated-outside-school-setting-en.pdf

5.5 Application in relation to elective home education

The UNCRC guarantees every child the right to grow up healthy, happy and safe. The well-being and safety of all children and young people should be of the utmost importance to all involved wherever they are educated and with support provided to parents and carers who have prime responsibility for this. All agencies and staff working with families and young people should have regard to this Framework and should offer advice and signpost them to age-appropriate education resources that encourage resilience and well-being, and can reduce the risk of harm. This includes ensuring families and children and young people access to support services such as local authority independent counselling support.

5.6 Application in early years settings

Local authorities have a duty to provide at least 10 hours of early education provision – Foundation Phase Nursery (FPN) – from the term after a child's third birthday. Provision can be delivered in maintained nurseries, normally attached to schools, stand-alone maintained nursery schools or in independent or third sector childcare settings (non-maintained settings) funded to deliver the Foundation Phase curriculum.

We know the early years are crucial to the development of every child. Ensuring their emotional well-being is fostered as early as possible will ensure our children and young people are more resilient in the future; the Foundation Phase curriculum has been developed with a specific focus on effectively supporting a child's well-being to enhance and unlock learning. Not all our learners are in schools; some of our youngest receive their early education in non-maintained childcare settings and it is essential that all children, whether they access education provision or not, feel safe, happy and supported. All practitioners working with parents/carers and young children, whether in the maintained or non-maintained sector, should be empowered to offer advice and relevant support as well as encouraged and supported to apply this Framework.

5.7 Meeting the needs of Welsh language and others for whom English is not their first language

Cymraeg 2050: A million Welsh speakers (2017)[26] is the Welsh Ministers' strategy for the promotion and facilitation of the use of the Welsh language. Receiving services through the medium of Welsh is a matter of need for many Welsh speakers and it is important that this need is met as a natural part of education and providing care and support.

Some people with emotional and mental well-being issues are particularly vulnerable because their care can suffer if they are not treated in their own language. It is important to remove from the user the responsibility to ask for services through the medium of Welsh, and ensure instead that the service offers them. This principle is

[26] gov.wales/cymraeg-2050-welsh-language-strategy

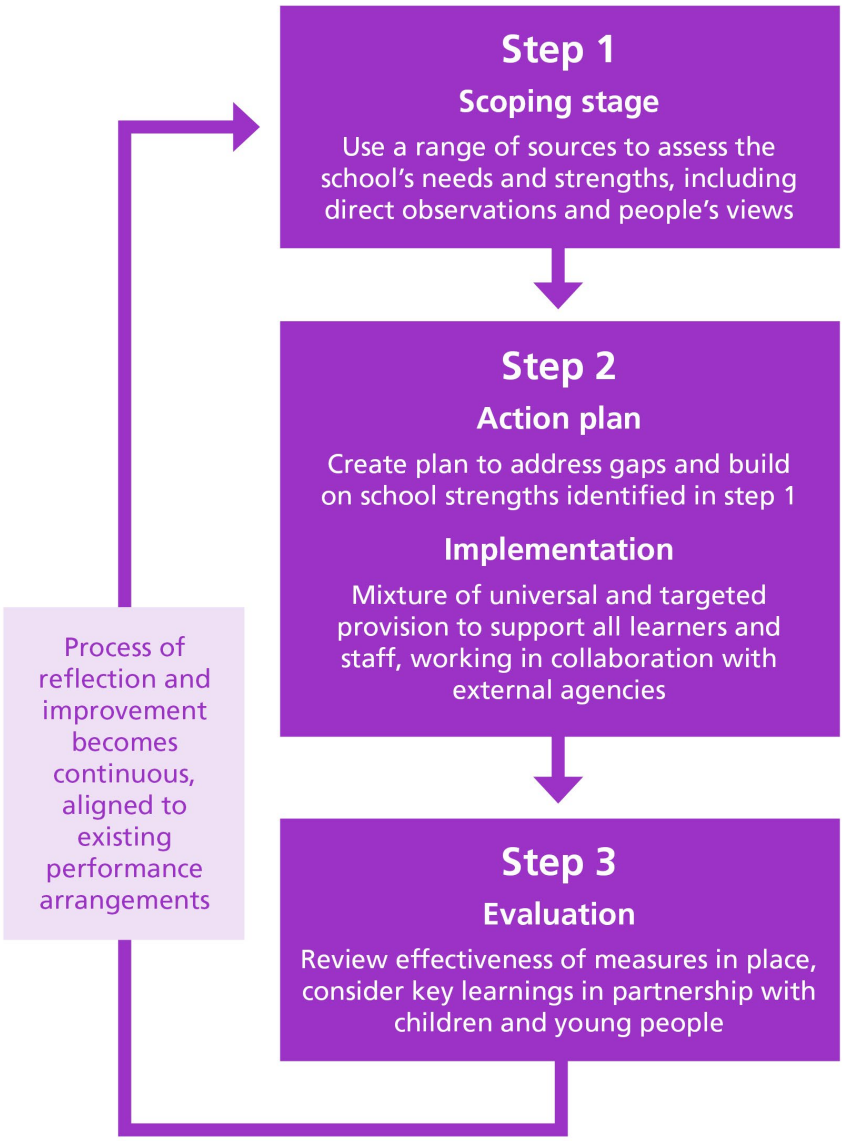
known as the ‘active offer’. Moving towards a more proactive approach to language need and choice may take time and will be dependent upon the availability of Welsh-speaking staff, but mental health services is one priority area where this should happen.

It is vital that there is parity of provision in both languages in line with the requirements of the Welsh Language Standards[27] and that provision should reflect the linguistic nature of the school and its catchment area. For many, Welsh is their everyday working language. Schools should ensure that interventions are available in Welsh and should consider the language preference of their learners when developing interventions and support. It would also be beneficial for Welsh-medium training opportunities and support in the workplace to be readily available.

In line with the requirements of the Equality Act 2010, refugees, asylum seekers and other minority groups, such as immigrant and traveller communities, should also not be discriminated against due to a lack of knowledge of English. It is important to ensure that resources are accessible to people for whom neither English nor Welsh is their first language. This is particularly true considering minority groups tend to be more adversely impacted by mental health. Access to language support, both orally and in writing, is essential to ensure that learners and their parents/carers understand the advice and support available. Schools will have clear protocols and policies in place to ensure the needs of learners for whom English is not their first language are met.

[27] gov.wales/welsh-language-standards-regulations

Flow diagram illustrating process for embedding a whole-school approach to mental health and emotional well-being



The flow diagram outlines the process a school's senior leadership team will follow in implementing their whole-school approaches, having regard to the overarching principles and values. The process will not be completed overnight and will require space and time. Changing things can feel risky for managers, staff and learners, but small changes create confidence to embark further on the journey towards a whole-school approach in which every action considers the well-being of all.

It is not meant to be over-burdensome but is intended to provide some consistency and equity of provision across Wales, building on the requirements of the new curriculum. A number of vehicles already exist that support activity and can be used to take forward the requirements of this Framework, such as the WNHSS and the work of the ACE Support Hub.

Step 1

6. Scoping stage

The planning process needs to start with a school's senior leadership team (engaging with the wider school community and external partners) assessment of the school's emotional and mental health needs – the local 'landscape'. It should highlight the school's gaps in provision as well as their strengths (which can be built upon further).

Measuring and assessing well-being is complex, with the mental health and emotional well-being of children and young people frequently changing throughout the course of their lives. In particular, during secondary school there are some dramatic changes in children's well-being, self-reported health and lifestyles. This illustrates the importance of assessing emotional and mental well-being using a range of sources to gain a robust evaluation that reflects all the needs of the school community.

This stage should also include consideration of staff well-being; the school's senior leadership team should utilise a range of data sources to assess their own needs and strengths, triangulating these to ensure findings are robust.

6.1 Evaluation

Effective self-evaluation is at the centre of creating a school as a learning organisation and supporting improvement. In Wales, we are placing robust self-evaluation at the heart of our new evaluation and improvement arrangements. School leaders, teachers, local authorities and regional consortia should use self-evaluation to drive improvements that help to achieve the four purposes for children and young people, with learning and well-being at the heart of the school's curriculum.

6.1.1. Self-evaluation

Given the importance of self-evaluation, the Welsh Government is developing a national evaluation and improvement resource to support schools in undertaking robust, enquiry-based self-evaluation. The national evaluation and improvement resource will provide schools with a range of principles and approaches, as well as practical case studies and resources, to support effective self-evaluation. It does not prescribe a particular approach, and schools are encouraged to make use of the resource to develop their approaches to self-evaluation, selecting the most suitable tools or approaches in the resource to adapt and use in their own context.

The national resource has not been developed as a stand-alone resource. There are significant links across self-evaluation relating to curriculum development, pedagogy, professional learning, the well-being of learners and staff, and the schools as learning organisations model. All schools will also be entitled to professional learning from regional consortia that builds their capacity to improve. This is likely to include

their self-evaluation arrangements and their use of enquiry-based approaches for monitoring and evaluation.

The resource will support schools to engage in evidence-based self-evaluation of what is working well and what they need to improve in order to have a greater positive impact on the well-being of learners.

Through self-evaluation, schools will identify their improvement priorities, including well-being. Once identified, school improvement priorities will be drawn together in a single, strategic school development plan, helping to reduce workload, streamline schools' strategic planning processes and avoid unnecessary duplication and bureaucracy. Schools should publish a summary of their development plan. As the accountable bodies for their schools, governing bodies will monitor the delivery of the development plan, taking action where progress against improvement priorities is unsatisfactory.

Some schools will also identify well-being as a particular strength as part of their self-evaluation processes. In these cases regional consortia will assess whether these schools have capacity to support other schools, and may facilitate school-to-school working and collaboration, as part of a self-improving system.

6.2 Direct observations and people's views

Schools' senior leadership teams are able to access data and intelligence on well-being needs through direct observation and through gathering people's views. Direct observations can take place across various leaning contexts, both inside and outside of the classroom. Key stakeholders including staff, parents/carers, learners and governing bodies should all receive regular opportunities to share their views. Examples of how views can be gathered include discussions with parents/carers on their child's progress, specific focus groups with parents/carers or learners, staff feedback, or as part of lessons working with learners to develop questionnaires and surveys to capture their views. Another important source of observation is provided by Estyn evaluations.

6.2.1 Estyn evaluations

Estyn will continue to undertake school inspections and thematic reviews of activity, such as the *Healthy and happy* report[28] which, among other things, evaluates how well primary and secondary schools in Wales support the health and well-being of learners. School inspections will continue to assess the contribution of each school to the well-being of its learners - the extent to which learners feel safe and secure and how well they are becoming healthy, confident individuals who understand how to make healthy choices in a range of areas. Inspectors will continue to assess how schools track and monitor learners' well-being, and determine how successful a school's provision is in helping learners to understand the impact of lifestyle choices

[28] www.estyn.gov.wales/thematic-report/healthy-and-happy-school-impact-pupils-health-and-wellbeing

and behaviours on their present and future mental and physical health and well-being.

6.3 Quantitative data

There is a range of quantitative data sources, both internal and external, that a school's senior leadership team may wish to use during the scoping stage. These include the following.

6.3.1 School Health Research Network (SHRN) data

Learners in maintained secondary schools in Wales currently complete the bilingual, electronic Student Health and Well-being (SHW) Survey every two years. This survey forms a key part of the work of the SHRN, of which all secondary schools in Wales now participate. The student level is complemented by a School Environment Questionnaire, which the senior leadership team in all schools complete on health-related policies and practices.

Schools that join the SHRN and collect data receive an individualised SHW report, based on learner responses to the SHW Survey. These reports provide member schools with data on key mental and emotional, and physical health topics, with national data for comparison.

Case study: Bassaleg School[29] – using data provided by the SHRN to support a whole-school approach to health and well-being

In response to the new curriculum, Bassaleg School have used a whole-school, evidence-based and learner-voice led approach to develop new teaching practices that prioritise mental health and well-being. This involved a distributed leadership approach that included staff and pupils using their 2017 SHW report to audit their curriculum and revise teaching practices.

Their revised tutor programme was described by Estyn as 'outstanding', 'transformational' and 'well-being-driven'. The director of standards for health and well-being and assistant headteacher asked all form supervisors to develop a bespoke tutor programme provision plan based on the needs identified in their SHW report. For example, they identified as an area of concern the proportion of students in Year 10 that engaged in sexting; thus, as a preventative measure, this topic is now considered with Year 9 learners. The present tutor programme that takes place every morning for 25 minutes now functions as an extension of the personal and social education (PSE) programme by covering topics such as mental health, resilience and LGBT+ diversity.

Bassaleg also established a Health and Well-being Area of Learning and Experience programme for Year 7 learners, again planned as a result of the data in their SHW report. Lessons cover three main topic areas, including nutrition, fitness and well-

[29] www.estyn.gov.wales/effective-practice/using-school-programmes-support-equality-and-diversity

being, which are delivered at least once every fortnight and include an assessment at the end of each term. Assessments are based on the Literacy and Numeracy Framework. The numeracy assessment of these projects includes the use of Bassaleg's SHW data, e.g. the graph depicting the proportion of students who usually eat breakfast every weekday is used to encourage learners to discuss the importance of breakfast. These tasks not only raise learners' awareness of different health and well-being topics, but also help develop their data analysis and interpretation skills.

As a self-evaluation tool to measure whether the changes they have implemented throughout the school have had a positive effect, Bassaleg are now comparing their 2017 and 2019 SHW Survey results to measure the impact the different interventions have had.

This information will be used to update and tailor the existing form tutor programme as well as to shape the new Year 8 Health and Well-being curriculum.

6.3.2 School-based management and regional data

Schools collect a range of data and intelligence, which can be used to inform and understand the well-being both of the learners and the school staff. This includes information on absence rates and on exclusions, as well as intelligence obtained through discussion with other professionals such as educational psychologists. However, caution needs to be exercised, as although data could be appropriately used to identify learners requiring extra help, it should not be used to attempt to 'diagnose' an individual's specific needs. Where specific concerns do exist, these should be discussed with the relevant specialists and referrals made as appropriate.

6.3.3 Welsh Network of Health School Schemes (WNHSS)

The majority of schools are already actively involved with the WNHSS, which supports schools to work towards the Welsh Government's National Quality Award using a whole-school approach to health and well-being. Healthy Schools practitioners support schools in action-planning to address health and well-being needs and are currently focusing on supporting mental well-being and physical activity, as well as infection prevention and control in response to the pandemic.

In addition, the Welsh Government has agreed to support implementation of this Framework by funding dedicated implementation leads in each regional area/local health board area.

The implementation leads will:

- provide capacity to support their multi-agency local partnership through directors of public health to help implement the whole-school approach in their areas
- provide additional capacity to the workforce for a whole-school approach to mental health
- mobilise the wider whole-school approach workforce in each area to support schools to undertake an assessment and support them to develop implementation plans for their WSAMH.

The implementation leads will work with existing key stakeholders to support schools in undertaking a baseline assessment and in developing an initial improvement plan/set of actions in relation to WSAMH.

6.3.4 Local authority activity

Local authorities can also provide benchmarking data, which compares information on a range of like schools or a cluster of closely geographically located schools. They can also provide wider information that should inform planning such as local area needs assessments. Local authorities, regional consortia and other partners (such as the WNHSS) should work with a school's senior leadership team and their partners to ensure that they are aware of the range of data sources available to them. They should also work with the school's senior leadership team to develop more robust data sets that profile community-based needs and inform the interventions and strategies employed by schools. Other sources of well-being information could also come from agencies such as the Youth Service, police and youth justice teams.

Case study: Y Pant Comprehensive School [30]
Y Pant Comprehensive School carries out a well-being audit regularly, which the school created themselves using free software. This audit gives every learner a valuable opportunity to share how they feel about themselves, their relationships and their progress in school. This is used by staff alongside other information about learners, such as their attendance and behaviour, to identify those who may benefit from additional support.

[30] www.estyn.gov.wales/thematic-report/healthy-and-happy-school-impact-pupils-health-and-wellbeing

Step 2

7. Action plan and implementation

Schools already produce development plans[31] that provide a strategic blueprint for improvement. The development plan sets out the actions a school will take to improve learner outcomes. It is informed by continuous self-evaluation and contextualised information and evidence (e.g. from SHRN), and contains the school's improvement priorities together with short-term and longer-term targets. It sets out how the school will achieve its targets in relation to its priorities and how it will use the resources it has available, including funding. It must also set out how the school intends to develop its staff. It is a live document that should be continuously refreshed to reflect the school's progress in meeting its priorities, taking account of the range of qualitative and quantitative data.

Schools that identify emotional and mental well-being as improvement priorities should include these in their development plan with appropriate actions and milestones. The actions and milestones should be informed by the requirements of this Framework to ensure consistency of provision. The plan should be informed by the findings of the school needs assessment, which is a process to help focus ideas and to decide what steps need to be taken to achieve the whole-school approach.

Where schools identify strengths in relation to well-being they should also consider how these can be built upon to further embed a whole-school approach, as well as where they may be able to support other schools.

School senior leaders should undertake a holistic approach to ensuring the well-being requirements of all learners and staff are met, and should consider this as part of their planning process.

7.1 School ethos

The Organisation for Economic Co-operation and Development (OECD)[32] identifies the following four key broad areas that influence learner well-being:

- psychological – learners' life satisfaction, sense of purpose, self-awareness and absence of emotional problems
- physical – learners adopting a healthy lifestyle, and learners' overall health
- social – learners' relationships with family, peers and teachers, and learners' feelings about their social life
- cognitive – learners' proficiency in applying what they know to solve problems.

An emotionally and mentally healthy school is one that adopts a whole-school approach to well-being; this helps children flourish, learn and succeed by providing

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[31] gov.wales/sites/default/files/publications/2018-03/school-development-plans.pdf
[32] www.oecd-ilibrary.org/docserver/9789264273856-6-en.pdf?expires=1578990731&id=id&accname=guest&checksum=7F4AA3FA436BE68A54F1761164F43F3C

opportunities for both them and the adults around them to develop the strengths and coping skills that underpin resilience. A mentally healthy school sees positive mental health and emotional well-being as fundamental to its values, mission and culture[33].

A whole-school approach involves all parts of the school working together and being committed. It needs partnership working between governors, senior leaders, teachers and all school staff, as well as parents/carers and the wider community. The whole-school approach needs to be embedded in a school's culture and ethos and has a significant impact on learners' health and well-being as it influences their sense of belonging and value. Learners expect school to be a safe and secure place, where they are valued equally and respected, and where their rights are promoted and upheld[34].

The key points can be summarised as follows – the school's senior leadership team should ensure:

- the school takes a holistic approach to supporting good mental health, which is seen as everybody's business
- the school supports every member of staff, including non-teaching staff, to work with learners in a nurturing way, treating learners with respect
- the school has in place appropriate policies or practices that actively promote and enhance well-being, such as ensuring appropriate levels of homework
- the school's behavioural and other policies should contain positive messages about the importance of learner well-being
- all aspects of the school day contribute to the sense of good well-being from arrival, through lessons and play/break times, to departure. The Estyn *Healthy and happy* report highlighted that the best schools are proactively positive with learners, greeting learners by name, smiling, providing a reassuring presence and quickly identifying anyone who may benefit from additional support
- learner feedback is actively encouraged and given due consideration
- learners are encouraged to work in partnership, moving from being competitive to collaborative
- parents/carers are seen as equal partners and are encouraged to engage in the school community. If parents/carers understand what is being taught in the classroom there is potential for them to transfer this to the home environment, reinforcing and building on the school's good work. In this respect, activity is already underway with the ACE Support Hub looking to extend activity to early years, pre-school, the foundation phase, parents/carers and the wider communities around schools.

[33] www.mentallyhealthyschools.org.uk/whole-school-approach/
[34] www.estyn.gov.wales/thematic-report/healthy-and-happy-school-impact-pupils-health-and-wellbeing

Case study: Ysgol Gynradd Pencarnisiog [35]
At Ysgol Gynradd Pencarnisiog the headteacher has successfully improved the culture of the school over the last two and a half years. The school historically had a culture that implied that small, rural schools do not have issues with learners' well-being, and being a learner in need of support or intervention carried a stigma. As a result, learners were not always supported well enough. The headteacher has worked with staff and parents/carers to promote health and well-being, putting it at the heart of her vision for the school. Learners in the school now speak freely about well-being and the importance of sharing worries and fears. Learners understand the value and impact of the intervention service in the school for learners who are struggling, even if they have not received support themselves. Staff in the school have a better understanding of the needs and feelings of learners and are improving learning experiences and support services in response.

7.2 Curriculum

The Curriculum for Wales Framework gives every school in Wales the opportunity to design their own curriculum. It encourages schools to build their own vision for their learners within the context of the four purposes and the learning defined at a national level. It provides the space for practitioners to be creative and to develop meaningful learning through a range of experiences and contexts that meet the needs of their learners.

Becoming 'healthy confident individuals' is one of the four purposes of the new curriculum and enabling leaders to develop healthy relationships will be a key part of this. In the new curriculum the Health and Well-being Area of Learning and Experience is about developing the capacity of learners to navigate life's opportunities and challenges.

The Health and Well-being Area of Learning and Experience highlights the importance of mental health and emotional well-being and its links with physical well-being and resilience. Learning about mental health and emotional well-being forms one of the statements of what matters in the Curriculum for Wales Framework. These statements will be mandatory elements of every school's curriculum. However, the new Framework allows professionals the flexibility to choose specific content that meets the needs of learners in their specific context. This includes:

- **outdoor learning** – the Welsh Government recognises the unique value of outdoor learning and the many benefits it brings for learners, including supporting the development of healthy and active lifestyles, developing problem-solving skills, and developing understanding and respect for nature and the environment in which they live. Outdoor learning will be considered across all areas of learning and experience; for example, the Health and Well-being Area will highlight the importance of regular experiences outdoors to support young people's physical and mental health

[35] www.estyn.gov.wales/thematic-report/healthy-and-happy-school-impact-pupils-health-and-wellbeing

- **relationships and sexuality education (RSE)** – RSE will be a mandatory element of the new curriculum for learners aged 3–16, and statutory guidance will be published as to what should be included. RSE will play an important role for the safeguarding and protection of all learners in Wales. Schools will have the potential to create safe and empowering environments that build upon learners' own formal and informal learning and experiences, offline and online. The aim is to **gradually** empower learners (at developmentally appropriate stages) to build the knowledge, skills and ethical values to equip them with the tools to be able to understand how relationships, sex, gender and sexuality shape their own and other people's lives. It seeks to support learners' rights to enjoy equitable, safe, healthy and fulfilling relationships throughout their lives
- the ability for learners to recognise, understand and speak out about discrimination and violence and know how and where to seek support and advice on a range of issues. We are clear that RSE should not be delivered in isolation. It should be considered as part of whole-school approach ensuring it is effectively integrated and coordinated as part of the whole curriculum. Professional learning is a key element in embedding comprehensive RSE through a whole-school approach. Schools should enable their teachers to access learning that can support them to develop confidence and knowledge regarding RSE topics.

7.3 Staff well-being

For a whole-school approach to be successful it cannot be limited to learner well-being, but must also consider the well-being of all school staff. Issues that affect teacher well-being can have a significant knock-on effect for learner well-being. Emotionally and mentally healthy teachers are better able to develop strong teacher–learner relationships. This in turn is important not simply in terms of ensuring academic attainment, but in fostering an ethos that nurtures the young person, building their cooperation, commitment, resilience and confidence.

All school senior leadership teams need to be aware of particular areas of stress that impact on staff well-being, and should ensure that evidence-based interventions are promoted, with staff supported in a timely and appropriate fashion when needed. In-school factors are not the only issues that can affect teacher well-being. The National Evaluation and Improvement Resource self-evaluation resource for schools enables senior leadership teams to review teacher well-being and identify common stressors such as high workload or excessive burdens of out-of-classroom activities. The resulting priorities and actions will form part of the school improvement planning process and help inform policies and plans related to addressing the workload and well-being of the education workforce.

The Welsh Government's national mission reinforces a commitment to reduce unnecessary workload and bureaucracy by providing greater clarity of what is and is not required in the classroom.

Steps already taken to address some of the issues include:

- development of a new evaluation and accountability system based on trust, respectful professional dialogue and proportionality

- publication of resources on ‘reducing workload’, as well as training materials and guidance in conjunction with our stakeholders (including Estyn, consortia and unions)
- introducing improvements to ensure equity of access for teachers to digital services via Hwb
- establishing the Managing Workload and Reducing Bureaucracy Group, in partnership with key stakeholders from all tiers and teacher trade unions, to address workload issues for the education workforce.

While it is clear that we are making progress, we need to continue to work collaboratively across the education profession. As announced by the Minister for Education, the four key priorities the Managing Workload and Reducing Bureaucracy Group is working towards are:

- to develop a Workload Charter and Toolkit for the school workforce
- to refresh and promote the Reducing Workload Resources and Training Pack and monitor take-up
- to further develop and circulate the training models and exemplar case studies produced across all four consortia regions to develop a cohesive approach to be applied on a national basis
- to carry out a sector-wide audit exercise to examine what data is collected across all tiers and how impact assessments on workload should be considered as part of policy development.

Additionally, the Welsh Government has commissioned the services of Education Support, a charity organisation with expertise in supporting the mental health and well-being of education staff. The Education Support project will run throughout the 2020/21 academic year and will provide a range of services ranging from live digital events, resilience training, peer support groups, well-being support materials for Hwb, and telephone support services.

While workload and the pressures of the profession are factors directly linked with well-being, another equally important ‘stressor’ is classroom behaviour and having to deal with behavioural and other issues related to the children and young people they teach. The whole-school approach and this Framework is designed to address those factors in particular by ensuring staff are supported to deal appropriately with issues in the classroom and that their own well-being is equally valued.

Schools’ senior leadership teams need to recognise the varied factors that affect teacher well-being. During 2021 the Welsh Government will undertake a leadership review, where we look at the support available for leaders across Wales to ensure we can provide clarity on responsibilities for all involved. The National Academy for Education Leadership (NAEL) is a grant-funded arm’s length organisation developed and launched in May 2018 that considers all leadership aspects for the education sector. Among other things, it considers quality of leadership development provision and acts as a conduit for how leadership should develop moving forward. It was set up at the request of the Minister in 2016.

As part of its work it has considered the health and well-being of leaders in the system as a result of COVID-19 and how they can be supported moving forward.

NAEL has recently held a conference with a theme of well-being. It is also convening a working group to look at the survey results of leadership well-being with a view to develop a well-being strategy for leaders in Wales.

Case study: Penllergaer Primary School [36]
Penllergaer Primary School, Swansea, paid for the local school-based counselling service to provide regular supervision for any member of staff who wished to participate. Staff who participated found it valuable to be able to share their feelings and experiences and learned skills in supporting each other. The school now runs its own supervision in-house.

7.4 School environment

The school physical environment (classrooms, outdoor spaces, dining and other communal areas and toilets) all contribute to a learner's sense of well-being. They also contribute to the well-being of the adults who work in and those who are regular visitors to the school.

The use of space, lighting, noise and temperature (as well as walls for display) can all contribute to children's behaviour and the school's ability to regulate that behaviour, as well as the extent of social interaction between learners and school staff. Access to and use of outdoor spaces also contribute to good physical and mental well-being.

For young people experiencing distress having access to safe, private (but not isolated) and calming spaces where they are not overlooked or overheard is important. Schools are used to providing spaces for use by school counsellors that meet these criteria, though there is also a need to balance the need to provide an available private nurturing space, together with not having such spaces labelled so as to avoid any stigma and discrimination attached to its use.

The 21st Century Schools and Colleges Programme[37] is committed to improving learning environments for our learners and to supporting schools to consider the effective use of educational spaces for all learners' needs. Early stakeholder consultation into the design of new-build and major refurbished school buildings ensure the health and well-being of learners is considered at the earliest stages. Local authorities and FE institutions are also encouraged to integrate appropriate design measures in order to make a positive impact on well-being.

7.5 Timing of the school day

Routine is an important part of children's lives. It provides structure and boundaries, and also supports teaching staff. While temporary changes to start and finish times may be necessary to facilitate social distancing during the pandemic, more

[36] From Estyn's *Healthy and happy* (2019) report.
[37] gov.wales/21st-century-schools-programme

permanent changes can be disruptive for parents/carers and children. In addition, shortened break times may detrimentally affect learners, particularly if time to eat, play, relax or socialise is limited. Schools and local authorities should ensure they carefully consider the impact on the
well-being of learners and parents/carers when considering making changes to school session times. Learning and teaching time should not be reduced as a result of making changes, nor should break times be reduced to an extent that may adversely affect learners' well-being.

7.6 The importance of play

Freely chosen, self-directed play makes a critical contribution to children's health and well-being and development. The Welsh Government places great value on play and its importance in the lives of children in our society. We are committed to supporting children's fundamental right to be able to play. Play is central to their enjoyment of life, contributes to their well-being and is essential for the growth in children's cognitive, physical, social, behavioural and emotional development. It is through play that children engage and interact with the world around them.

In recent decades there has been a decline in children's freedom to play and explore on their own, independent of direct adult guidance and direction. This has resulted from parents' fears (such as of strangers, traffic, bullying and dangers in nature), the increased time and weight given to schooling and, outside of school, children spending more time in education settings (such as football training, dance or music lessons) where they are directed, ranked, and judged by adults.

It is key that schools support free play for children of all ages by providing sufficient time within the school day for play and break times. Free play allows children to learn to solve their own problems and become competent in pursuit of their own interests and happiness. Evidence shows that active play contributes strongly to children's health and well-being. It is shown as contributing to both children's physical and mental health, reducing childhood obesity and reducing the likelihood they will suffer from anxiety, depression and other disorders.

The removal of break time as a punishment for bad behaviour and its inclusion within behavioural management policies can cause stigmatisation and can constitute bullying. It is also in conflict with children's right to play.

Schools should also be aware of the Health and Safety Executive's statement 'Children's play and leisure – promoting a balanced approach'[38], which recognises the benefits of challenging play opportunities, and acknowledges that in supporting 'the provision of play for all children in a variety of environments…HSE understands and accepts that this means children will often be exposed to play environments which, whilst well-managed, carry a degree of risk and sometimes potential danger.'

[38] www.hse.gov.uk/entertainment/childs-play-statement.htm

Children's right to play is enshrined in Article 31 of the UNCRC. The UN General Comment 17 on Article 31 notes that schools have a major role in the promotion of the right to play.

Wales was the first nation in the world to put play on a statutory footing. Local authorities in Wales must assess and, where practicable, secure sufficiency of play opportunities to meet the needs of families in their area. Regulations and statutory guidance set out the wide range of matters across several policy areas that local authorities have to take into account in their play sufficiency assessments. As part of their play sufficiency assessments, local authorities must assess to what extent:

- children are provided with an interesting play environment for breaks during the school day
- children are provided morning, lunchtime and afternoon play breaks.

Wales – A Play Friendly Country (2014) is statutory guidance to local authorities assessing for and securing sufficient play opportunities for children in their areas. It supports local authorities in complying with the duty under section 11 of the Children and Families (Wales) Measure 2010. The statutory guidance notes that schools provide an important opportunity for children to play during the school day and for periods before and after classes. Schools can also provide valuable play space at weekends and during holidays.

Play Wales, the charity that supports children's play in Wales, has created some useful guidance and resources that schools can use[39].

7.7 Information, awareness raising and advocacy

Good progress has been made in recent years in raising awareness of poor mental health and tackling stigma and discrimination across society. In the school environment school teaching staff should encourage learners to discuss, and consider their own (in a way which does not make them feel pressured to disclose personal issues) and others emotional and mental well-being, including how to develop empathetic responses to their peers. The new curriculum, and in particular, the Health and Well-being Area of Learning and Experience, provides opportunities to embed this approach within specific lessons and across learning as appropriate.

Mental health literacy, arising from the concept of health literacy, is defined as understanding how to obtain and maintain positive mental well-being[40]. It is an important empowerment tool, in particular for those young people with ALN, as it them better understand their own well-being and enables them to act on this information. It increases people's resilience and control and enhances help-seeking behaviour.

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[39] www.playwales.org.uk/eng/publications/schoolsgroundstoolkit
[40] https://gov.wales/advocacy-standards-and-outcomes-framework-children-and-young-peoplewww.mentalhealth.org.uk/a-to-z/m/mental-health-literacy

Schools can play a key role in developing the mental health literacy of their learners and empowering children and young people to make informed decisions. School senior leadership teams should consider their target audiences (e.g. learners, parents/carers and staff) and look for innovative ways of making information available to each; for instance, on the school website supporting older learners to act as peer mentors and encouraging all school staff to feel comfortable signposting to relevant well-being support resources and information. They should ensure that information is publicised at times of possible greatest need (e.g. during exams), ensuring regular campaigning and key messages are promoted in appropriate formats such as social media.

There are also a range of external agencies, particularly operating within the third sector, that can provide schools with support and resources, both in terms of providing information and support for learners and parents/carers, and in terms of training staff and providing advocacy services. Access to advocacy support, particularly for those with greater levels of poor mental well-being, can be especially helpful, as children and young people often report feeling unsure and not knowing where to turn to during this difficult period. Access to youth worker support can help provide an accessible relationship with a trusted adult, particularly for those young people who may find it difficult to look for support from teachers or those perceived as being in positions of authority.

As part of our commitment to support a consistent whole-school approach across Wales, the Welsh Government will work with partners to provide a range of agreed information and awareness-raising materials that schools can access.

Independent Professional Advocacy: National Standards and Outcomes Framework for Advocacy for Children and Young People in Wales (2019)[41] sets out well-being outcomes for people who need care and support and carers who need support; this includes advocacy. The Framework states people must have the opportunity to speak for themselves and contribute to the decisions affecting their lives, or have someone who can do it for them. The achievement of this must be measured; it is vital commissioners of advocacy services and advocacy service providers can measure the quality as well as the quantity of their work and be assured they are making a positive difference to the lives of children and young people. The NSOF therefore sets out the underpinning standards and outcomes in relation to advocacy.

The National Approach to Statutory Advocacy (NASA), which has been in place since 2017, sets out shared national expectations on access and availability of (independent professional) advocacy. Underpinned by the NSOF, common components of a service specification and reporting template, the NASA reinforces and secures a consistent offer and experience for children and practitioners. The NASA further evidences and informs future delivery and improvement through quantitative and qualitative reporting at local, regional and national levels.

[41] gov.wales/advocacy-standards-and-outcomes-framework-children-and-young-people

The task and finish group held their final meeting on 25 January. A legacy document is being finalised that will be available on the Welsh Government website. This will include the component documents of the NASA:

- *Independent Professional Advocacy: National Standards and Outcomes Framework for Advocacy for Children and Young People in Wales*
- service specification
- range and level mechanism
- national reporting template
- guidance for advocacy providers on completion of the national reporting template.

Under the NASA 'Children and young people are entitled to an active offer of advocacy from a statutory independent professional advocate (IPA) when they become looked after or become the subject of child protection enquiries leading to an Initial Child Protection Conference'. Section 21 of the Part 10 Code of Practice (Advocacy) – provides more detail on this[42].

The Welsh Government also currently funds Meic[43] – the information, advice and advocacy helpline for children and young people – which is a helpline service for children and young people up to the age of 25 in Wales. The service offers a telephone/text chat line, as well as a website providing advice and guidance relating to any matters that could affect children and young people.

In addition, Tros Gynnal Plant have a website (see https://whatisadvocacy.cymru/) that is a tool for learners to find out how they can access advocacy services in Wales.

7.8 Universal provision

All children and young people should have access to a range of tools and support for their emotional and mental well-being both at school and at home, if a blended learning approach is required. Universal provision is not about learners requiring and accessing dedicated specialist support, but rather it is about supporting them to understand their own
well-being in building resilience and in developing coping mechanisms to manage the everyday stresses and challenges experienced throughout life, as well as in knowing when and how to access support. This should be reflected by a range of universal provisions that learners receive both within the classroom, such as introductions to emotional literacy, or outside of the classroom, including though youth work approaches or universal pastoral support.

Work to integrate elements of the WNHSS with the requirements of this Framework and the support of the implementation leads will help schools in identifying their

[42] gov.wales/sites/default/files/publications/2019-12/social-services-and--well-being-wales-act-2014-part-10-code-of-practice-advocacy.pdf
[43] www.meiccymru.org/

priorities for improvement and their strengths upon which they can build sustainable provision.

However, universal support does not need to be through the provision of formal programmes, though many formal programmes are available and can provide a structured approach to delivery. Rather, the school ethos of nurturing young people, having trusted relationships with school staff, being able to talk about issues and the way well-being is taught through a school's new curriculum will be all that is required in many instances. Other actions that support well-being, such as establishing greater links with PRUs and providing learners with the opportunities for outdoor activities, weekly unstructured time for well-being activities, or quiet drop-in spaces they can access when they need 'time out', should also be considered.

Where school senior leadership teams do choose to use a structured universal intervention they should have access to evidence-based interventions and the autonomy to choose the intervention(s) that best meet their needs. When delivering such interventions, school senior leadership teams should consider working together in clusters and/or with other partners in a multi-agency approach to support each other, to develop communities of practice and to achieve economies of scale when procuring interventions from external providers. Local authorities and regional consortia can provide support and commission this on a local or wider regional basis.

School senior leadership teams, teachers and wider school staff should actively recognise the link between learner and staff well-being and their school policies and actions (which include tackling bullying[44], safeguarding, healthy relationships, play and recreational opportunities, learner participation and equalities). These policies should be reviewed to ensure that they do not detract from, but align and reinforce where possible, their
whole-school approach. Senior leadership teams and teaching staff should also consider the importance of maintaining a routine in times of disruption, for instance ensuring supply teachers are informed of the needs of classes and the learners they are teaching, and existing classroom protocols.

As part of our commitment to support a consistent whole-school approach across Wales the Welsh Government will work with partners to assess the range of universal provision in Wales and provide a 'toolkit' of good practice.

Case study: Archbishop McGrath Catholic High School[45]
Archbishop McGrath Catholic High School has a Friday running club that is for both staff and learners. This club provides a shared opportunity for staff and learners of any ability to go for a run together in the local area during lunchtime. This promotes positive relationships and shared values, and benefits learners' health and well-being.

[44] gov.wales/school-bullying
[45] From Estyn's *Healthy and happy* (2019) report

7.9 Targeted provision

Sometimes children and young people will need support over and above universal provision. As detailed elsewhere in this Framework, being emotionally and mentally healthy is not black and white. There is a wide spectrum, or continuum, of well-being and everyone, including children and young people, will move across the spectrum at different points in their lives as challenges and both internal and external factors affect them. Targeted provision may also need to be considered for some children during times of transition (see section on transition).

Targeted provision should be proportionate to need and range from time-limited low-level support, such as an empathetic response from a trusted professional (e.g. a teacher) or other talking-related therapies, to more specialist support for those with suspected mental health or behavioural problems provided by specialist services such as CAMHS. In each case school senior leadership teams should have access to a range of evidence-based interventions (delivered by the school staff or appropriate professional) to support the young person. This provision should be offered and delivered in as de-stigmatising a way as possible and the offer of targeted provision should not result in learners having to miss their preferred classroom or extra-curricular activities. Wherever possible, parents/carers should be encouraged to be involved in any discussion around provision for their child or young person.

The school's senior leadership team should have good working relationships with external support services and know how to access them when needed. Mental health services should be available and responsive to support schools in this way, particularly around issues of risk and self-harm. Indeed, often a supportive telephone or face-to-face consultation with a mental health professional can prevent the escalation of a referral to specialist services. For young people, being able to talk to a trusted adult who they know well can be far more therapeutic than being referred to a remote professional that they have never met before and have to wait several weeks to see.

However, school staff need to feel confident that they are doing all they need to, and are not missing anything important in that supportive role. Ultimately, it supports a move away from a 'refer-on' culture to one where staff feel confident enough to be able to 'hold on', knowing they are supported and that their value as the person who knows the young person best within the school setting is recognised. To facilitate this, schools need to conduct, document and consult on risk assessments, skills assessments and workload impact assessments. Control measures identified in this process (e.g. altered timetables, reduction of other duties, recruitment of staff, training, etc.) need to be implemented and senior managers need to liaise with appropriate external bodies and agree documented service level agreements that identify how they will work together.

Other direct interventions can include nurture group provision, the role of emotional literacy support assistants (ELSAs) and alternative lunchtime provision for learners with sensory issues or anxiety. In addition, informal methods such as peer mentoring can form part of the targeted offer. Targeted provision should be based on evidence of need rather than diagnosis, because, as previously mentioned, many children and

young people will have real needs but not diagnosable mental illness. Diagnosis should not be used as a gatekeeping mechanism for accessing targeted interventions either within or outside the school setting.

As part of our commitment to support a consistent whole-school approach across Wales, the Welsh Government will work with partners to assess the range of targeted provision in Wales and provide a 'toolkit' of good practice.

Case study: Ysgol Gynradd Aberteifi [46]
Ysgol Gynradd Aberteifi has used the Pupil Development Grant funding to create a pupil pastoral worker (PPW) post to develop links with hard-to-reach parents/carers. This person also coordinates staff training with a focus on learner well-being, delivers a specific programme to target learners' emotional needs and provides counselling sessions in the school for learners and parents/carers. The PPW works very closely with a wide range of specialist agencies and seeks expert external support where necessary.

The PPW has established trusting relationships with parents/carers and holds regular informal 'drop in' sessions for parents/carers to discuss matters of concern or share information. In addition, the PPW makes regular home visits to parents/carers who do not feel comfortable coming to school. The PPW has been trained to deliver a wide range of beneficial programmes to both learners and parents/carers, such as coping with bereavement, controlling negative emotions and dealing with domestic violence.

The PPW also coordinates the delivery of a wide range of tailored intervention programmes that are delivered by other staff within the school. These include support for anger management, emotion coaching, play interventions and a programme for raising learners' self-esteem.

The school has also provided training to all staff that enables them to use a range of strategies to promote positive engagement at class level. All learners (including those with ACEs) benefit from consistent approaches to develop their resilience and positive mental health. Whole-school training in recent years includes training on attachment disorder, emotion coaching, restorative approaches, and supporting the children of incarcerated parents/carers and those exposed to domestic abuse.

7.10 Provision for children and young people with specific needs

School senior leadership teams will support the health and well-being of all of their learners through positive well-being environments, good learner–staff relationships and universal/targeted initiatives as outlined above. However, some patterns of behaviour mean that a child or young person will need more targeted and intensive support. These patterns of behaviour can include:

[46] From Estyn's *Knowing your children – supporting pupils with adverse childhood experiences (ACES)* report (2020)

- disordered eating and poor body esteem
- risk-taking and continuous disruptive behaviour
- bullying other children[47]
- substance misuse
- frequent school absences and those experiencing loneliness and isolation
- those suffering low mood and anxiety or poor self-esteem.

Schools' senior leadership teams need to accommodate the needs (and potentially long-term issues) of learners falling within these categories when considering their learner and parent/carer population in order to develop well-being plans as part of wider school improvement policies.

As part of our commitment to work with partners to assess the range of targeted provision and provide a 'toolkit' of good practice, we will consider the particular needs of these learners.

7.11 Self-harm and suicide

Suicidal ideation and self-harm is also an issue school staff will encounter, though contrary to what we hear in the media, suicide is a rare event among children and young people. Self-harm is more common, with around 1 in 10 adolescents reporting having self-harmed, though most young people who self-harm stop before adulthood. However, coming across instances of suicidal thought and/or expressions of self-harm can be very distressing, both for the young person concerned and the adult that they have disclosed the information to (or who has become aware of the issue from some other source).

Recognising this the Welsh Government published *Responding to issues of self-harm and thoughts of suicide in young people*[48] in 2019. The guidance has been produced to support teachers, as well as other professionals who regularly come into contact with children and young people, in dealing with issues of suicide and self-harm as they arise. It supports early intervention and prevention and the safe management of self-harm and suicidal thoughts in learners when they present. It is not meant to supplant specialist training, rather it provides a quick and accessible source of reference to the general principles of best practice and signposts to other sources of support and advice.

School senior leadership teams, teachers and other school staff should all be aware of the guidance and ensure its existence is promoted widely among staff. They should also not be afraid to talk about the issues, and there is no evidence that a conversation with a young person where you try to understand the reasons and circumstances for self-harming makes them more likely to self-harm or puts the idea into their head. In fact, non-judgemental conversations may encourage them to seek help in the future.

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[47] gov.wales/sites/default/files/publications/2018-03/respecting-others-anti-bullying-overview.pdf
[48] gov.wales/sites/default/files/publications/2019-08/responding-to-issues-of-self-harm-and-thoughts-of-suicide-in-young-people-guidance.pdf

In the rare instance of a suicide, this will affect the whole school community. Both the school's senior leadership team and their local authority should have suicide prevention and intervention strategies in place, including in relation to postvention to use after a suicide or suicide attempt of a learner or school staff member.

7.12 Provision for vulnerable children and young people

Some learners are at higher risk of facing poor well-being and experiencing adverse outcomes. School senior leadership teams should be taking an inclusive and non-stigmatising approach to ensuring good well-being for **all** of their learners, regardless of circumstance. However, it is important to acknowledge that some learners may need additional support at different times and more targeted early intervention to prevent negative experiences.

School senior leadership teams should consider their learner and parent/carer population when developing their well-being plan as part of the wider school improvement process to make sure it accommodates the needs of any learners who are part of one or more vulnerable or historically marginalised groups, including:

- children and young people under supervision of children's services
- care-experienced children and young people
- children and young people who are engaged with the youth justice system
- children and young people with ALN
- children and young people at risk of disengaging with education
- children and young people at risk of youth homelessness
- LGBT+ children and young people
- young carers
- refugee and asylum seeker children and young people[49]
- Gypsy and Traveller children and young people
- children and young people with chronic illness
- children from Black, Asian and Minority Ethnic backgrounds, who may be uncomfortable discussing mental health issues due to stigma.

When considering the needs of these learners schools and service providers (such as youth offending teams, health services, specialist services and local authority children's services) need to develop positive working partnerships with the school to effectively support these vulnerable children and to build their resilience. School senior leadership teams should take account of these learner's circumstances and factor in flexibility and empathy to their response.

In addition, there are times when learners are more likely to need support with their well-being, such as:

[49] www.wmsmp.org.uk/wp-content/uploads/ACEs-in-Child-Refugee-and-Asylum-Seekers-Report-English-final.pdf

- around times of transition (see section below)
- during exam periods and following the release of exam results
- following traumatic experiences, e.g. bereavement, parental separation or an asylum journey.

Case study: Gilwern Primary School [50]
In Gilwern Primary School, trained staff use the emotional literacy support assistant (ELSA) approach to support vulnerable learners effectively. The approach provides a reflective space where a learner is able to share honestly their thoughts and feelings, and aims to understand the psychological need behind poor self-esteem or undesirable behaviour. Through the approach, a learner in the school with significant behavioural and social needs was supported to relate better to their peers, to improve their decision-making in social contexts, and to be better at identifying risky situations. Using the same approach, an anxious learner who had transferred from a different school was helped to settle well, and a learner with a history of poor attendance was supported, through a phased return, back to full engagement with school.

7.13 Transition

Transition between home and education settings, education settings and school, primary and secondary school, or between different schools, has been highlighted as a time that can be particularly destabilising for some learners, such as those with ALN. For younger learners the importance of early years support, establishing partnerships between parents/carers and education settings from the earliest stage will help smooth the process. Other transition points include health transitions (including older learners moving from children's to adult services), where these external transitions can cause anxiety, worry and concern that may manifest in the classroom. This may be exacerbated by schools not being engaged at an early enough stage, or not engaged at all. This in turn may impact on the learner's education, in addition to creating challenges around joined-up working between school and health.

Schools are very familiar with the issues surrounding transition and many take steps to ensure that transition between education settings is made as smooth as possible. The best transition plans[51] clearly set out how parents/carers, education settings and schools will work together to effectively meet the emotional and mental health needs of learners (e.g. through peer support networks) in advance of the transition into secondary education.

Consideration should also be given to learners who move schools outside of the usual transition points. These moves are often the result of a geographic relocation, and for some, such as the children of armed forces personnel, can be a frequent issue. The learner may be more vulnerable because of their lack of familiarity with the new area and loss of local friend networks, and may be at greater risk of

[50] From Estyn's *Healthy and happy* (2019) report.
[51] www.legislation.gov.uk/ukpga/2002/32/section/198

loneliness and isolation. School senior leadership teams and local authorities should have effective information-sharing protocols established to support this kind of transition.

The other key transition time for all learners is when they finish school and begin the transition to the workforce or FE/HE. This can be a time of stress and anxiety, and additional well-being support to learners in their final year of school is recommended. Research[52] shows that moving to a new environment, academic and social demands, and anxiety around finding a job are all risk factors for learners' mental health. School senior leadership teams should work with colleges, universities and other post-16 learning providers to support learners' transition, including by building resilience and sharing learner information within agreed data-sharing arrangements. This will help post-16 providers to offer the necessary support and ensure that learners can succeed in their studies.

Case study: King Henry VIII Comprehensive School [53]
King Henry VIII Comprehensive School works closely with its partner primary schools to take a comprehensive approach to making transition as smooth as possible. The focus through the range of activities is to build positive relationships between learners, parents/carers and the staff at King Henry VIII prior to learners arriving there in Year 7. The approach includes:

- teachers from King Henry VIII contributing to lessons in Years 5 and 6
- as well as those in Year 6, learners from Year 5 visiting King Henry VIII for activities
- music and sports events during Year 6 for all partner primary schools at King Henry VIII School
- informal parents'/carers' evenings
- well-being leader from King Henry VIII visiting partner primary schools to meet learners, discuss expectations, hopes and fears about life in secondary school

7.14 Leadership and staff training

Positive relationships between school staff and learners are at the heart of ensuring a whole-school approach to emotional and mental well-being. It is the everyday 'little things' that teachers do that have surprisingly far-reaching outcomes for learner well-being. Studies show that what matters to learners is that teachers listen, are encouraging and positive, take an interest in them as people and empathise with their difficulties[54]. However, this is only possible if staff have the confidence and time to actively listen to learners as well as to respond appropriately even to challenging or concerning topics. Staff need appropriate training for this and the space to put it into practice. They also need to be supported to maintain their own well-being and

[52] www.instituteofhealthequity.org/resources-reports/improving-school-transitions-for-health-equity
[53] From Estyn's *Healthy and happy* (2019) report
[54] Roffey, S (2017) 'Ordinary magic' needs ordinary magicians : the power and practice of positive relationships for building youth resilience and wellbeing' https://gov.wales/school-nursing-framework

have access to appropriate supervision, particularly when dealing with more challenging issues that have the potential to impact on their own well-being.

Teachers and leaders should be given opportunities and time to access training on how they are able to support learners' well-being. Some teachers may also wish to develop a greater knowledge and professional understanding of more specific issues and should have access to a range of resources and additional training to do so. Such professional learning opportunities will also support the design and implementation of a school's curriculum. More and more of such professional learning opportunities are becoming available, many through blended or online courses.

We have made and will continue to make significant investments in digital learning resources to support teachers in their professional learning journey. We are already building on the successful resources on Hwb to provide high-quality blended and remote learning experiences. We are working with higher education institute (HEI) partners to develop a range of resources for all schools focused on health and well-being and enquiry and reflection. These resources will be made available via Hwb in due course.

HEI partners are also supporting work to significantly upscale our National Professional Enquiry Programme (NPEP). During 2020/2021 over 300 schools will be developing as professional enquirers, focusing on a range of enquiry themes including a range of inclusion-focused enquiries linked to health and well-being and vulnerable learners.

Enquiry outputs will continue to feed into the wider Curriculum for Wales Professional Learning Programme delivered by regional consortia. We will continue to build upon these strong professional learning foundations as we move closer towards 2022.

Understanding and having a knowledge of the emotional and mental well-being of learners, as well as a need to recognise individual learner needs, is a core part of our new programmes in initial teacher education. To support this, and as part of our commitment to support a consistent whole-school approach across Wales, the Welsh Government is working with partners to develop training modules on child development, emotional and mental well-being, neurodevelopment and pedagogy, as well as others that would be available to teachers from initial teacher training, though newly qualified teachers and as part of continuous professional development.

However, rather than limiting emotional and mental well-being training to leaders and teachers, it is important that appropriate training resources are available for all school-based staff who work directly with children and young people. Some school support staff have a specific role in relation to promoting/supporting well-being, e.g. school counsellors, school nurses, educational psychologists and education learning support assistants. Staff in these roles have an important role to play in raising awareness of emotional and mental well-being issues among other members of staff and act as sources of advice and support. They should be given time to allow them to support learners and staff as part of multidisciplinary teams to provide consultation, liaison and advice where appropriate. Joint training, to foster a greater

understanding of the different roles members of staff have and to build relationships, should also be considered.

Case study: Aneurin Bevan University Health Board
School nurses provide invaluable support within the whole-school approach in providing support to learners for emotional well-being as part of their role in delivering the national school nursing framework[55].

Emotional support is usually provided through weekly school nurse drop-in sessions, which are well attended and highlight issues such as self-harm or anxieties. During the pandemic, when access to learners has been limited health services have adapted by use of the virtual technology Attend Anywhere which provides anonymity for learners and has a far reach across school communities.

Aneurin Bevan University Health Board have been undertaking a transformation-funded project to deliver enhanced drop-ins virtually and face-to-face in collaboration with psychology support. While this is currently being formally evaluated, initial uptake by learners appears increased and interim feedback from both school nurses and learners is positive.

With the experience during the pandemic and the roll out of Attend Anywhere across Wales, this model could be replicated as good practice. It is suggested that, where appropriate, school nurses work together to provide a shared online drop-in clinic resource for young people to access.

School senior leadership teams, including governors, should ensure staff have access to refresher training through the national approach to professional learning that aligns with the new professional standards, the schools in Wales as learning organisations approach and professional learning model, to create a vision fit for the evolving education system in Wales for all educational practitioners and not just teachers.

The national approach to professional learning is designed to ensure:

- that schools, leaders and teachers are able to access best practice in defining and sharing professional learning at school level, especially through the use of critical enquiry and collaborative learning
- that the providers of professional learning – the regional consortia, our universities and others – design professional learning experiences that are high quality, accessible and fit for purpose, e.g. through designs that include collaborative enquiry and e-learning.

Integral to the national approach is ensuring that professional learning for all practitioners is adequately resourced, including both financial resources and time for teachers and leaders to engage with high-quality development opportunities.

[55] gov.wales/school-nursing-framework

7.15 The role of youth work

The important role of youth work in supporting the mental health and emotional well-being of learners was emphasised in the *Mind over matter* report[56] and in the inquiry[57] the Children, Young People and Education Committee undertook on youth work in 2016.

Youth work provides welcoming, safe spaces in which young people are able to develop, talk about issues that may be affecting them, and build resilience. It is a vital preventive service, helping reduce the need for more acute, costly interventions further down the line. It can therefore have a substantial impact on children and young people's emotional and mental well-being. It does this by establishing trusted relationships with adults and peers, and offering young people opportunities for learning that are educative, expressive, participative, inclusive and empowering.

Youth work is a universal entitlement, delivered by both voluntary and local authority youth services, and is open to all young people within the specified 11–25 age range. Many schools already have established links with youth workers and youth work services and should be able to access local youth work support for young people, including those with emotional and mental health issues, via their local authority and voluntary sector partners.

Youth work and youth workers need to be seen as 'part of the team'. School senior leadership teams should consider how to work effectively with their local youth work teams, both through the local authority and through the voluntary sector, to reduce duplication of services and to increase the diversity of support on offer to learners. This includes youth work embedded within the school and based in the wider community. There are many examples of recent reports citing the benefits to young people's well-being from schools and youth workers operating in partnership. These include through curriculum implementation, by improving engagement, attendance, and behaviour, by developing emotional resilience, and through the delivery of mental health support and RSE.

Where schools require additional support to engage with or deliver youth work approaches with young people they can learn about what provision is available by contacting their local authority principal youth officer and the Council for Wales of Voluntary Youth Services.

7.16 Whole-system roles and responsibilities, and relationships with external services and parents/carers

As indicated, schools are but one part of a wider system that includes the family and friends of children and young people as well as a myriad of general and specialist support services designed to support the child and wider family. School senior

[56] www.assembly.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf
[57] www.assembly.wales/laid%20documents/cr-ld10870/cr-ld10870-e.pdf

leadership teams need to be an open partner with these other ‘players’. In relation to the whole system, local authorities, working through the RPBs and/or PSBs should work to hold partners to account and ensure their full engagement in the process so that schools are not left ‘holding the baby’ and are able to access appropriate support, at the appropriate time for their learners.

Building resilience and support for children and young people in schools through to community-based support is critical and will need to draw together a broad range of key stakeholders. This is all underpinned by rights-based, values-led, child-centred, attachment and trauma-informed approaches. The key ingredients to a whole-system approach will need to consider:

- the link to the whole-school approach
- the point of access to a range of early intervention and intensive support options
- community-embedded expertise to support trauma, self-harm and risk
- developing children, young people and family-led innovation, such as through peer support, digital and social media
- the need for resilient communities, safe housing, healthy food, leisure, sports, arts, etc.

NHS providers will be one of the main sources of advice and support to schools and should operate a policy of ‘no wrong door’ when dealing with emotional and mental well-being needs. Work is already underway in many parts of Wales to provide a more collaborative joined-up approach, such as the work being pioneered across six local authorities by the CAMHS school in-reach pilots. These pilots have demonstrated that developing relationships across organisational boundaries is a driver of successful delivery. Picking up the telephone for advice from mental health professionals, combined with training, can be an alternative to a referral, which CAMHS professionals may be unable to deal with directly.

This collaborative joined-up approach should enable each school to access consultation, liaison and advice from specialist mental health services. Advice and discussion should occur prior to any referral and alternative signposting should be considered prior to referral to more specialist services. In particular, positive examples of strengthening relationships between services is seen in different areas of Wales where multi-agency panel meetings have been convened, allowing staff to present cases and gain advice from the panel of different specialists. The Wales Accord on the Sharing of Personal Information (WASPI) allows the sharing of necessary pertinent information between agencies to occur in a straightforward and timely manner, ensuring that children and young people experience a cohesive and joined-up service when they are in distress. Such collaboration aims to empower school staff who have become trusted adults to learners and who may be struggling to feeling confident in supporting learners.

The third sector also has a significant role to play in supporting a whole-school approach to health and well-being and is a valuable source of expertise on working with schools and with young people. Indeed, the third sector is an essential partner in developing whole-school approaches. They provide a range of services from providing a conduit to access under-represented groups of parents and learners; providing independent child-focused support to children and young people, and to

teachers and learning staff; and supporting children and young people's voice in the process as expert facilitators, particularly supporting inclusive practice with a wide range of children with additional needs. There are many third sector organisations whose missions align with the goals of this Framework and who can offer schools invaluable support. Schools need to be aware of and engage with third sector providers in their area.

Case study 1
The Aneurin Bevan University Health Board, as part of their whole systems approach to child and adolescent mental health and well-being transformation, have developed Single Points of Access for Children's Emotional Well-being Panels (SPACE Panels) in each of their local authority areas. These forums meet on a weekly basis and co-ordinate all requests for support around issues to do with behaviour, mental health and emotional well-being. Representatives from each service that offers input in this area attend, including specialist CAMHS, primary care mental health support services, Families First, educational psychology services, youth services and third sector providers.

The forum works on the principal that a child, young person and family's need can be matched to the service that best fits at that point in time, and operates on a 'no wrong door' basis. This prevents families and referrers having their requests rejected because they don't meet the criteria, for example; and feeling that they are starting from scratch in working out where to turn next.

These forums have proved invaluable in matching demand with available resources and in time, it is hoped, they will be a vital vehicle for highlighting gaps in provision and highlighting the direction RPBs need to take to address these gaps through future service development.

The added advantage is that each representative develops positive relationships with, and a deeper understanding of, the whole range of services in their area.

Case study2
Hywel Dda School in-reach pilot have developed and maintained collaborative working relationships with third sector agencies – e.g. Amethyst Project, Area 43 (counselling) – sharing information appropriately, resulting in timely and effective outcomes for children and young people. Strong links are maintained with colleagues in specialist CAMHS where information gathered from school meetings is fed back. Networking has been a beneficial opportunity to share good practice, e.g. attending/participating in conferences.

Regular contact with schools, e.g. structured consultations with training opportunities to reach the wider workforce have taken place, while the development of a newsletter promotes upcoming events along with supportive information. The service has begun offering reflective sessions to school staff, having identified through consultations the need. Protected time is offered to discuss staff well-being along with their individual concerns. To date five well-being drop-in sessions between two secondary schools with 12 staff taking up the opportunity.

7.16.1 Together for Children and Young People Programme (T4CYP(2))

Supporting and complementing our whole-school approach the NHS-led Together T4CYP(2) is a Welsh Government priority with cross-cabinet commitment. It aims to improve the way services provide emotional well-being and mental health support for children and young people, through coproduction with those with lived experience, their families, communities, NHS health boards, local authorities, and the third sector. T4CYP(2) has three areas of focus:

- EHES
- neurodevelopmental services
- RPBs.

The agreed programme objectives for 2021 are to:

- develop a national framework that describes the EHES that should be available in all areas of Wales, with the aim of addressing the so-called 'missing middle'. This will include working with RPBs
- continue to embed the neurodevelopmental pathway and standards developed through the first phase of the Programme.
- support the development of a whole-system response for children and young people with neurodevelopmental conditions. This work will include relevant linkages to implementation of the ALN Act provisions. The development of the EHES National Framework will seek to provide an early offer for children and young people and their families, who otherwise would be referred to the neurodevelopmental team.
- work with wider partners through RPBs to align to the direction of travel already set by Welsh Government
- work with RPBs to undertake a mapping exercise of current provision, with a view to supporting the adoption of the EHES National Framework at the board level.

National Framework for EHES

A draft high-level framework has been developed and consulted on. A more detailed framework, complete with digital-based support will be developed to embed the new coproduced Framework on a regional footprint later in 2021.

EHES is based on the NEST (nurturing, empowered, safe, trusted) Framework. NEST marks an important culture shift from asking what is wrong with a child towards asking what a child's NEST is like in terms of their mental health and well-being. Partnership and neurodiversity remain key to the NEST approach.

The six sections of NEST are:

- having one consistent adult in a child's life and being well supported
- a whole-school/-system approach
- resilient communities
- coproduction and innovation
- easy access to expertise around risk and trauma
- a single point of access for services that support mental health and well-being.

Neurodevelopmental workstream

The programme has been working with a range of stakeholder and partners to establish a holistic vision, based on a children's rights approach to shape both NHS services and influence wider support services across a range of neurodevelopmental conditions and co-occurring needs, including attention deficit hyperactivity disorder (ADHD) and autism. The information will be used to enhance the drawing together of multi-disciplinary teams at a more local level, as part of planned work to review and update the current national pathway and standards.

Neurodevelopmental digital provision

Currently, children, young people and their families have to wait for their first consultation to receive the first tailored advice and support. Coupled with the increase in demand and impact of COVID-19, families could find themselves without an intervention for a prolonged period given the current size of the service relative to the demand.

To assist in addressing this, the programme is working with a number of partners to progress a plan to develop a bespoke online tool that could:

- increase and supplement existing neurodevelopmental assessment and diagnosis capacity
- build resilience and enhance efficiency across the system in line with prudent healthcare measures, as part of a blended support offer
- be commissioned on a 'once for Wales' basis.

A contract to make the necessary adaptions to an existing tool to test proof of concept has been awarded. This tool will aim to bring together current assessment tools used across Wales in a fully bilingual and timely way. The plan of the programme is to complete proof of concept with a view to progressing to a live test in early 2021.

RPBs

Work has commenced in establishing a group with a view to developing a shared vision for the future embedding of services, supported by genuine collaboration in order to achieve cultural change. This area of work aligns to the Children's Commissioner's report *No Wrong Door*[58]. Early engagement sessions with RPBs have taken place and early adopters will be sought in early 2021. Work is in hand with RPBs to establish the current position and future plans for emotional well-being and mental health of children and young people; this is planned for spring 2021.

7.16.2 The role of parents and carers

The Welsh Government is committed to promoting the principles of positive parenting which is consistent with the basic principles of the UNCRC. To support this approach, the Welsh Government wants parents/carers to be given information, support and encouragement to enable them to choose the most positive approach to raising their children. We want children and parents/carers to have good bonding

[58] www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/

and attachment from the outset, and encourage parents/carers to have positive and supportive relationships (whether they live together or not) to support effective co-parenting. We want all children to get the very best start in life and to thrive. Support to promote positive parenting is delivered at different points in a child's life through parenting groups and one-to-one work and ranges from informal, universal parenting support for parents/carers, through to more targeted, specialised interventions. Parenting programmes could enable parents/carers to feel confident to talk to and support their child's well-being and learning at home.

Local authorities have responsibility for deciding the precise nature of local service delivery, depending on local circumstances and identified needs within their own areas. The Welsh Government's *Parenting in Wales: Guidance on engagement and support*[59] – is the principal statement on parenting support policy and sets out principles, expectations and vision for how parenting support services should be provided and contains a firm expectation for positive parenting principles to be promoted actively and consistently.

Welsh Government's 'Parenting. Give it time' campaign, launched in November 2015, supports the actions within the Prosperity for All strategy to deliver extended, coherent support for parenting, focused on positive parenting and early intervention. It promotes positive parenting messages for families with children up to the age of seven years of age, through social and print media and digital advertising. A dedicated bilingual website[60] – including 'Our Faces of Parenting' families, Facebook and Instagram pages, provides parenting tips, information and advice on common parenting concerns and signposts parents/carers to sources of further support. A suite of advice and information guides to support the wider challenges of parenting has been developed and is available online or as printed versions. Over 80,000 booklets and a suite of information sheets, created with key professionals and experts working with children and translated into 10 community languages, have been provided to local services such as the Family Information Service, Flying Start and Families First settings, GP surgeries, health visitors, schools and libraries. We are working towards enhancing the information and support we already provide to parents and families and have made a commitment to expand the age range from 0–7 years of age to 0–18 years of age.

A new 'Parenting. Give it time' campaign, 'Parenting Moments' focuses on three key themes – 'children's behaviour', 'give them time' and 'supporting you'. Material to support the campaign has been developed, including a 'hero film' advert and a series of short positive parenting-themed films to raise awareness of the campaign. A managing behaviour film, developed by an early years professional, has been created and promoted on the 'Parenting. Give it time' website and social media channels. In addition, a series of short films, blogs and top tips resources, developed by parenting practitioners and experts in the field of parenting, have been developed promoting positive parenting messaging on a number of key topics such as routines, screen time, children's behaviour and parenting styles.

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[59] gov.wales/parenting-engagement-and-support-guidance-providers
[60] gov.wales/parenting-give-it-time

Many schools successfully engage with parents/carers and families to support the well-being of learners and to help ensure that children don't fall behind with their learning. They are key partners in supporting the whole-system approach to well-being, developing and reinforcing well-being messages in the home.

Step 3

7.17 Evaluation and coproduction

School senior leadership teams should evaluate the effectiveness of their plan as part of wider school improvement to ensure it is meeting their requirements, involving all parts of the school population of learners and staff in the evaluation. Learners, in particular, should not be considered as passive recipients only, rather they should be seen as valued contributors. As such, they should be involved at the very outset of and throughout the school's establishment and implementation of its whole-school approach. Estyn's *Healthy and happy* highlights the importance that staff and leaders place on listening to learners, not just having systems in place for pupil representation.

Evaluation will be informed by the data and intelligence sources identified at 'Step 1'; this should then become a process of continuous improvement, with schools updating their plan as new and emerging priorities are identified.

Coproduction with both learners and parents/carers should be central to all aspects of this work and in particular evaluation. At its heart are reciprocal relationships built on trust, respect and mutuality. Opportunities to input into the plan and to be a part of monitoring and accountability processes can be facilitated through groups such as the school council, parent–teacher associations and governing bodies, but schools should also allow for individual learners and parents/carers not in such a group to participate. School senior leadership teams should consider how learners will hold them 'to account' for adhering to the plan. In particular, emphasis is best placed on the views of those children and young people who are 'expert by experience'.

School senior leadership teams should consider a range of methods for coproduction with learners, staff and parents/carers. Questionnaires and focus groups, which gather views on aspects of school life (including values, ethos and relationships) can be useful in informing the evaluation.

Case study: Cantref Primary School [61]
Cantref Primary School empowers learners by giving them a range of suitable leadership roles and responsibilities, and enabling groups of learners to develop the school's work on the UNCRC. As a result, learners have a very strong voice in the school, show respect to everyone in the school community and feel equally valued. The culture in the school allows learners to carry out 'learning walks' where they observe learning activities and then provide helpful and respectful feedback to relevant staff.

7.18 Governance and accountability

Within the school, well-being is of core importance to the functioning of all schools and should make up a part of routine leadership discussions. The senior leadership

[61] From Estyn's *Healthy and happy* (2019) report

team and the governing body must take ‘ownership’ of the plan, ensuring it is kept under continuous review as a part of school development planning, ensuring barriers and challenges to implementation are addressed. Progress needs to be reported to the governors, through the headteacher’s report to governors, on a regular basis taking into account the school’s context and the particular needs of its population.

Locally, in smaller schools, the small school population will mean that the senior leadership team can effectively oversee activity, though for larger schools it may be beneficial to appoint a named person who leads and acts as coordinator, a source of advice and an advocate for well-being. School pastoral leads, WNHSS coordinators and other well-being leads exist and could fulfil such a role; this should therefore not place any further undue burden on staff. Staff should have access to appropriate time, training, support, supervision and communication, and will work closely with the schools wider pastoral team as well as act as the link officer for external partners and agencies. Named individuals should act as plan coordinators as well as sources of advice and support to others within the school and externally. They should advocate and champion well-being.

Larger schools may find that this is too much work for any one individual and may choose to share the workload across a number of staff. This would also have the advantage that institutional knowledge and experience is maintained during times of staff ‘churn’. However, while an individual may lead activity it needs to be stressed that this is still a joint responsibility for all school staff and the senior leadership team. Having a named individual should not lead others to think they do not have a central role to play in taking forward the whole-school approach.

More widely, in order to effectively meet well-being needs there is a requirement for joint working across education, health and social care sectors (together with other partners such as the third sector). This requires a culture of collaboration and strong relationships across organisations. This can often be difficult given different organisational cultures but there are benefits not only for young people, who will find they have access to appropriate support in a timely fashion, but also to organisations. These benefits can include the cost-effective delivery of services, improved effectiveness and efficiency (as appropriate interventions can prevent more serious issues developing in the longer-term), and promoting a whole-systems approach and shared responsibility among services. Local authorities should ensure that arrangements for supporting and developing learners’ emotional and mental well-being and related outcomes are scrutinised by elected members.

In line with their responsibilities under the Part 9 guidance[62] RPBs and their relevant substructures operate to ensure partners work together to develop an integrated, whole-system, regional approach to developing and delivering services that support the emotional health and well-being of children and young people. This ensures a coherent approach to delivery of key policy frameworks including this Framework and the whole-school approach, the linked work of the T4CYP(2), and the ‘no wrong door’ approach.

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[62] gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

Annex 1: Implementing whole-school approaches in Wales (examples)

Many organisations, in particular third sector organisations, are now active in this field and are working with schools in Wales and across the UK to support well-being. The following are two examples of such work currently underway in Wales.

A. Mind Cymru's whole-school approach to mental health

Initially we conducted a rapid review of over 150 research articles, both published and grey literature, to understand the existing evidence base for mental health interventions in schools in English-speaking countries. Building on this evidence base, across Wales and England, we carried out in-depth conversations with 130 children to find out what they want and need. We asked over 140 teachers and parents what they think is missing. We also spoke with our expert local Minds, who are already providing support to children and young people in schools.

We found that schools want to do more but find it hard to find the time or resource and say they need expert help. Teachers and parents/carers told us they want a whole-school approach to mental health. They want to understand the issues, to have the tools and resources they need, and to know where to access support for young people and themselves so they can feel more confident and have important conversations.

> "Everyone should get support and help."
>
> Learner
>
> "School community must work together for the benefit of pupils, teachers and parents."
>
> Parent
>
> "Please tell me how, rather than another why. Most accept there is a need, we need support on how to implement."
>
> Senior leadership team member

Learners told us they want help for their mental health in schools. They want help that's respectful, practical and flexible, not medical or judgemental. Young people told us they place huge value on their mental health and well-being and want it to be given the same importance as academic success.

We found lots of different ways to develop a whole-school approach to mental health, but limited evidence that backs up what works best. What's clear is that support needs to be broad enough to reach all members of the school community, but flexible enough to give specialist support to those who need help the most.

In partnership with six local Minds across Wales and England, including two in London, we took a service-design approach working alongside 2,000 members of the school community to design and develop core interventions of the whole-school approach to mental health.

Aim of our approach

Our aim is to help learners to cope more easily with the challenges of everyday life, help them to manage stress, and to build supportive relationships with their peers. Every school that follows our approach will:

- promote good mental health and well-being to everyone as a right
- support everyone with a mental health problem
- find causes of poor mental health and find ways to keep everyone well
- respect diversity and promote equality
- build external partnerships to support learners achieve their very best.

Mind's model
Once schools have signed up to Mind's whole-school approach to mental health, they are supported through a four-step programme:

Step 1: Whole-school mental health survey
All members of the school community (learners, parents and school staff) complete a survey to understand their knowledge of their school's approach to mental health and their personal mental health experiences. Alongside this, a designated member of the senior leadership team completes a survey on behalf of the school to understand the school's current approach to mental health.

The results of the surveys are compared in order to understand the school's current strengths, differences in practice and perception, and areas for development.

Step 2: Bespoke action plan
The school is supported to recruit a representative action planning group made up of learners, staff and parent/carer representatives. The group are responsible for reviewing the whole-school mental health survey data and designing an action plan to enhance strengths and address areas for development.

Step 3: Implementation of action plan
Actions can be largely grouped under three categories.

1. School-owned actions, e.g. review of policies and procedures, appointing lead member of SLT/governor for mental health
2. Mind interventions, e.g. mental health awareness training for staff, one-to-one support for learners, peer support for parents/carers
3. Signposting to community assets

Step 4: Monitoring and evaluation
To measure the impact of the whole-school approach to mental health pilot we have a two-level monitoring and evaluation process.

1. Quantitative evaluation of interventions utilising validated measures – to access impact at an intervention level
2. Whole-school mental health survey check in – to access impact at a school level and review areas targeted in the action plan.

Schools are encouraged to continuously review their action plan in relation to the findings of the monitoring and evaluation as well as changing needs within their school.

Impact of the approach
Mind's whole-school approach to mental health has been or is being delivered in 35 schools. Our evaluation of the 17 schools taking part in 2018/19 has shown:

- there are some indications that culture is starting to change, e.g. where **conversations** about **mental health** have been **encouraged**
- there has been **positive change** to learner and staff **mental well-being** and **coping** skills
- the programme has had a **positive impact** on learner and staff **knowledge** about mental health
- the programme has helped pupils and staff to feel more **confident to support others.**

B. The Exchange and Swansea local authority whole-school approach to supporting psychological well-being in primary schools

The Exchange and Swansea local authority have worked collaboratively to establish a whole-school approach to promoting, protecting and developing the psychological well-being of children in primary schools. In recognition that the counselling provision that The Exchange' delivers in secondary schools is not appropriate for primary schools, a considered and well-researched model was created, tried and tested to establish a framework that is both **strategic** (coherent across the whole school and with other mental health providers) and **operational** (providing age-appropriate interventions to respond to the emotional/psychological distress of children). As schools provide the learning opportunities for children's academic and social development, The Exchange' model provides a parallel approach to psychological well-being that complements the natural development of learners through their school years (primary and secondary).

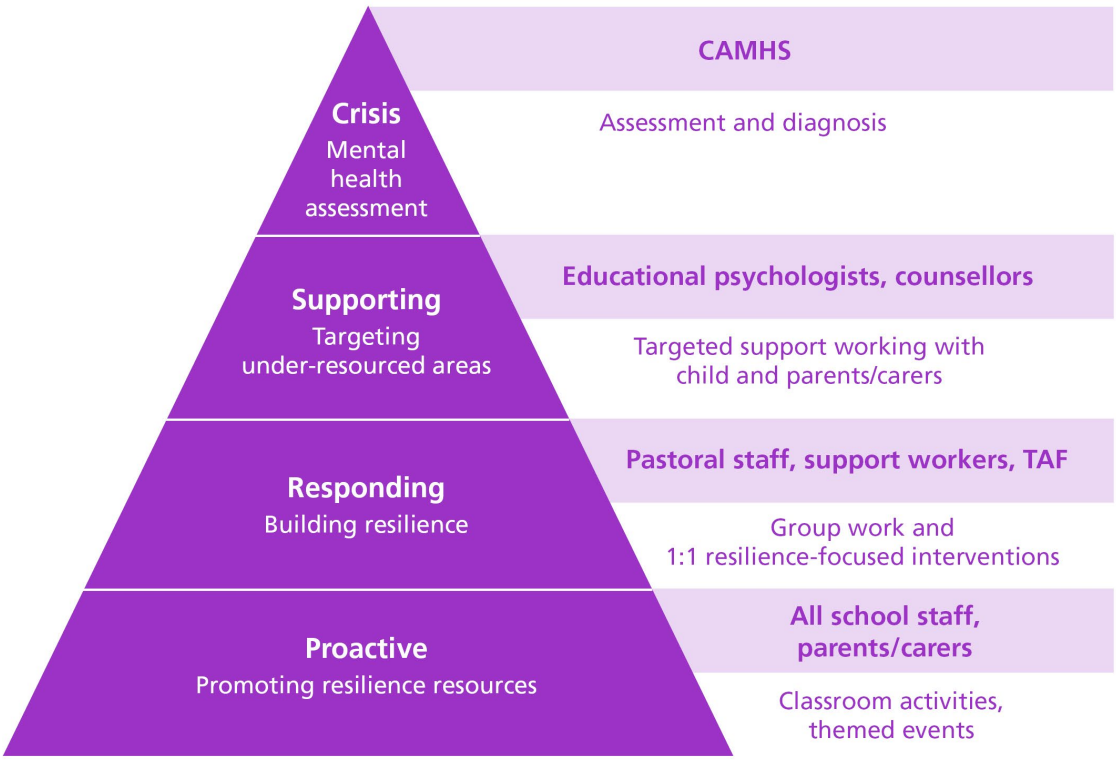
This approach to psychological well-being, based on international research, identifies three distinct, but overlapping, areas of psychological resilience; each of the three areas requires specific resources to grow and develop within the child in order to support resilient emotional and psychological well-being.

- Externally derived resources (relationships and belonging)
- Internally derived resources (identity and becoming 'me')
- Interactively derived resources (self-management and interacting with others)

The development of these resources is a process that begins in childhood and then continues through the full lifespan of the individual. The specific psychological resources for development linked to each of the three areas can be clearly identified and because of this, supportive interventions (both proactive and reactive) can be introduced to target these areas; in this way they are nurtured to grow within the child. When the adults in a child's life appreciate that the psychological difficulties that a child is experiencing are due to being 'under-resourced' in specific areas it allows the adults to support the child appropriately and consider what can be done to nurture the growth of the resources.

The key concepts of this framework are easily accessible because they are explained in straightforward terms: there are the ‘I have’ resources (externally derived) the ‘I am’ resources (internally derived) and the ‘I can’ resources (interactively derived). This makes adopting the framework as a whole-school approach quickly achievable.

Learning how to identify which of the specific areas of resilience are ‘under-resourced’ is the next step and requires a more in-depth approach but is easily learnable by staff in a school. From that point on, the school may apply this knowledge to determine how interventions that already exist in the school (e.g. nurture groups) are now focused on building specific resources within the child. In addition, there are new interventions that school staff can learn to use to target specific areas of resilient well-being in a child or a group of children together. Even ‘hard-to-reach’ children, who require more specialised professional support, will be helped using the same framework concepts and with the same targeted approach of building and nurturing the ‘under-resourced’ areas of their mental well-being.



This was achieved in Swansea through three phases.

Phase 1 – Whole-school training and proactive interventions
Primary school staff and partner services – Team Around the Family (TAF), educational psychology, behavioural support, youth workers – were introduced to the framework. This created a shared understanding of how the resource-based approach aligns itself with the natural psychological development of children. The emergence of a shared language of resilience began to be used to map the existing interventions and school-based activities to the three dimensions of psychological well-being. This opens up new opportunities for **proactive** support in the school. This can be having a ‘Let’s be friends’ campaign across the school or it can be preparing

Year 6 for the transition to secondary school through one of the Exchange Intervention Programmes (e.g. The Big Adventure programme).

Phase 2 – Recognising struggles and Identifying need in terms of being 'under-resourced'

Specific training to key pastoral teams to help staff apply the model where they observe that a learner is having difficulty (i.e. responsively). A core aspect of application of the model is to be able to assess resilience and identify areas of strength and areas that are under-resourced: protective factors and resource-deficits. It is only from this that it is possible to create tailored support plans focused on strengthening areas of resource-deficit. This helped staff to become more focused in building psychological well-being because it provided a model of how to make best use of how current school-based provisions (ELSA, Nurture) support the specific dimensions of resilience and so support could be targeted.

- ✓ This reduced the number of referrals to specialist services
- ✓ The referrals that were made were more appropriate
- ✓ A shared joined-up language improved communication between professionals and aided consultations
- ✓ The right inteverntions were put in place to support under-resourced areas of resilience

Phase 3 – Schools investing in enhancing skill sets for supporting psychological well-being

Key pastoral staff and teachers were provided with training in a variety of intervention programmes designed to support children to build up the resources they need for healthy psychological development. Some themes include self-esteem, friendships, parental separation, transition, self-regulation and bereavement. The programmes improve the confidence of school staff when supporting the emotional and psychological well-being of children. Early intervention became readily accessible through trained staff in each school. This improved sustainability within the context of a whole-school approach.

Annex 2: The strategic and legislative framework

Legislation, strategy and guidance that supports the whole-school approach

The **Equality Act 2010**[63] places a due regard duty on public authorities to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations between those who share a protected characteristic and those who do not.

This may include removing or minimising disadvantage and taking steps to meet the needs of people from protected groups where their needs are different to other people's.

The Welsh Government's **Strategic Equality Plan**[64], reiterates the objective to put the needs, rights and contributions of people with protected characteristics at the heart of the design and delivery of public services.

The **Well-being of Future Generations (Wales) Act 2015**[65] came into force in April 2016 and seeks to improve the social, economic, environmental and cultural well-being of Wales. It makes public bodies think more about:

- the long-term
- work better with people, communities and each other
- look to prevent problems and take a more joined-up approach.

The Act has seven well-being goals, shown in figure 1, creating a vision to (among other things) make Wales healthier, more equal, globally responsible and more resilient.

[63] gov.wales/equality-plan-and-objectives-2020-2024
[64] gov.wales/equality-plan-and-objectives-2020-2024
[65] gov.wales/well-being-future-generations-wales-act-2015-guidance

Figure 1: 7 well-being goals of the Act

The **UNCRC**[66] is the most complete statement of children's rights ever produced and is the most widely ratified international human rights treaty in history. In 2011 Wales became the first country in the UK to make the UNCRC part of its domestic law. Under the UNCRC 'a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.'

Building on the UNCRC, the **Rights of Children and Young Persons (Wales) Measure 2011**[67], was passed at the National Assembly for Wales in January 2011. The Measure strengthened and built on the rights-based approach of the Welsh Government to making policy for children and young people in Wales. It placed a duty on all Welsh Ministers to have due regard to the substantive rights and obligations within the UNCRC and its optional protocols.

Prosperity for all – the national strategy[68] was published in September 2017. It contains the Welsh Government's twelve strategic objectives for 2017–2021 and the steps it proposes to take to meet them. It includes improving mental health as one of its six priority areas for action.

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66 gov.wales/childrens-rights-in-wales
67 www.futuregenerations.wales/about-us/future-generations-act/
68 gov.wales/prosperity-all-national-strategy

Taking Wales Forward (2016–2021)[69] is the Welsh Government's five-year plan to drive improvement in the Welsh economy and public services, delivering a Wales that is prosperous and secure, healthy and active, ambitious and learning, united and connected. It includes a commitment to work with schools, employers and other partners to improve
well-being and promote better emotional health.

Education in Wales: Our national mission[70] published in September 2017 sets out how we intend to improve the school system by developing transformational curriculum and assessment arrangements that place well-being at the heart of education. Enabling objective 3 (Strong and inclusive schools, committed to excellence, equity and well-being) further states our intention to embed emotional well-being, ensuring it has the same status as physical well-being.

Curriculum for Wales Framework[71] **Includes the Curriculum for Wales guidance and curriculum requirements set out in legislation.** One of the four purposes of the new curriculum is to support children and young people to become healthy, confident individuals, building their mental and emotional well-being by developing confidence, resilience and empathy. The four purposes are at the heart of the new curriculum and schools will be required to develop a curriculum that enables learners to make progress towards these. mental and emotional well-being forms one of the statements of what matters in the Health and Well-being Area of Learning and Experience. It is intended that these statements will be mandatory within a school's curriculum.

The Health and Well-being Area of Learning and Experience draws on subjects and themes from mental, physical and emotional well-being. To inform and support the curriculum development process descriptions of learning seek to articulate what it means for learners to progress in understanding and supporting their physical, mental and emotional
well-being. The 'Designing your curriculum' section provides schools and practitioners with further detailed guidance on designing a curriculum to support learners' health and well-being.

The **Welsh Network of Healthy School Schemes**[72] (WNHSS) was launched in 1999 to encourage the development of local healthy school schemes within a national framework. Each local scheme is responsible for supporting the development of health-promoting schools within their area. The WNHSS describes a health-promoting school as one that 'actively promotes, protects and embeds the physical, mental and social health and
well-being of its community through positive action'. This can be achieved through policy, strategic planning, staff development, curriculum, ethos, physical environment and community relations. Within the scheme, there are seven different health topics

[69] gov.wales/taking-wales-forward
[70] gov.wales/our-national-mission-0
[71] hwb.gov.wales/curriculum-for-wales
[72] www.publichealthnetwork.cymru/en/social-determinants/education/welsh-network-of-healthy-school-schemes-wnhss/

that schools need to address, one of which is mental and emotional health and well-being.

Together for Mental Health[73] a strategy for mental health and well-being in Wales (October 2012) sets out our priorities to improve the mental health of the nation and to tackle stigma and discrimination. It places improving the well-being of children and young people at its heart, recognising that by addressing issues early we can ameliorate more serious issues developing later in life.

Social Services and Well-being (Wales) Act 2014[74] brings together local authorities' duties and functions in relation to improving the well-being of people who need care and support, and carers who need support, into a single Act. It provides the statutory framework to deliver the Welsh Government's commitment to focus on well-being, rights and responsibilities.

The Welsh Government has issued ***Connected Communities: A strategy for tackling loneliness and social isolation and building stronger social connections***[75], which recognises the impact that being lonely and/or socially isolated can have on our physical and mental well-being. It also deals with the importance of the relationships we have with friends, family, colleagues and neighbours in giving us our sense of belonging and
well-being.

A Healthier Wales[76] sets out the Welsh Government's plan for a long-term future vision of a 'whole-system approach to health and social care', which is focused on health and
well-being, and on preventing illness.

Children Act 2004[77] builds on and strengthens the framework set out in the Children Act 1989, with provisions that relate directly or indirectly to agencies' responsibilities to safeguard and promote the welfare of children.

Additional Learning Needs and Educational Tribunal (Wales) Act 2018[78] makes provision for a new statutory framework for supporting children and young people with ALN.

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[73] gov.wales/together-mental-health-our-mental-health-strategy
[74] gov.wales/social-services-and-well-being-wales-act-2014-childrens-rights-impact-assessments
[75] gov.wales/loneliness-and-social-isolation-connected-communities
[76] gov.wales/healthier-wales-long-term-plan-health-and-social-care
[77] law.gov.wales/publicservices/social-care/Local-authority-responsibilities/Safeguarding/safeguarding-children/responsibilities-under-children-act-1989-and-children-act-2004/?lang=en#/publicservices/social-care/Local-authority-responsibilities/Safeguarding/safeguarding-children/responsibilities-under-children-act-1989-and-children-act-2004/?tab=overview&lang=en
[78] gov.wales/additional-learning-needs-and-education-tribunal-wales-act

Youth Work Strategy for Wales[79] and ***Implementation of the Youth Work Strategy for Wales***[80] sets out an ambitious programme of collaborative action intended to both improve youth work provision and our offer to young people.

Mind over matter[81] is a report by the Children, Young People and Education Committee of the National Assembly for Wales on the step change needed in emotional and mental health support for children and young people. The report made a number of recommendations, including several relating to the provision of support in education and on the development of the whole-school approach.

The approach also fits with the **Children's Commissioner's five Principles for a Children's Rights Approach**[82] as follows.

1. Embedding – Through this guidance schools and public services are encouraged to link their policies and services to children's rights under the UNCRC. All activities within a whole-school approach play a part in enabling children and young people to experience and take up their human rights.
2. Equality and non-discrimination – This guidance enables schools to combat discrimination and stigma through universal and targeted provision and the requirement to pay attention to specific issues.
3. Empowerment – through learning about mental health and well-being and experiencing an environment where they are supported, learners experience greater opportunities to support their own health and those of others.
4. Participation – this guidance encourages learners to be involved in developing, delivering and evaluating the whole-school approach through coproduction principles.
5. Accountability – the guidance expects a transparent governance structure to the whole-school approach and accountability to learners.

Welsh Language Standards – The Welsh Language Wales Measure 2011[83] provides that the Welsh Ministers can specify five types of standards in regulations: service delivery standards, policy-making standards, operational standards, promotion standards, and record-keeping standards. Although it is the Welsh Ministers that specify the standards, it is for the Welsh Language Commissioner to decide which standards a body has to comply with.

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[79] gov.wales/youth-work-strategy-2019
[80] gov.wales/implementation-youth-work-strategy
[81] https://business.senedd.wales/mgIssueHistoryHome.aspx?IId=25377
[82] www.childcomwales.org.uk/resources/childrens-rights-approach/childrens-rights-approach-education-wales/
[83] law.gov.wales/culture/welsh-language/standards/?lang=en#/culture/welsh-language/standards/?tab=overview&lang=en

No Wrong Door: bringing services together to meet children's needs

Comisiynydd Plant Cymru
Children's Commissioner for Wales

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The context of this report – June 2020

This report was due to be published on 19th March 2020. However, as we prepared to launch the report, the global Coronavirus pandemic gathered pace and cases in Wales began to increase substantially. It became clear that publishing this report, and the recommendations it contains for the Welsh Government and our health and social care services, would not be appropriate at this time of national emergency.

As the nation slowly and carefully begins to plan its recovery from the pandemic, it seems more important than ever to ensure that our services are working closely together to respond to the needs of local populations. We have therefore revisited this report and decided to publish it at this time. A simple, smooth, 'no wrong door' pathway to support for those who require it is what we would all want to see for our children and their families. It is also a more efficient and effective way to run our public services. We have, nonetheless, made some alterations to some of our original recommendations to reflect the current context.

We are mindful that, as we enter a phase beyond that first emergency response to the pandemic, the landscape of health and social care in Wales will have changed significantly. While of course this means strains upon some resources, and difficult budgetary decisions, we have hope that it also means we have an opportunity to build some of the learning from this crisis into our services, and that the chance to rethink how we deliver our public services provides the opportunity to establish a Wales-wide 'no wrong door' approach to children and young people's mental health and wellbeing. The mental health and social care of our most vulnerable children and young people must be a clear priority going forward. We require a wraparound response to meet their care needs.

There have been new developments during this pandemic that we would want to see continue. Particularly, we were pleased to see the rollout of direct phone support from CAMHS professionals for parents in some local health board areas. We were also pleased to see the rollout of the national 24-hour phone and text listening and advice phone line – the CALL helpline. These initiatives demonstrate that rapid change is possible and that some of the hoops we have made families jump through in the past before speaking to someone to get immediate reassurance or advice were probably unnecessary and may have cost public services more money too.

The messages and recommendations of this report are more vital now than ever, and the current crisis has shone a light on some of the underlying issues, such as a lack of suitable residential provision for children with complex needs, for example.

All fieldwork undertaken for this project took place before the 'lockdown' measures which began to be implemented in mid-March 2020.

Mental Health, Wellbeing and Care during and after this crisis

At the time of writing, it isn't easy to say exactly how children and young people's mental health and wellbeing will have been affected by this crisis. What we do know is that all children and young people's lives have been affected in some way by the coronavirus pandemic – many will have seen changes to their ability to access their human rights under the United Nations Convention on the Rights of the Child

(UNCRC), such as the right to relax and play (article 31) and the right to an adequate standard of living which meets their physical and social needs (article 27). I am also concerned that some children may have been denied the right to the best possible healthcare (article 24); or been less well protected from violence, abuse and neglect (article 28) during this time.

In May 2020, we asked over 23,700 children and young people in Wales[1] about their thoughts and feelings during this pandemic. One of the key findings was that while 83% of children and young people were confident that if they needed it they could get help for their emotional or mental health from friends or family, 52-53% were confident they could get help from a website or on social media, teachers or other school staff, or their doctor. 43% said they would feel confident getting help from a mental health team in their area, and 39% said they would feel confident getting help from school counselling. We want children and young people to feel confident that *whoever* they go to for help should be able to either provide support directly, or to point them in the right direction of support.

The support and care children need may have been restricted at this time, or the ordinary avenues by which children and young people and their families access this support have not been available, such as through schools, or through routine GP appointments, for example. The Commissioner has raised these concerns in written evidence to the Senedd's Health, Social Care and Sport Committee's inquiry into the impact of the Covid-19 outbreak on health and social care in Wales[2]. As we consider how our society looks and feels over the coming months and years, the safety, care and support of our most vulnerable children and young people must be at the forefront of our plans.

Our health and social services have responded in heroic fashion to this crisis. However, the issues highlighted by this report have not gone away, and our regional partnerships must accelerate their work to better integrate wraparound health and social care support for our children.

[1] Children's Commissioner for Wales (2020) *Coronavirus and Me*. Available at: https://www.childcomwales.org.uk/coronavirus-and-me-results/

[2] Children's Commissioner for Wales (2020) *Inquiry Response: Health, Social Care and Sport Committee inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales.* Available at: https://business.senedd.wales/mgConsultationDisplay.aspx?id=391&RPID=1520629561&cp=yes

Foreword by Sally Holland Children's Commissioner for Wales

Sally Holland, Children's Commissioner for Wales

Too often, I hear of situations where health, social care and other professionals are (sometimes literally) arguing over the heads of children and young people with complex needs; when they cannot agree who is responsible for their care. In some cases this has led to Welsh Government Ministers being called to court over these stalemates between services, as was recently highlighted in the media[3].

We are all responsible for the care of children in Wales. As one participant in this project put it, simply: "we should want what good parents want for their children".

As part of this project, I have visited every Regional Partnership Board in Wales, whose job it is to bring services (primarily health and social care) together regionally to serve the needs of their local population. Two of the seven Boards told me that the discussion as a result of my visit was the longest conversation their Board has ever had around children's issues. I am glad to hear that this project has got the Boards talking about children and young people, but I was concerned to hear that these conversations were not already happening.

All Boards I visited were transparent about the fact that adult services, particularly older adult services, had been their focus until recently. Of course, the adult and particularly older adult population is very much in need of integrated services in their region and it is not my intention to pitch one generation against the other with this report. Yet, as Children's Commissioner, it is my duty to highlight children and young people's needs. This is not to say that all Boards haven't progressed with integrating services for children and young people too, but it is fair to say that significantly more resource has been focused on the integration of adult services.

The examples used in this report are designed to share practice and to encourage regions to consider the work of others. However, while these examples are encouraging, all Boards would say themselves that they are not yet in the position they would like to be. Additionally, it is important to say that what works in one region may not work in another – the purpose is not to tell regions how they should be doing things, but to highlight practice examples in the hope that they might learn from each other, to provide reassurance that many of the regions face the same challenges, and to encourage Boards to continue the good work that they are doing.

[3] BBC News (2020) *Judge highlights secure bed shortage for young in Wales.* Available at: https://www.bbc.co.uk/news/uk-wales-51332798

I have been pressing Welsh Government, the NHS, health and social care commissioners, local authorities, and many others, on the need for what I call a 'no wrong door' approach for children with complex needs. A 'no wrong door' approach means that whatever the reasons for a child being in distress, when they ask for help, they should not be told they have come to the wrong place, or feel like they have knocked on the 'wrong door'.

I would like to thank the members of the National Youth Stakeholder Group for Emotional Wellbeing and Mental Health (NYSG), who helped us establish our approach to this project. When discussing the 'no wrong door' concept, the group asked me to ask all of the Boards: 'what does the right door look like?', and I have made sure that I ask every board that question. Most of them struggled to answer this question as well as I would like the first time, but I was pleased that most regions do want to move towards a 'no wrong door' approach. I want to now know how they will make it happen.

I have tried to stay true to the advice given to me by the young people from the National Youth Stakeholder Group – one member of the Group told me to "pressure the Boards and be as brutal as needed". I feel that I have been when I've needed to be!

I would like to put on record my sincere thanks to the Chairs, members and supporting staff of the Regional Partnership Boards for accommodating me and my team. All regions were welcoming, helpful and generous with their time. I would also like to thank the professionals from across different sectors working with children and young people with complex needs, and third sector representatives, who provided their insight for this project.

Sally Holland

Key Messages

- The global pandemic has laid bare how stretched mental health and social care is for our most vulnerable children and young people. Our health and care services are predicted to see a significant increase in need over the coming months, and a regional, coordinated, response will be required to ensure that our support offer is sufficient to meet this demand.
- In most areas of Wales, children and young people experiencing distress with mental health, emotional wellbeing and behavioural issues are waiting too long to get the help they need, and are being 'bounced' between services who cannot agree who is responsible for their care. We want to see services wrap around children and young people and their families, not for them to have to navigate complicated systems. We should respond on the basis of need, not just diagnoses.
- Regions need to move rapidly towards a 'no wrong door' approach in responding to children and young people's emotional wellbeing and mental health needs. This means that they should not keep being told that they are knocking on the wrong door when trying to access help. This could include panel or hub models to provide timely joined-up help, drop-in centres, multi-disciplinary teams, models to make sure fewer children and young people need to go away from home to receive specialist care, or plans for specialist residential care closer to home.
- We are particularly encouraged by the Gwent region's SPACE-Wellbeing early help panels that are the most advanced example we have found of a timely, 'no wrong door' approach to supporting families where children are experiencing mental or emotional health issues or behavioural difficulties. There are also other good examples across Wales where regions are starting to pull services together to help children with complex needs. Regions need to do more to learn from each other where good practice examples exist, and to be more ambitious in aiming for a 'no wrong door' experience right across their regions.
- Children and young people with learning disabilities still too often face a complicated and stressful experience as they move from children's to adult's services. There are promising signs in some regions, but we have not seen the change 'on the ground' that we would like, and encourage all regions to re-visit their plans for this vulnerable group.
- We are encouraged that all regions now have specific multi-agency groups to consider the needs of children and young people, although some of these are very new. We want regions to go further and invite children and young people to be active participants in the Board's work. It will be up to each Board how they involve children and young people, but however they do this it should be informed by active engagement with children and young people in their region.
- There have been recent welcome changes to Welsh Government policy, such as earmarking significant funding specifically for children with complex needs, strengthening the duty on regions for children's participation in their work, and the publishing of a broader definition of children with complex needs so that regions should be working towards providing integrated services for all

children in distress. However, Welsh Government needs to do more to support regions in achieving 'transformation' of services for children and young people with complex needs, for example by working with regions to share learning and support projects, and providing longer term financial support beyond 'kick-starter' funding.

- Regions need to work with children and young people, their families, and the adults that care for them to re-shape the way services work. This includes being more accessible and transparent about the work they do, both in terms of face-to-face working with children and young people and their families, and in ensuring their online presence is up-to-date and accessible.
- Funding and resources need to be seen as 'whole-region', not just as the property of local authorities or the local health board.
- The Commissioner, accompanied by young people, will be meeting with every Regional Partnership Board again in 2021-22 to review progress against her recommendations.

What are Regional Partnership Boards?

"Listening to young people is the most important thing to remember"

NYSG Member

Regional Partnership Boards (RPBs) were set up in 2016 with the purpose of bringing together local authorities, local health boards and the third sector to address the health and social care needs of their populations. The Boards include representatives such as elected members of local authorities, the local health board, local social services representatives, local health representatives, third sector representatives, care providers and several others.

There are seven RPBs in Wales, which share the footprint of every local health board in Wales, and includes the local authorities within that health board area. There seven RPBs are:

- Gwent Regional Partnership Board
- North Wales Regional Partnership Board
- Cardiff and Vale Regional Partnership Board
- West Glamorgan Regional Partnership Board
- Cwm Taf Morgannwg Regional Partnership Board
- West Wales Regional Partnership Board
- Powys Regional Partnership Board

The RPBs are required by law to prioritise the integration of services for children with complex needs.

A fuller explanation of the policy context around RPBs is contained in the 'Policy Context' section of this report on page 22.

Introduction – *No Wrong Door*

This report is about how children and their families who seek support for a range of needs often find that they have to navigate a very complex system, may fall through gaps where there are no services to meet their needs, or be on a waiting list for a long time only to be told that they were waiting in the wrong queue, or have been knocking on the wrong door all along. The Commissioner and her team believe that services should wrap around families, rather than them having to fit into what is out there, and that help should be provided as early as possible to prevent more serious problems developing.

The Regional Partnership Boards provide an opportunity for services across a region to plan together a much better experience for children and their families when they need additional help.

This report focuses on two specific groups of children and young people: those with complex emotional wellbeing or mental health needs who may have other significant needs too; and transitions to adult services for young people with learning disabilities.

Regarding emotional wellbeing and mental health, the Commissioner's Investigations and Advice team regularly hear from children and their families of situations which demonstrate the lack of integrated services for children with complex needs. Children, families and professionals who work with them across services regularly tell us that children are being 'bounced around the system'; that they approach professionals for help and are told they have a long wait for support and when they are seen they told they aren't the right people to help and are sent elsewhere. In extreme cases this results in children and young people being 'held' in limbo between services, sometimes on beds in adult wards or on paediatric wards where they may be a danger to themselves and other children, under the constant watch of multiple professionals to try to keep them safe, or in inappropriate provision which doesn't meet their needs and risks traumatising them further.

Receiving a particular diagnosis can be a huge relief for families, and can often mean access to the necessary care and support. However, it can also narrow the offer of provision that a child needs as they now 'sit with' health, or social care. We need a truly child-centred approach, where the needs and circumstances of that child are responded to with a holistic, multi-agency, wraparound approach, regardless of whether or not there is a formal diagnosis.

In relation to the experiences of young people with learning disabilities as they approach transition to adult services, this work was influenced by the issues highlighted by the Commissioner's 2018 report, *Don't Hold*

Back[4]. Young people and their families told us that they were not involved enough in their own care, that there are different thresholds across services, and that every service has a different way of managing the transition from child to adult services.

This report is not meant to be an exhaustive analysis of the work of Regional Partnership Boards (henceforth RPBs), but instead wishes to highlight practice across Wales that may assist other regions, share challenges and barriers, and make a set of recommendations to improve the regional integration of services, and most importantly the experiences of children and young people with complex needs. The practice examples given in this report do not reflect all the work of all RPBs in relation to children with complex needs, and equally some regions will be undertaking similar work to those practice examples identified in other regions.

Throughout this report, we will be referring to the terms learning disability, neurodevelopmental disorders/services, and 'behaviours that challenge'/'behavioural issues'. An explanation of our understanding and use of these terms is contained in a glossary in appendix 1.

[4] Children's Commissioner for Wales (2018) *Don't Hold Back – Transitions to Adulthood for Young People with Learning Disabilities.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Dont-Hold-Back.pdf

Real Life Experiences

When we asked young people what regions should be doing for children and young people, one response was to "talk about case studies not statistics". Here are some recent real life examples that have come to the attention of the Commissioner's Investigations and Advice team ahead of the original publication date in March 2020:

- A child who has experienced complex trauma and attended A&E multiple times following suicide attempts. Due to the severity of violence towards their parents, police were called out to the property most nights of the week, attending for several hours each time. The child was receiving support from their local social care department, but no therapeutic support. The family were told that Child and Adolescent Mental Health Services (henceforth CAMHS) are unable to help.

- A family believed their child needed a secure placement, as they were a danger to themselves. We were told that social services were trying to source alternative placements and had approached dozens of residential facilities, none of which could accommodate the child. We were told the reasons given were because they did not meet their criteria. The child remained at a mental health in-patient unit, even though professionals agreed it was not an appropriate placement. The child then spent months on a paediatric ward, which was not a suitable setting for their needs.

- A child with a learning disability whose home environment was no longer safe for them to stay at. The child has been placed at several different locations across Wales as services have struggled to deal with the child's behaviours. At one of these placements there were no therapeutic interventions available and as the child was much younger than others at the placement, the older children bullied them, causing further trauma.

- A child with a life limiting condition and related significant healthcare needs had been receiving health care in one local authority, and then changed foster placement to another health board area. The two health boards involved were now disputing who has the responsibility for the health needs of this young person as they had reached the age of 18 over the course of the move.

- A child was kept in a mental health facility for weeks despite having no mental health diagnosis as there was no alternative provision.

- A child had attempted suicide three times in three weeks. Their parents felt that they would not be able to keep the child safe at home but felt no one listened to their requests. Eventually the child was discharged, without appropriate follow up.

- A child displaying behaviours and difficulties which suggest dyslexia and dyspraxia who has not been in school for over four months due to social and school anxiety issues. They were referred to CAMHS, who said that the young person did not meet the criteria for further support. CAMHS stated that the young person may have Autistic Spectrum Disorder (ASD) traits. The child's school

completed a referral to the neurodevelopmental team. In the meantime, the concerning anxiety behaviours got worse and the family were extremely worried. The local education service has identified an EOTAS provision that would help the child study for their school exams but this cannot be actioned unless the child is actively receiving mental health support through CAMHS. The family asked the GP to re-refer the young person to CAMHS. The child has recently been seen by primary care CAMHS and offered therapeutic support to help with their anxiety. The child is still not in school.

- A child had taken an overdose which resulted in them being admitted to hospital. Since being discharged from hospital, we were told that the child received no support, despite the family being told that the child would be able to access support in the community. The family called the local CAMHS service and were told the child is on the waiting list for an appointment with CAMHS but they were unable to provide a date. The child was also on a waiting list for their school counsellor. The social services department told the family that it is CAMHS' responsibility to support the child and as a result they did not offer any support.

- A child had been detained under the Mental Health Act and was taken by police to A&E. The child had not been diagnosed with a mental disorder. The child was placed at the hospital on an adult ward and supervised by two agency staff from the mental health unit they had previously been at. The child was unable to return to the unit as they were unable to manage the young person's behaviour. The child was moved to another hospital, again on an adult ward but this time segregated from the rest of the ward. A multi-agency meeting was arranged to agree next steps. The meeting was attended by 16 professionals, including one from the child's local CAMHS, the relevant social services department, and one of their lawyers. The meeting was chaired by the Clinical Director for CAMHS in the child's health board. Social Services maintained that they were not able to provide the child with any form of secure accommodation as the young person was about to turn 17, and not subject to a Care Order.

These examples are illustrative of many more such cases we have heard about. When we presented some of these examples to the RPBs, every one told us that they recognised these sort of situations.

As well as disagreements between health and social services departments, professionals working with these young people have also told us of standoffs between education and health with, for example, local education authorities saying that young person's learning needs are down to underlying health problems and it should therefore be entirely down to health to fund.

For those children whose needs are such that they require secure residential provision, many are placed far away from their families and friends in places across England like Stoke, Northamptonshire or Birmingham, and in one case as far as Glasgow in Scotland, as there are not suitable placements for them here in Wales.

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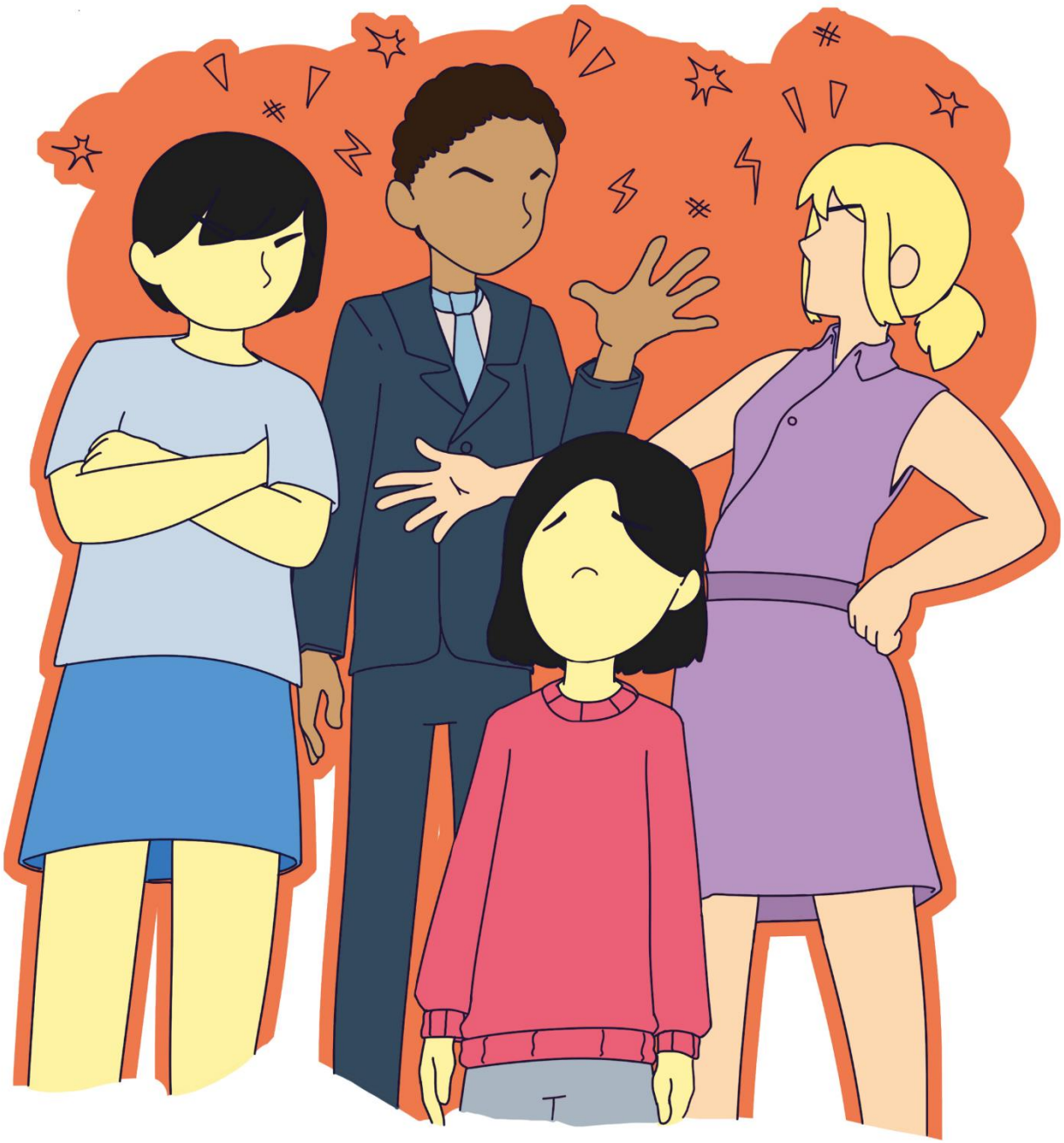

‘I hear of situations where health, social care and other professionals are (sometimes literally) arguing over the heads of children and young people with complex needs’

In response to some of these issues, the Commissioner has previously made the following recommendations to Welsh Government.

Annual Report 2017-18 recommendations[5]

- I recommend that Welsh Government takes action to require Regional Partnership Boards (RPBs) to set up specific multi-agency planning structures for children and young people that will report to the RPB. They should also require RPBs to take steps to integrate children's social care and mental health services into multi-disciplinary teams, that will respond to the needs of their local populations of children and young people who require emotional, behavioural or mental health support and treatment.

The Welsh Government accepted this recommendation[6] 'in principle', but would not commit to requiring RPBs to set up these structures at the time.

- I recommend that Welsh Government takes concrete steps towards commissioning new provision that can meet the care and mental health needs of the small number of young people with very challenging behavioural and emotional difficulties, for whom there is currently very little suitable residential provision in Wales.

The Welsh Government accepted this recommendation, but did not set out any "concrete steps" as we had recommended.

Annual Report 2018-19 recommendations[7]

- Welsh Government should ensure new ring-fenced funding specifically for the purposes of jointly commissioned mental health and social care residential provision for the small number of children and young people with the most complex needs in Wales.

The Welsh Government accepted this recommendation[8] 'in principle', saying that work was underway to develop solutions for joint commissioning arrangements, subject to funding implications.

- Welsh Government should also act to ensure that the existing mental health in-patient units in Wales make changes necessary to extend the range of young people who can be safely cared for there.

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[5] Children's Commissioner for Wales (2018) *Annual Report and Accounts 2017-18.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2018/09/Annual-Report-2017-18.pdf

[6] Welsh Government (2018) *The Welsh Government Response to the Annual Report of the Children's Commissioner for Wales 2017-18.* Available at: https://gov.wales/sites/default/files/publications/2019-10/the-welsh-government-response-to-the-annual-report-of-the-childrens-commissioner-for-wales-201718.pdf

[7] Children's Commissioner for Wales (2019) *Annual Report and Accounts 2018-19.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Annual-Report-2018-19.pdf

[8] Welsh Government (2019) *The Welsh Government Response to the Annual Report of the Children's Commissioner for Wales 2018-19.* Available at: https://gov.wales/sites/default/files/publications/2019-12/response-to-the-annual-report-of-the-childrens-commissioner-for-wales-2018-2019.pdf

The Welsh Government accepted this recommendation, saying that work was already underway to extend this provision where admission criteria has previously been tightened, and new service specifications for in-patient units were being consulted on.

- Welsh Government should take action to develop secure mental health provision in Wales for the very small number of children who require this care.

The Welsh Government accepted this recommendation, saying that 'work is underway to understand the nature and type of provision required and options for delivery to best meet the young people's needs'.

Don't Hold Back recommendation[9]

- The Welsh Government should ensure that Regional Partnership Boards are making substantial and effective progress on the integration of services for people with learning disabilities, children with complex needs and transition services as required by the Social Services and Well-being (Wales) Act 2014: Part 9 Statutory Guidance (Partnership Arrangements).

The Welsh Government promised to consider the *Don't Hold Back* report in the work of the Ministerial Advisory Group which supports the delivery of the recommendations of the *Improving Lives* report.[10]

[9] Children's Commissioner for Wales (2018) *Don't Hold Back – Transitions to Adulthood for Young People with Learning Disabilities.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Dont-Hold-Back.pdf
[10] Welsh Government (2018) *Learning Disability Improving Lives Programme.* Available at: https://gov.wales/sites/default/files/publications/2019-03/learning-disability-improving-lives-programme-june-2018.pdf

What is this project all about?

"Help should come to you; you don't keep coming to them"

NYSG Member

"Ask once - you should never be turned away"

NYSG Member

This project has at times been complicated to explain to people, largely because the work of RPBs is not widely known about, but also because integrating services does not always result in something straightforwardly tangible – although we believe it can be with improved transparency and accountability.

With the National Youth Stakeholder Group for Emotional Wellbeing and Mental Health - 7 March 2020 (Courtesy of T4CYP)

In an attempt to ensure clarity relating to our project outcomes, in July 2019 we asked young people from the National Youth Stakeholder Group for Emotional Wellbeing and Mental Health what they thought was important for us to focus on for our project.

These are some of the things they told us.

What is the project trying to achieve?

"It is about supporting children and young people's mental health and other needs too"

"Make sure children and young people who need it get the right treatment before it's too late"

"You should be able to go to them and they help you. You shouldn't be sent away to find all the different services yourself"

"Getting people like teachers, social workers, health specialists to work better together"

How would you describe the project in a few words?

"Young people shouldn't have to run a mile for help"

"Un-complicating things"

"Stand together for children and young people"

"Improving lives for children and young people"

"National problems, local solutions"

"Finding the services that fit with you"

What should RPBs do to better serve children and young people?

"The emotional well-being team and CAMHS need to stop throwing people out because they have other issues or needs"

Unite to un-complicate'

NYSG Member

"Involve young people in your meetings as we want to offer our ideas or our support"

"They need to get rid of the attitude of people being 'too bad' / 'too complex' or 'not bad enough'"

"They need to consider children who have mental health and other needs like autism and learning disabilities"

"Making services about prevention - intervene before the chid is critical"

"Start helping children before it gets too complicated and severe"

"Help and information for children's families"

"More in place for children who need to go to hospital because of mental health issues"

"Other places for children who need to go to hospital as it's really scary at the moment or they can't get the help they need as they aren't old enough"

"Recognise rights of children and young people under the UNCRC"

"Young people should be at the centre of all support services and there should be no barriers in place to prevent young people from receiving the support that they need and deserve"

"Listening to young people is the most important thing to remember"

"Have a young person to represent the regions and health boards along with 'fancy' people"

"Don't beat around the bush. Talk about what's going on in minds of teens who suffer from mental health issues"

"Talk about case studies not statistics"

"Services need to communicate with each other – it should be mandatory"

"Important to be clear, transparent and simple"

"Children are suffering and every single individual MUST have way access to support, regardless of circumstances (disabilities, non-supportive families)"

Children's Human Rights under the United Nations Convention on the Rights of the Child (UNCRC)

We asked the young people which of Children's Human Rights under the United Nations Convention were most relevant to this project, and they said:

Mapping the work of Regional Partnership Boards with the National Youth Stakeholder Group - 7 March 2020 (Courtesy of T4CYP)

- Articles 1 and 2: every child has the same rights, and every child should enjoy every right all the time no matter who or where they are
- Article 3: adults must act in the best interests of children
- Article 4: government should help children because they have to, not just because they want to; and because they want to, not just because they have to
- Article 9: a child's human rights should be respected when a child is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests
- Article 12: a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them, the views of the child being given due weight in accordance with the age and maturity of the child
- Article 13: children have the right to access and impart information
- Article 16: the right to privacy
- Article 19: protection from being hurt, badly treated or neglected
- Article 20: a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State
- Article 23: a child has the right to special care and support if they have a disability or mental health issue
- Article 24: a child has the right to the best possible level of health care and to facilities for the treatment of illness
- Article 25: a child has the right to regular reviews of their care if they have been placed in a facility for the purposes of care, protection or treatment

- Article 27: a child has the right to an adequate standard of living for their physical, mental, spiritual, moral and social development
- Article 37: a child has a right not to be deprived of liberty unlawfully or arbitrarily, and if they are deprived of their liberty legally they should be treated with humanity and respect for dignity
- Article 39: a child has the right to physical and psychological recovery and social reintegration if they have been affected by neglect, exploitation, abuse, inhumane or degrading treatment or punishment
- Article 42: government must let children know about their rights

We visited the National Youth Stakeholder Group again in March 2020, before publishing our report, to let them know what we had found, and to give them an opportunity to influence the report further. Their contribution in that session was also extremely helpful, with their key message being that for RPBs to work for children and young people, they need to listen to and actively involve children and young people.

Duty to have due regard to the UNCRC

Unfortunately, we know of cases where several of the above human rights have not been experienced by children and young people because services are not joined up enough to support them.

As RPBs are specifically responsible for the plans that implement the response to the Population Needs Assessment, which is a requirement of Section 14 of the Act (paragraph 16 of the Part 9 statutory guidance), RPBs and their component agency members are exercising functions of the Act. We have therefore concluded that RPBs must have due regard to the UNCRC (under the section 164 duty to cooperate and provide information in the exercise of social services functions).

We are pleased to see that Welsh Government recognises this duty in their recently revised Part 9 statutory guidance, and we expect all RPBs to explore how they can now actively respond to this duty through their responsibility to children with complex needs.

What does the Right Door look like?

Policy Context

Regional Partnership Boards

Regional Partnership Boards came into being through the Social Services and Well-being (Wales) Act 2014[11], under the Part 9 partnership arrangements of that Act. They began their work in 2016.

There are seven RPBs in Wales.

While each RPB shares a footprint with their local health board, there is variance between the RPBs in terms of the number of local authorities, and other strategic partnerships (such as Public Services Boards), that are contained within their borders.

The current composition of partnership bodies under each RPB is as follows:

- Gwent Regional Partnership Board - Aneurin Bevan University Health Board and Monmouthshire County Council, Newport City Council, Caerphilly County Borough Council, Torfaen County Borough Council and Blaenau Gwent County Borough Council.
- North Wales Regional Partnership Board - Betsi Cadwaladr University Health Board and Flintshire County Council, Wrexham County Borough Council, Isle of Anglesey County Council, Gwynedd County Council, Denbighshire County Council and Conwy County Borough Council.
- Cardiff and Vale Regional Partnership Board - Cardiff and Vale University Health Board and Cardiff City and County Council and the Vale of Glamorgan Council.
- West Glamorgan Regional Partnership Board – Swansea Bay University Health Board and Swansea City and County Council and Neath Port Talbot County Borough Council.
- Cwm Taf Morgannwg Regional Partnership Board - Cwm Taf University Health Board and Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council and Bridgend County Borough Council.
- West Wales Regional Partnership Board - Hywel Dda University Health Board and Pembrokeshire County Council, Carmarthenshire County Council and Ceredigion County Council.
- Powys Regional Partnership Board - Powys Teaching Health Board and Powys County Council.

It is important to note here that the Cwm Taf Morgannwg RPB, consisting of Merthyr Tydfil, Rhondda Cynon Taf and Bridgend local authority areas has only existed since April 2019. Previously, Bridgend fell under the previous Western Bay, now West Glamorgan, region.

[11] National Assembly for Wales (2014) *Social Services and Well-being (Wales) Act 2014.* Available at: http://www.legislation.gov.uk/anaw/2014/4/contents

What do Regional Partnership Boards do?

The Welsh Government's stated purpose of requiring local authorities and health boards to establish Regional Partnership Boards is:

> *to manage and develop services to secure strategic planning and partnership working between local authorities and local health boards and to ensure effective services, care and support are in place to best meet the needs of their respective population.*[12]

Regional Partnership Boards are required to prioritise the integration of services in relation to:

- *Older people with complex needs and long term conditions, including dementia*
- *People with learning disabilities*
- *Children with complex needs*
- *Carers, including young carers*
- *Integrated Family Support Services*

In relation specifically to children with complex needs, the (recently revised) Part 9 statutory guidance[13] states that there should be a focus on both preventative services for children and families, and care and support services for those children and young people that require it. Firstly, integrating services, care and support to create opportunities for prevention and early intervention, including the promotion of good emotional health and wellbeing. The aim being to provide support for families to prevent the child becoming looked after, or enter custody. Secondly, there should be an integrated approach to delivering services for children with complex needs who require them, including transition arrangements from children's to adult services.

The importance of the role of RPBs for the future of health and social care services has been recognised by the Welsh Government's 10 year plan for health and social services: *A Healthier Wales*[14]. In that plan, the Welsh Government has stated that it wishes to achieve 'seamless local health and social care' by 2028:

> *Regional Partnership Boards, which bring together local authorities, health boards and third sector providers, will occupy a strong oversight and coordinating role. Regional partnership working will be at the heart of how we will develop high value models of integrated health and social care, which will be promoted for wider adoption across Wales.*

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[12] Welsh Government (2015) *Social Services and Well-being (Wales) Act 2014 Part 9 Statutory Guidance (Partnership Arrangements).* Available at: https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

[13] Welsh Government (2015) *Social Services and Well-being (Wales) Act 2014 Part 9 Statutory Guidance (Partnership Arrangements).* Available at: https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

[14] Welsh Government (2018) *A Healthier Wales: Our Plan for Health and Social Care.* Available at: https://gov.wales/healthier-wales-long-term-plan-health-and-social-care

The importance of Regional Partnerships for children and young people with complex needs has also been recognised by the recently refreshed improvement programme for children and young people's mental health, the Together for Children and Young People Programme (2), which has dedicated one of its three work streams to working with RPBs to adopt an 'early help and enhanced support framework'[15].

Funding available to RPBs

Two of the largest pots of money available to RPBs to take forward the Welsh Government's *A Healthier Wales* ambitions have been the Transformation Fund and the Integrated Care Fund (ICF).

The Transformation Fund was launched in 2018 and provided up to £100 million of funding over 2 financial years (2018-19 and 2019-20) for RPBs to apply for. The Fund is designed to encourage innovation which in turn leads to transformation of services within regions:

> *In particular the Fund is designed to quickly validate the 'scalability' of new models (their ability to expand from a locality to a region, or from a region to other regions) and to test whether they are 'transformative' (affordable and sustainable, changing or replacing existing approaches rather than adding an extra layer on to them).*[16]

The Health Minister announced earlier in 2020 that the Fund would end in 2021, with £11 million remaining for RPBs to bid for over 2020-21[17]. However, it has since been announced in the Welsh Government's Supplementary Budget of May 2020 that this £11 million will no longer be available as this funding has been repurposed 'in order to directly support actions for the response to the COVID-19 pandemic'[18].

The Integrated Care Fund (ICF) was launched in 2014-15. Whilst initially focusing on supporting older people, particularly around avoiding unnecessary of inappropriate admissions to hospital or residential care, in 2016-17, 'children and adults with complex needs', 'children and adults with learning disabilities' and the Integrated Autism Service were brought within the scope of the fund[19]. In 2018-19[20] and again in 2019-20[21], an additional £15 million was made available through the ICF for children at risk of being looked after, in care, or adopted.

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[15] National Assembly for Wales (2019) *Letter from the Minister for Health and Social Services, Welsh Government, to the Chair of the Children, Young People and Education Committee, dated 9th December.* Available at: http://www.senedd.assembly.wales/documents/s96729/Letter%20from%20the%20Minister%20for%20Health%20and%20Social%20Servcies%20-%20T4CYP%20-%209%20December%202019.pdf

[16] Welsh Government (2019) *Welsh Government Transformation Fund 2018-20 – Guidance.* Available at: https://gov.wales/sites/default/files/publications/2020-01/transformation-fund-2018-21-guidance.pdf

[17] National Assembly for Wales (2020) *Health, Social Care and Sport Committee – Welsh Government Draft Budget 2020-21.* Available at: https://www.assembly.wales/laid%20documents/cr-ld12995/cr-ld12995%20-e.pdf

[18] Welsh Government (2020) *Supplementary Budget 2020-21 – Explanatory Note.* available at: https://gov.wales/sites/default/files/publications/2020-05/1st-supplementary-budget-2020-2021-note.pdf

[19] Wales Audit Office (2019) *Integrated Care Fund.* Available at: https://www.audit.wales/system/files/publications/integrated-care-fund-report-eng.pdf

[20] Wales Audit Office (2019) *Integrated Care Fund.* Available at: https://www.audit.wales/system/files/publications/integrated-care-fund-report-eng.pdf

[21] National Assembly for Wales (2020) *Children, Young people and Education Committee – Scrutiny of the Welsh Government Draft Budget 2020-21.* Available at: https://www.assembly.wales/laid%20documents/cr-ld12993/cr-ld12993%20-e.pdf

In the most recent available data (2018-19), just 8.6% (£4,823,854) of actual spend from ICF allocations was spent on children with complex needs; with 8.1% (£4,535,977), 5.4% (£3m) and 2% (£1,141,652) spent on child and adult learning disabilities, the Integrated Autism Service, and carers (all age, including young carers) respectively. This compares to 57.8% (£32,329,527) for frail and older people. We therefore welcomed the additional funds in the 2019-20 allocation.

Other funding opportunities for 2019-20 included the £7.2 million Early Years and Prevention Funding which is for the 'prevention of ill health' and was made available to 'enhance system leadership and allow for upscaling of universal prevention schemes'.

What do we mean by 'children with complex needs'?

Until February 2020, the Social Services and Well-being Act and its accompanying Part 9 statutory guidance did not offer a definition of what is meant by 'children with complex needs'. The definition offered by the amended guidance is:

- *Children with disabilities and/or illness*
- *Children who are care experienced*
- *Children who are in need of care and support*
- *Children who are at risk of becoming looked after*
- *Children with emotional and behavioural needs*

This includes supporting effective, integrated transition arrangements from children's to adults' services.

We are concerned that the previous lack of a formal definition has led to several Boards operating using a relatively narrow definition of children with complex needs. For example, this may only include children with a diagnosed mental health or complex and multiple disabilities. We believe that such a narrow definition risks excluding some of the most vulnerable children and young people. We visited some Boards where the Chair was still asking the question "what does complex needs mean?" We need to get beyond asking this question and start finding solutions for children who are in distress and need help and support, as is their human right.

The National Commissioning Board Wales includes the following understanding of complex needs within their guidance[22]:

This guidance covers a wide range of complex needs, the typologies of which are listed below:

- *Complex due to chronic health conditions (including life-limiting conditions)*
- *Complex due to sensory impairment (e.g. blind, deaf)*

[22] National Commissioning Board Wales (2018) *Guidance for Regional Partnership Boards - Integrated Commissioning of Services for Families, Children and Young People with Complex Needs.* Available at: https://www.wlga.wales/guidance-for-regional-partnership-boards-integrated-commissioning-of-services-for-families-children-and-young-people-with-complex-needs

- *Complex due to physical disability and associated conditions such as learning disability and / or autism*
- *Complex due to the display of risky, challenging and or harmful behaviours*
- *Complex due to mental ill health*
- *Complex due to learning disability and/or autism*
- *Complex due to context (e.g. abuse, neglect, growing up with domestic violence, growing up as a refugee/asylum seeker). The circumstances of some young people will become complex because in addition to their original needs they have also become involved in the youth justice system.*

It should be noted that the needs of some children will straddle more than one typology. It should also be noted that not all children with one typology will be complex. For example, a child with autism may or may not have complex needs, it depends on how their autism impacts on them and/or the co-existence of other complexities such as health conditions. In less complex cases where the child or young person requires care and support the Regional Partnership Board should ensure effective referral pathways to meet needs (e.g. effective pathways between health and social care after the identification of sensory impairment). This will prevent needs from escalating and becoming more complex.

Importantly, the guidance goes on to say that…

> *Whilst we have described typologies above the term 'complex' should refer more to the complex service provision required, rather than a way of labelling children and young people.*

However, some individual Boards have undertaken individual exercises to establish what they define as children with complex needs. For example, one board has settled on a three-point definition:

- *Children and young people who have experienced complex trauma (often challenging teenagers with complex attachment difficulties).*
- *Children and young people with ASD/learning disability and challenging behaviours.*
- *Children and young people with physical disabilities and complex health needs.*

We do not favour one of these definitions over the other, but we do believe the definition should be as broad as possible to include all children who experience distress and require help and support from multiple agencies. As we will explore later in this report, there is a clear need for a shared language between health, social services, education and other agencies, and between regions, over what is meant by complex needs and how we respond to those needs. This must include those children and young people who currently fall between the gaps in our services, as demonstrated by the case studies featured earlier in this report.

We therefore welcome that the recently published Part 9 statutory guidance includes a definition of children with complex needs. We believe this definition is sufficiently broad and can be adopted by all Boards to

create a shared language between health, social care, education, and all other relevant services. We would encourage all RPBs to consider the more specific definition offered by the National Commissioning Board Wales in guiding them to address the needs of those children and young people covered by the broad definition in the new Part 9 statutory guidance.

Recent action from Welsh Government and others

We are pleased that Welsh Government and partners have, in the last couple of years, taken action to improve policy and funding guidance for RPBs, in relation to the needs of children with complex needs, as outlined above.

In 2018-19, the Welsh Government consulted on and amended the *Partnership Arrangements and Population Assessments Regulations*[23]. The amendments included ensuring education and housing representatives sit on the Boards. It did not require the RPBs to pool funds for provision for children with complex needs, however, as the Commissioner has called for.

The National Commissioning Board Wales produced guidance in late 2018 called 'Integrated Commissioning of Services for Families, Children and Young People with Complex Needs', which is designed to assist RPBs in successfully commissioning integrated services. The Institute of Public Care (IPC) have since engaged directly with all but one of the RPBs in day-long workshops to raise awareness of the guidance and to encourage innovation and transformation.

In response to the Commissioner's calls, in February 2020 the Welsh Government published their revised Part 9 statutory guidance, which updated several elements of the guidance around children and young people, including:

- A definition of children with complex needs which is broader than some RPBs are currently interpreting it, and which can provide the framework for a shared language for professionals;
- A recognition of the duty for RPBs to have due regard to the United Nations Convention on the Rights of the Child, and an expectation to follow the UNCRC's principles;
- More specific wording encouraging a focus on prevention and early intervention for complex needs (including mental health);
- Explicit wording on the extension of the local authority section 12 duty[24] (participation of children and young people) to RPBs;
- An expectation that RPBs should establish multi agency sub-groups to discuss children and young people's needs;
- A requirement for education and housing representatives to be members of RPB's;

[23] National Assembly for Wales (2019) *The Partnership Arrangements and Population Assessments (Miscellaneous Amendments) (Wales) Regulations 2019 – No. 760 (W.143).* Available at: http://www.legislation.gov.uk/wsi/2019/760/pdfs/wsi_20190760_mi.pdf

[24] National Assembly for Wales (2010) *Children and Families (Wales) Measure 2010.* Available at: http://www.legislation.gov.uk/mwa/2010/1/section/12

- An expectation that RPBs should consider developing regional commissioning strategies and pooled fund arrangements for residential care for children and young people with complex needs.

At the start of 2020, in response to pressure from the Children's Commissioner and her team, a Task and Finish Group was established to review future provision for the small number of children and young people with complex needs whose needs cannot be met only in the current system of either secure welfare (social care) or in-patient or secure mental health provision. This Task & Finish Group is due to report in July 2020 and we expect this work to lead to rapid action to establish residential provision which meets the needs of these children and young people. In a letter of 18th June 2020 the Deputy Minister has confirmed to the Commissioner that the Task and Finish Group work has concluded with key conclusions that will underpin the next phase of work. The Commissioner will be meeting with Welsh Government and RPBs early in July to discuss the Group's findings and the proposed way forward.

Methods – What did we do?

Talk about case studies, not just statistics

NYSG Member

Before writing formally to each RPB in Wales, the Commissioner wrote in April 2019 to all Board Chairs to alert them to the fact that we wished to visit their region to discuss their work for children with complex needs. The Commissioner then wrote to every Board in Wales in August 2019, requesting to meet with the Board. An example of one of these letters can be found in Appendix 2.

During the autumn and winter of 2019/20, the Commissioner and her team visited every Regional Partnership Board in Wales. The Commissioner attended all but one of the Board's full meetings, and attended a session of the Children and Young People's Transformation Board of that remaining RPB. In these meetings, she challenged the Boards on the four areas outlined in her letter.

The Commissioner also wrote, in the autumn of 2019, to several third sector organisations and other stakeholders who work with children and young people with complex needs, to ask for their views on the needs of these children and young people, the services that are currently in place for them across Wales, how effectively these work for children and young people, and the effectiveness of RPBs in integrating services for them.

The Commissioner's team then undertook a thematic analysis of the key issues emerging from the data collected before compiling this report. The work has been guided by the National Youth Stakeholder Group on Mental Health and the Commissioner's youth and adult advisory panels.

Findings

Part 1: What are RPBs doing to ensure they address the needs of children and young people with complex needs across their region?

Specific multi-agency sub-groups to consider children and young people's needs

All the Boards have been honest with us that children and young people have not been a large part of their work plan for most of them until recently. A number of RPBs raised the loss of the previous Children and Young People's Partnerships[25], and said that this had led to a gap in focus on children and young people. Several stakeholders from third sector organisations told us that, because of this, and the focus being upon the older adult population, there has been little or no representation on the Boards themselves from professionals working with children and young people, let alone professionals working specifically with children with complex needs.

The first part of the Commissioner's recommendation in her Annual Report 2017-18 recommended that:

> *Welsh Government takes action to require Regional Partnership Boards (RPBs) to set up specific multi-agency planning structures for children and young people that will report to the RPB.*

We are pleased to say that the Welsh Government have now heeded our calls on this, and the new Part 9 guidance includes an expectation that RPBs should establish multi agency sub-groups to discuss children and young people's needs. We are pleased to report that all RPBs do now have specific multi-agency planning structures for children and young people

However, they are very much at different stages of development. In one region, a specific group has been in place since July 2013, before the Social Services and Well-being (Wales) Act 2014 came into force. Others ranged from having a specific group established for several years, to only just having begun. In one region, the new children's group had only met once when we visited, in late 2019, and had not yet reported into the RPB. Where there were established sub-groups we were able to see how this has made a difference to the board's ability to focus on children and young people's issues. There is little progress to report from some of the new sub-groups.

While we welcome the dedicated sub-groups, some members of Boards have expressed concerns that the Boards can become a 'rubber stamping exercise' if all the 'real work' is devolved to sub-groups. It is

[25] Welsh Assembly Government (2000) *Children and Young People: A Framework for Partnership.* Available at: https://dera.ioe.ac.uk/10502/1/q262a360_english1.pdf%3Flang%3Den

important that the Board itself has a broad view of all its areas of work. There were also concerns that the children and young people's agenda could become so large that "it could become tokenistic". The RPB which raised this told us that they had taken the approach to do a smaller number of things regionally, but that they felt make the biggest difference. One example of this would be that region's creation of two new roles to embed professionals from one service's team into another to ensure a response informed by both health and social care services.

Case Study: Powys RPB

Powys RPB have a sub-group called the 'Start Well Partnership' which focuses on children's issues. Underneath this sub-group sits 5 key work streams: developing a multi-agency early help hub; integrated emotional health and well-being and youth support; placement and adoption; developing resilience; and active and healthy lifestyles. Each work stream has its own action plan to track progress against. There is also a cross-cutting group for issues such as safeguarding advocacy and the Welsh language. These work stream groups meet every 8 weeks and feed up to the Start Well partnership which meets every month; which in turn feeds into every other meeting of the RPB. Work that has been taken forward through the Start Well partnership includes Powys' Early Identification Partnership meetings in schools, held termly in every high school in the region

Funding and incentivising integrated working for children and young people

A new focus on children and young people?

> Priorities can't be driven by just money
>
> *RPB Member*

Several of the Boards have made funding bids to both the Transformation Fund and the ICF in relation to integrating services for children with complex needs. It seems clear to us that there is not enough evidence of use of the Transformation Fund specifically for children with complex needs by RPBs, apart from in a couple of the regions. We would like to have seen more direction from Welsh Government in encouraging the use of Transformation Funding for children and young people.

Every Board welcomed the ring-fenced ICF funding, with several commenting that having child-focussed funding has made regions think about children and young people where they wouldn't have before. One RPB member commented that the process of scoping out the current arrangements in place for children and young people with complex needs had made the board 'have some idea of what the process of finding help must be like for families'.

Several Boards commented that the impetus recently from Welsh Government through ICF funding in particular, and the forthcoming (as they were at the time of meeting with the Boards) changes to the Part 9 statutory guidance, have led to more focus on children and young people at the RPB. One RPB member stated that "Welsh Government has taken a step forward in underlining that the ICF is about children too"

and another that Welsh Government had made it clear that children and young people's services are 'a national priority'. We have seen for ourselves where there has been a clear response to this direction from Welsh Government, an example of which would be the recent action of setting up sub-groups to discuss children and young people's issues, which is now an expectation under the revised statutory guidance.

Sustainable funding for the long-term?

Raised by both RPBs themselves and stakeholders is the issue that, while the funding made available to RPBs is very much welcomed, the long term ambitions of a seamless health and social care system are difficult to realise when funding is often only guaranteed for a relatively short period (ordinarily one or two years). While the funding is clearly very valuable in 'kick-starting' projects, we also heard from Boards who told us that it is difficult to demonstrate value in applying for extensions to funding or alternative funding sources in a one or two-year period when the changes the Board wishes to make are in some cases fundamental culture shifts, and will take time to take root. It was also raised that it is difficult to evaluate the effectiveness of projects quickly enough to provide the data for re-application or for new funding opportunities when the Boards are working to such short timescales.

It also appears that experiences of the timeliness of funding allocations has differed between Boards with some expressing frustration at the length of time waiting to hear from Welsh Government on whether their applications have been successful.

Top-down or bottom up approaches?

Some shared with us their anxiety over what they saw as 'imposed targets' from Welsh Government. While there was general agreement that the priorities are the correct ones, there were some who shared concerns over 'top-down' objectives incentivised by funding streams. It was felt by some that where 'targets' are imposed it means RPBs have to deliver in certain ways, which may not be the best approach locally, viewing the conditions attached to the funding opportunities as 'directional', and not flexible enough. An opinion was expressed with us that some feel Welsh Government aren't trusting regions enough to deliver in their area. These issues were reflected in the recent Wales Audit Office report on the ICF[26], which stated that the way in which the fund has been allocated by Welsh Government and used by Regional Partnership Boards may have limited the fund's potential.

Where this has been an issue, one board member told us that they are deliberately trying not to just 'make the service fit to the pot of money'. Another told us that 'priorities can't just be driven by money'. It would be concerning, of course, if a region was able to demonstrate a transformative proposal which they judge to be the best solution for their population, which did not fit the funding criteria.

Our position is that, while we acknowledge these concerns, there is a need for Welsh Government to take the lead on directing RPBs through funding incentives and through guidance. The effectiveness of this can

[26] Wales Audit Office (2019) *Integrated Care Fund.* Available at: https://www.audit.wales/system/files/publications/integrated-care-fund-report-eng.pdf

be demonstrated by the establishing of sub-groups for children and young people, and the use of certain ring-fenced funding opportunities.

A call for clarity over different funding opportunities

Some Boards shared a concern that the various and sometimes complicated mix of funding streams available to RPBs across all their responsibilities can be confusing. Indeed, we saw for ourselves some confusion at a meeting we attended over the different funding stream available. Specifically, this confusion was in relation to the Early Years and Prevention Funding, and the board decided that they needed to seek clarity over whether the funding is for early years or prevention, or both. There was also a plea from some for funding opportunities to be communicated more clearly with the Boards – to be informed as soon as possible that the opportunity exists so that they have sufficient time to prepare bids. This is particularly the case for RPBs as they meet relatively infrequently compared to the organisations which constitute them, and will often need to seek approval or buy in from colleagues in their individual agencies before the bid can be agreed and submitted.

A regional approach to funding arrangements?

There were comments that when grants are paid to one agency, on behalf of the wider RPB, this may lead to a power differential as, for example, social care may feel they need to approach health for money held with them, when this money should be viewed as a common, pooled resource. We are pleased to see, therefore, that the new part 9 statutory guidance states that:

> …a bit like a death in the family
>
> *A RPB Member, on arguments between providers around who should pay for services*

> *Local health boards and local authorities should also consider any funding issued to Regional Partnership Boards from Welsh Government, such as the Integrated Care Fund and the Transformation Fund, as a form of pooled budget. Although this will not require a formal partnership agreement, the commitment of any expenditure under the Integrated Care Fund, or similar funding streams, should be the subject of a written agreement.*

The Part 9 partnership regulations were amended in 2019[27] to include a requirement for partnership bodies to 'establish and maintain a regional pooled fund in the exercise of their care home places for older people and family support functions'. The amended regulations go on to say that 'nothing in this regulation prevents partnership bodies from establishing and maintaining pooled funds or regional pooled funds for carrying out any other functions'. The most recent Part 9 statutory guidance now states that RPBs 'should consider developing pooled fund arrangements for Services such as…residential care for children with complex needs'. However, we believe that the Welsh Government should consider making pooled funding a requirement in order to achieve a 'no wrong door' approach for children and young people with complex needs as not all regions are demonstrating a tangible long term wraparound service for their children and

[27] National Assembly for Wales (2019) *The Partnership Arrangements and Population Assessments (Miscellaneous Amendments) (Wales) Regulations 2019 – No. 760 (W.143).* Available at: http://www.legislation.gov.uk/wsi/2019/760/pdfs/wsi_20190760_mi.pdf

young people. This could be specifically for the purposes of multi-agency early help models, or for residential provision for children and young people with the most complex mental health and social care needs.

While every board welcomed the new transformation funding, one member of an RPB described the transformation funding, while very welcome, as 'a bit like a death in the family', with the individual services and local authorities within the region arguing over the money and how it should best be spent. Clearly, this response does not view funding opportunities as regional, for all areas within the region to benefit.

The Boards themselves have not utilised funding to its full potential as there are several examples of ICF funding, for example, being used for projects which do not support a regional approach, but are only designed to focus on a particular service in a particular part of the region, without plans for how this practice will be up-scaled. Some Boards discussed the potential for the regional agenda to be contradictory to how some areas are organised because of historic policy. The example given by more than one board member is the previous focus on Communities First funding, which targeted specific areas. The view of some was that, putting aside its merits, this effectively created a postcode lottery, whereas the regional approach is one of equity across diverse regions. A culture shift is needed for regions to truly think regionally rather than services or areas competing with each other for funding. This should have happened by now, and we are concerned to hear that these attitudes still exist.

Part 2: What are RPBs doing to make sure children and young people's voices are being heard?

Members of the National Youth Stakeholder Group told us…

"Involve young people in your meetings as we want to offer our ideas or our support"

"how can they be 'partnership' boards if they're not working in partnership with children and young people?"

"Have a young person to represent the regions and health boards along with the 'fancy' people"

Under article 12 of the UNCRC every child 'who is capable of forming his or her own views has the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.'[28] The revised Part 9 statutory guidance on partnership arrangements[29] states that the RPBs are required to 'make such arrangements as it considers suitable to promote and facilitate participation by children in decisions of the authority which might affect them'. The statutory guidance also states that 'people who use services must be actively involved and engaged in the work of the Regional Partnership Boards', and RPBs are expected to engage directly with the Social Value Forums (made up of third sector organisations, co-operatives and social enterprises) in their region[30].

Engagement with and involvement of children and young people

While it is encouraging that specific sub-groups concentrating on children and young people's issues are now operational within every RPB in Wales, direct engagement and co-production with children and young people is less evident. There was recognition in several of the Boards that more needed to be done to directly involve children and young people in their work, and to provide them with the skills to be able to co-produce elements of the Boards' work. When we visited, most Boards told us that they were actively considering how best to involve the voice of children and young people in the work of the board, but a majority could not demonstrate satisfactorily work that they had undertaken already to involve children and young people in their work.

[28] https://www.childcomwales.org.uk/united-nations-convention-on-the-rights-of-the-child-full-text/

[29] Welsh Government (2015) *Social Services and Well-being (Wales) Act 2014 Part 9 Statutory Guidance (Partnership Arrangements).* Available at: https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

[30] Wales Cooperative Centre (2018) *A Toolkit to Develop Social Value Forums.* Available at: http://walescoop.wpengine.com/wp-content/uploads/2018/09/walescoop-social-values-FPE-5.09-2.pdf

There were encouraging signs in most of the boards that there is more of an understanding of the need to 'do with, not do to', as a citizen representative told us in one region. For example, one region discussed plans to ensure that an ability to outline how children's voices would influence the service being provided is part of their commissioning processes.

We saw a mixed level of involvement of and engagement with children and young people. Some Boards set their priorities for their sub-group from direct consultation with children and young people, which is pleasing to see. Other Boards chose to hold regular meetings with their local youth forums to ensure they were able to influence the board's work. Some Boards had young people sitting on their children and young people's sub-group. One board shared the observation that young people can get exhausted by the range of forums they attend, and so they are trying to think of different ways to involve them which doesn't involve attending more meetings. We would suggest considering co-production or providing training as young commissioners so that young people feel that they are making a direct contribution to the policies and commissioning of the board.

Case Study: Cardiff & Vale RPB

Cardiff and Vale RPB undertook a 'Listening to Families' exercise in 2018 which asked for both the experiences of people with learning disabilities, and their expectations. These expectations included a proactive not reactive early intervention response, pooled budgets, continuity of staff, to be listened to, streamlined appointments and reviews, suitable environments for children while attending appointments, services meeting their needs, a key worker or lead person, and someone to assist with minor tasks without the need for continuous referrals.

The Commissioner has produced a framework called *The Right* Way, which is designed to help public services implement a children's rights approach to working with children and young people[31]. We would encourage RPBs to use this framework to assist them in engaging with children and young people. We would also encourage RPBs to refer and sign up to the National Participation Standards[32]

[31] Children's Commissioner for Wales (2018) *The Right Way*. Available at: https://www.childcomwales.org.uk/resources/childrens-rights-approach/right-way-childrens-rights-approach-wales/
[32] Welsh Government (2016) *Having a Voice, Having a Choice: Children and Young People's National Participation Standards*. Available at: https://gov.wales/children-and-young-peoples-national-participation-standards

Case Study:

Cwm Taf Morgannwg RPB

Cwm Taf Morgannwg RPB have made involving children and young people more in their work a priority. The Board's own strategic priorities have been shaped by working with young people, for example through Youth Forums and individual projects which have taken a coproduction approach to designing services with young people. The Board are now working to develop more long-term arrangements for co-production. For example, the scoring criteria for third sector ICF grants available to projects with a focus on children with complex needs includes the need to develop a co-productive approach to improving children and young people's mental health and wellbeing. Successful applicants will also need to attend a coproduction workshop.

The next step for the RPB is to hold a workshop with young people, with the RPB Chairperson attending, to develop with young people a longer-term more strategic approach to how they want to be involved in co-production of the Board's work. Young people said that they did not want to just to come and sit on the region's sub-group for children or on the board, as they felt this could be tokenistic, and they have told the RPB they want their involvement to be meaningful. The board's strategic group for children and young people have worked with children and young people, including representatives attending Youth Forums in the region, to come up with a set of priorities, of which the key concerns are around emotional health, wellbeing and mental health. The strategic group will be guided by this priority in their work.

As Cwm Taf Morgannwg is a newly-formed region, they are taking the opportunity to undertake a mapping exercise of the current provision across the region from universal to specialist provision, from conception to age 25. ICF revenue funding has also been identified for developing third sector and community support for children and young people.

Direct involvement and co-production

More than one of the RPBs did not demonstrate the direct involvement of children and young people with the work of the board in the correspondence we had with them, or when we met with them. While one board had recently committed to work under co-production principles and told us they were in the process of setting up the structures to enable this, there is certainly not enough evidence of co-production being employed across the work of the Boards. This was also reflected in the views of stakeholders. A citizen representative told us that they felt there was 'no sense of equal ownership for children and young people' at the (children and young people-focussed) sub-group they attended. We would like to encourage all Boards to consider how they can best ensure children and young people are empowered as citizens to have ownership over particular elements of the Board's work plan, where these plans affect them.

The Welsh Government's recently amended Part 9 statutory guidance includes the extension of section 12 of the Children and Families (Wales) Measure 2010 to RPBs. From February 2020, therefore, RPBs are now required to 'make such arrangements as it considers suitable to promote and facilitate participation by children in decisions of the authority which might affect them'; to publish information about these arrangements and to keep this information up to date[33]. From what we have seen when visiting the Boards, several of them will need to make changes to their current approach in order to achieve this.

Case Study:
West Wales

The RPB have worked with people (including young people) with learning disabilities and others to develop a West Wales Learning Disability Charter which includes lists of what people with learning disabilities want and covers human rights, access to community facilities and assets, relationships, social life, support from professionals and advocates, health support, support to be independent, and support to be able to communicate in the way that works best for the individual.

The RPB have been working with the 'Dream Team', a group of people with learning disabilities. A member of the Dream Team sits on the Learning Disability Programme Group which sits underneath the Board.

Adults acting on behalf of children and young people and those who look after them

Stakeholders we spoke to told us that Social Value Forums, which every RPB is responsible for establishing and engaging with under the Social Services and Well-being Act[34], were not being utilised as they should be. This was reflected in the need for the recently published toolkit from the Wales Cooperative Centre[35] which outlines how RPBs should be using their Social Value Forums to ensure the views of their local populations, including children and young people, reach the board and are part of their work. One citizen representative told us that they felt there could be a national network to support citizen representatives so that they feel supported, as they can feel isolated when attending RPB meetings. We also have concerns about the involvement of third sector partners, which are explored in part 5 of this report.

There is a wider issue around the importance of citizen engagement to the work of the RPBs. As well as the importance of reflecting issues of the region properly, active citizen engagement is essential to getting people living within your region to 'buy in' to the regional transformation project, and to be taken along on the journey, as outlined by the Wales Centre for Public Policy in their recent review of *A Healthier Wales'*

[33] National Assembly for Wales (2010) *Children and Families (Wales) Measure 2010.* Available at: http://www.legislation.gov.uk/mwa/2010/1/section/12
[34] Welsh Government (2015) *Social Services and Well-being Act Part 2 Code of Practice (General Functions).* Available at: https://gov.wales/sites/default/files/publications/2019-05/part-2-code-of-practice-general-functions.pdf
[35] Wales Cooperative Centre (2018) *A Toolkit to Develop Social Value Forums.* Available at: http://walescoop.wpengine.com/wp-content/uploads/2018/09/walescoop-social-values-FPE-5.09-2.pdf

commitment to public engagement[36]. We discuss the need for much improved transparency, accessibility and accountability of the board's work further in part 5 of this report.

It was noticeable that after several of the Board meetings that we attended, citizen representatives followed staff out of the meeting to raise issues with us, or followed up with the team thereafter. Some of these representatives told us that they didn't feel able to contribute fully during the main meetings, that they feel they are there to 'rubber stamp' as priority seems to be given to the main statutory agencies to contribute to each discussion item first, or that the set-up of the meetings did not make them feel able to make a contribution.

[36] Wales Centre for Public Policy (2020) *Public Engagement and 'A Healthier Wales'*. Available at: https://www.wcpp.org.uk/publication/public-engagement-and-a-healthier-wales/

Part 3: No Wrong Door for children with complex needs experiencing emotional wellbeing or mental health issues

"Mental health isn't just black and white, it's colourful"

NYSG Member

As highlighted by the case studies in a previous section of this report, children and young people should receive a multi-disciplinary response which wraps around their needs, regardless of whether they have a formal diagnosis (such as a mental health or neurodevelopmental disorder). Too often, we expect children to fit into the boxes of either health or social care services, when an individual's needs rarely do fit neatly into one box or the other.

The second part of the Commissioner's 2017-18 Annual Report recommendation to Welsh Government was to…

> *…require RPBs to take steps to integrate children's social care and mental health services into multi-disciplinary teams that will respond to the needs of their local populations of children and young people who require emotional, behavioural or mental health support and treatment.*

This part of the report will explore how far RPBs have come in creating a 'no wrong door' approach for children with emotional and mental health needs.

Providing support for children and young people based on levels of distress

The Commissioner has not been alone in calling for the shift in focus towards responding to need, regardless of formal diagnosis. The Senedd's Children, Young People and Education Committee published a report called *Mind Over Matter*[37] in April 2018 on their inquiry into emotional and mental health support for children and young people in Wales. In August 2019 the committee made several follow-up recommendations[38] highlighting key gaps that require attention.

The committee found that:

- There is a 'missing middle' of children who are not deemed unwell enough to receive specialist mental health treatment, but who then receive no alternative support.
- Waiting times for assessment by CAMHS has improved, but there is little evidence that this has led to quicker treatment.

[37] National Assembly for Wales (2018) *Mind over Matter - A report on the step change needed in emotional and mental health support for children and young people in Wales.* Available at: https://www.assembly.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf

[38] National Assembly for Wales (2019) *Letter to Minister for Education and Minister for Health, Welsh Government, from the Chair of the Children, Young People and Education Committee – 8th August 2019.* Available at: http://www.senedd.assembly.wales/documents/s92917/Letter%20to%20the%20Minister%20for%20Education%20and%20Minister%20for%20Health%20and%20Social%20Services%20-%208%20August%202019.pdf

The committee made a series of recommendations to Welsh Government which included the need to 'outline how it intends to address the challenges faced by the group of children and young people who do not meet the threshold for specialist CAMHS but for whom alternative services are not available'; make psychological therapies more readily available to children and young people who need it; set out a clear plan for how to support the estimated 40-50 per cent of children and young people who do not the meet the threshold for neurodevelopmental diagnosis but are experiencing distress and need help; and to improve crisis and out-of-hours provision.

The committee highlighted the specific role of schools in supporting young people with emotional and mental health issues, as well as the youth service, youth justice, and all those agencies involved in the child or young person's life.

Integrating services for children and young people displaying emotional distress and mental health issues

We found that while most RPBs were able to demonstrate pockets of good practice in terms of integrating services for children and young people experiencing emotional distress, these had in almost all examples not been scaled-up across the region. Given the focus of Welsh Government funding, it was concerning that despite these incentives there were few examples of concrete plans to scale-up good practice using that funding.

From our discussions with the RPBs, we found several examples where services are not yet linked up enough to respond to children and young people in distress who require help. For example, we heard from regions where the health board has a Single Point of Access system for children's mental health, but where social services were not partners in this service. Regions told us that mental health services are not responsive enough to children and young people, whenever they need it. For example, there are limited or no mental health support services outside of school hours in most regions. This includes inpatient settings, which do not accept patients on weekends.

Residential provision for children and young people with the most complex needs

The Commissioner has encouraged RPBs to consider how they can provide new residential provision for children and young people with the most complex needs who require mental health and social care input in one place. Where a region was looking to provide new residential provision for children and young people with the most complex needs, they told us that they face a particular challenge where local authorities can't agree on committing revenue. This stemmed from one local authority not being able to demonstrate the same level of need as others and therefore was reluctant to commit revenue across the whole region. In relation to commissioning beds in secure health or social care accommodation, Boards told us that local authorities had separate commissioning strategies, making a joined up approach across the region difficult. We were also told that when young people transition to adult services and require

residential provision, their new residential setting can be a vastly different experience to their previous accommodation, with less time outside and less activities offered, for example.

A shortage of suitable residential provision

Boards told us of their frustration at an inability to access accommodation for young people who need it in a timely way due to the fact there are no secure NHS inpatient beds in Wales. Waiting times for secure beds are an issue across the UK meaning that there is huge demand on all secure accommodation facilities. Where children and young people are placed in secure accommodation, the child or young person could be placed in a number of locations across England, and even as far as Glasgow in Scotland.

RPBs told us of feeling restricted in actions they can take as there is a need to receive a diagnosis of a mental health disorder in order to access a mental health bed and, relatedly, the problem of distinctions in language between mental health *illness* and mental health *risk*. One RPB member told us that they felt the current tiered model for Child and Adolescent Mental Health Services (CAMHS) is 'flawed' and leaves an 'iceberg' of unmet need.

As reflected in our case studies earlier in this report, RPBs' testimony also pointed to a situation where services are unable to agree whether a young person with complex needs and mental health issues should be placed in a secure mental health or social care setting, leading to delays and inappropriate placements for that child or young person.

Demand and capacity for integration

Boards reflected an increase in the numbers of children and young people presenting in crisis, and a large increase in demand for neurodevelopmental services, as has been reflected nationally[39]. We were told that care and support for those children and young people with the most challenging emotional and behavioural support needs is not available to many because of a shortage of specialised staff. We were told that there are also particular recruitment issues in mental health services for children and young people in the earlier stages of experiencing mental health issues.

RPBs with particularly large geographical footprints and/or particular issues of rurality shared with us that they felt achieving equity of services is more difficult due to the distance needing to be covered and the resources needed to serve their populations. Some Boards told us that it is also more difficult for rural areas to achieve 'critical mass' to demonstrate the need for services in their area. There was comment that 'everything costs more' when attempting to integrate services across a large rural area.

We were told that these issues of demand and capacity mean that it can be difficult for professionals to work across teams, for example involving social workers in the work of some CAMHS teams as there is not the capacity for professionals to be embedded with the work of another team.

[39] Together for Children and Young People (2019) *Mind Over Matter Report Follow-up: Together for Children and Young People Programme Update.* Available at: http://senedd.assembly.wales/documents/s87903/CYPE5-15-19%20-%20Paper%20to%20note%203.pdf

These challenges reflect much of what we heard from individual services, as well as reflecting the findings of the Senedd's Children, Young People and Education Committee's *Mind over Matter* report. We are interested in how RPBs are either tackling or at least mitigating these challenges.

Responses - Early Help and Enhanced Support

All of the Boards have at least begun to think about how they can provide early help and enhanced support for children and young people in distress in an integrated way. We found that RPBs recognise the need for early intervention for children with complex needs and / or emerging emotional wellbeing or mental health issues.

Stakeholders also emphasised the need for a wraparound community response to situations where CAMHS referrals are made and a young person is either awaiting assessment, or has been told they do not meet the criteria for support. Stakeholders told us that there is not enough support for families when supporting their child through mental health services.

We were pleased to see, as some of the following case studies show, that regions are beginning to provide this response, or are considering their approach. We found three different models being trialled:

- Some areas have chosen to pursue a 'hub' type model, where services should be available in one place for families to access.
- Others have developed a 'panel' model where individual children's circumstances are discussed in one room with a range of professionals, and where an action plan is put into place immediately.
- Another approach is to 'embed' professionals from one service into another (for example, a CAMHS professionals working directly in social services teams, or with schools) to provide advice, training and support so that their expertise can be utilised by those professionals who have most regular contact with those young people.

‘There are good examples across Wales where regions are starting to pull services together to help children with complex needs’

Done in the right way, we believe all of these approaches have merit and have the potential to significantly improve the response for children and their families.

Case Study:
Powys RPB

Powys RPB have used ICF funding to provide additional support to young people experiencing mental health and wellbeing difficulties, who do not meet mental health criteria, but still require support. Additional CAMHS workers provide assessments and consultation with young people, families and services and ensure support is then accessed either through 1:1 support sessions or group work. Individual support is provided by the Youth Intervention Service to include work around emotional regulation, confidence, self-esteem and resilience building. The counselling service in Powys is running group sessions in schools to support children and young people with emotional wellbeing, exploring issues such as anxiety and exam stress. The Youth Intervention Service also works with children and young people who are not educated in mainstream school settings, providing information and support on emotional health and wellbeing. Powys Youth Service and Powys Sports Development team are providing a broad range of opportunities and activities as well as peer mentoring to support emotional health and wellbeing.

"Young people should be at the centre of all support services and there should be no barriers in place to prevent young people from receiving the support that they need and deserve"

NYSG Member

"You should be able to go to them and they help you. You shouldn't be sent away to find all the different services yourself"

NYSG Member

Case Study:
Gwent RPB

Gwent RPB has developed a model of Single Point of Access for Children's Emotional Wellbeing and Mental Health (SPACE-Wellbeing) panels. These panels are in place across the 5 local authority areas of Gwent. This work has built on the existing 'Early Help Panels' which were already in place in Monmouthshire and Newport, and expanding these models across the other three local authority areas of Torfaen, Caerphilly and Blaenau Gwent. The 'scaling up' of these panels has been achieved through mental health innovation and transformation funding. Some Welsh Government Transformation Funding has also been used to fund this project.

The panels meet once per week and take referrals from multiple sources: GPs, schools, social services, but also parents and families. The referrals are taken for children who have complex needs which might include a history of trauma, family issues, mental health disorders, social care needs, and disability.

Attendees at the panel which the Commissioner visited in Monmouthshire (the Monmouthshire Early Help Panel) include representatives from a wide range of services: including social services, primary and specialist mental health services, substance misuse services, the local authority's sports and leisure service, youth services, school-based counselling service, Building Stronger Families service, third sector mental health provision, learning disability transitions service, young carers organisation, housing services, and youth enterprise services.

In this panel meeting, over 20 children and young people were discussed in the space of 1 ½ hours. All children and young people were given an immediate intervention (or if appropriate a sequence of interventions). These ranged from a simple visit to meet with the young person over a cup of tea and discuss local support options, an offer to join the young carers' support group, support to join a social or sport activity, bereavement counselling or play therapy to, in a small number of cases, the involvement of specialist CAMHS. The panel aim to take into account the whole of the family's circumstances where this is available to them and respond to all needs relevant to that young person, as far as they can.

An evaluation of the panels is currently underway, but the board are able to display a reduction in demand to specialist children's mental health, as a result of children and families being allocated to other more appropriate sources of support through the panels.

Case Study:
North Wales RPB

North Wales RPB successfully applied for Welsh Government Transformation Fund money for work based on a set of regional principles delivered locally within the three localities (West, Central and East) within North Wales.

The first area of work is around 'early help and support' – integrated support including new approaches to early help and accessing therapeutic support. This will build on existing examples such as Flintshire Early Help Hub. Flintshire Early Help Hub is a multi-agency service which co-locates professionals from social services, North Wales Police, Health, Youth Justice, Education, Family Information Services, Early Years Support and others including third sector. A third sector coordinator acts as a point of contact –working with the family to find community-based solutions to meet their needs.

North Wales is also planning to provide 'edge of care support' – extending access to therapeutic support through integrated teams / pathways for children and young people to help them remain in family home setting.

Case Study:
Cardiff & Vale RPB

Through ICF revenue funding, Cardiff & Vale have established an Adolescence Resource Centre, an intensive support programme for young people aged 11-17 at risk of having to leave their current family environment, which works with the whole family, where this is appropriate, to develop an individualised safety plan to encourage an improvement in the young person's situation and relationship with their family, and aims to avoid placement in care as far as possible.

A case example shared with us showed a young person displaying various high-risk behaviours. A family safety plan was agreed which included access to art therapy which was described as a real breakthrough by the young person and her family.

Case Study:
West Glamorgan RPB

Using ICF revenue funding, the RPB has created two new roles of CAMHS liaison officers – embedded in the social care single point of contact teams in each of the two local authorities in the region. The liaison officers, who are experienced CAMHS nurses, provide consultation and advice on work with children's emotional health; training events on a variety of topics such as self-harm, anxiety, low mood and behavioural issues; and joint assessments as well as short-term direct joint work to achieve the most effective intervention for the family. This service has been successful in proving its effectiveness, with improvements to the number of patients on CAMHS waiting lists over the past three years, and it is planned that the service will be funded by core CAMHS funding by 2021/22.

Case Study:
Maison des Adolescents

In 2018, the Commissioner visited a 'Maison des Adolescents' in France. These 'young people's houses' offer a wide range of services in one place, easily accessible to the local community by foot or public transport. Maison des Adolescents are in place across France and provide an accessible venue for those seeking support with mental health, emotional or behavioural concerns. Young people and their families can receive immediate advice and information. Some are offered access to services such as support groups and those most in need are booked for a future clinical appointment. As well as first response mental health professionals, social work and youth work advice and support are also available as needed, depending on the individual. Such a setting could provide a 'no wrong door' approach that aimed to support concerns early, hopefully preventing some children escalating into a crisis situation which might lead to a young person becoming looked after or requiring clinical mental health services.

Following this visit, the Commissioner wrote a blog and encouraged regions to consider this approach at national mental health events, and in her visits to each region.

Cardiff & Vale RPB have received ICF capital funding for the development of a drop-in centre in the centre of Cardiff, along the lines of this model. West Glamorgan RPB have also secured a Swansea city centre venue which could provide a wraparound service. There is little detail available on either yet, but this is a model that we would like to see considered by other regions, where appropriate.

Case Study:

Gwent RPB

ISCAN (Integrated Service for Children with Additional Needs) acts as three single points of access across three parts of Gwent (north, south and west) for referrals for children and young people with disabilities and developmental difficulties. The three ISCAN co-ordination teams are based in each of the three children's centres.

Referrals are accepted for children / young people aged 0 – 18 who are displaying concerns in two or more elements of their development. This includes referrals for children / young people requesting an assessment for ASD / ADHD. The referral needs to be completed by a professional and must outline clearly the child / young person's difficulties but must have signed parent / carer consent.

Once ISCAN receive a referral form and relevant supporting information, the child / young person is listed for discussion at the ISCAN panel meeting. The ISCAN panel is made up of professionals including a paediatrician, consultant psychiatrist, paediatric specialist nurse, representation from the neuro-developmental team, therapy services, educational psychology service and local authority children with disabilities team. The family liaison officer from each children's centre is also in attendance. An outcome report is sent to the parents detailing the discussion and decision about the next steps in managing the child's / young person's care.

Several stakeholders pointed to the SPACE-Wellbeing model in Gwent in particular as a good practice example. Conversations with those involved have highlighted that discussions with parents can be difficult as they try to persuade them that a swift, wraparound multi-agency formulation is preferable to, for example, sitting on a waiting list for CAMHS or the local neurodevelopmental team. Families can sometimes expect (understandably given the lack of wraparound options generally across Wales) that an appointment with CAMHS or a diagnosis might provide the 'golden ticket' to the service they need. Of course, sometimes they do. Early help models aim to provide a wraparound service for those children who would otherwise wait for several weeks or months, often only to be told they can't be helped.

The Commissioner and her team regard this to be a very promising model and have urged other regions in subsequent meetings to consider this approach.

Responses – Residential provision for children and young people with the most complex needs

Placing a child or young person in a residential setting away from their family or carers is a significant decision. However, there are times when this is necessarily the best option for the child or young person. There are also times when, as outlined earlier in this report, the right residential provision just doesn't exist. Frustration at the

'no more than bouncers'

A RPB Member, on staff in inappropriate residential provision for children with complex needs

lack of this provision was expressed by all RPBs and several stakeholders. 'Out-of-county' placements were described by several of the Boards as a big issue which has not yet been properly addressed. One Board member described residential provision for those children and young people who did not 'fit the service' and were being placed in inappropriate provision as 'containment, not therapeutic', where staff are 'no more than bouncers'.

There is a need for regions to undertake an analysis of all the options available within their region for children with complex needs. A comprehensive understanding of the landscape across the region is needed for regions to be truly on top of what provision is available currently so that they can properly plan how to deliver an integrated service for their children and young people. This includes step up and step down services for those requiring residential provision. The lack of services in the community for children and young people at risk of entering or having just left residential provision was raised by all Boards.

This report will now highlight some examples of practice in different regions of Wales looking to tackle or mitigate some of these issues:

Case Study:
North Wales RPB

As part of their successful Transformation funding, the RPB is establishing 'assessment and support teams' – short-term residential assessment with a multi-disciplinary on site team to identify the most appropriate placement to meet the support needs and desired outcomes for young people with complex needs, and who are experiencing crisis or escalating concerning behaviour. This is designed to be intensive support to build individual and family resilience and facilitate de-escalation.

In response to the RPB's market position statement for Children and Young People's Residential Care, Fostering and secure accommodation, part of the aim of this work is to provide step-up provision when behaviours become unmanageable at home; and step-down provision from hospital discharge. The assessment and support teams will aim to bring together agencies to make decisions on the best longer-term provision which can be offered to the young person while they are staying at the short-term residential setting.

Case Study:
Powys RPB

Powys RPB have applied for funding for therapeutic provision for children and young people within residential social care settings. The RPB are confident that such provision would mean that those young people who 'fall between' mental health residential placements and social care residential placements will be able to access a service that would meet their needs in one setting. We look forward to hearing more about this work, if the funding bid is successful.

Case Study:
West Glamorgan RPB

West Glamorgan's Multi-Agency Placement Support Service (MAPSS) is designed to deliver a multi-disciplinary therapeutic approach to develop carers and professionals' understanding and confidence, reduce placement and educational instability; and improve outcomes for care experienced young people and carers.

MAPSS objectives are to promote secure attachment as a means of helping young people and their carers maintain placements (residential and educational) so that young people can feel safe enough to develop supportive attachments/relationships, opportunities for positive growth and start to process developmental trauma. These aims are achieved through helping professionals such as social workers, carers or teachers, best understand young people, their development, the trauma they have experienced and how this can present challenges for their care.

Therapeutic interventions are offered to care experienced young people, carers, teachers and other sources of support. These young people may be in foster placements, residential placements or placed with family or friends. Interventions are bespoke to the child's, carers' and educational circumstances. They aim to 'wrap around' the child by bringing all professionals together around the child with a shared attachment and trauma recovery therapeutic approach. In addition to direct support, MAPSS delivers training to carers, schools and social work staff.

Case Study:
Gwent RPB

MyST has been developed by the Gwent Partnership Board to provide a mental health service to children and young people looked after aged 5-21. MyST works with a small population of young people who would otherwise be placed in residential children's homes, residential schools, secure units and mental health hospital units. The service has an intensive approach to enable young people with highly complex psychosocial needs to be cared for and educated in their communities. Work takes place across the young person's ecosystem; directly with young people, birth family members, foster carers, schools and professional networks. The multidisciplinary teams are accessible 24 hours a day, every day of the year. Alongside using psychological therapies with young people and families, MyST equally focus upon bringing systems together to share an understanding of the young person, to integrate everyone's approach, to build a resilient adult network to persist through challenging times and to jointly manage risky behaviours. The work of the service means that more young people can grow up in their own communities. Young people report improvements in their mental health and their needs de-escalate. Professionals report feeling more able and confident to work with the young person and their system. Alongside the clinical outcomes of this service, costs savings are achieved through re-patriating young people from costly placements, and multiagency working is practised and improved.

As mentioned elsewhere in this report, the Commissioner has recommended in her most recent Annual Report that Welsh Government should ensure new ring-fenced funding for RPBs specifically for the purposes of jointly commissioned mental health and social care residential provision for the small number of children and young people with the most complex needs in Wales[40]. Some of the Boards have told us that they are 'ready and willing' to work with Welsh Government on getting these facilities up and running. We would urge Welsh Government to engage with the regions and begin the process of creating these jointly commissioned services immediately following the current review.

Case Study:
West Wales RPB

West Wales RPB have been actively pursuing the possibility of new residential provision for children and young people who require residential care which is 'one step down' from secure accommodation. Local authorities and the local health board have been working together on this proposal, and a potential venue has been identified. We look forward to hearing more about this work.

We are pleased to see that the Welsh Government is taking some action on this through the recently established task and finish group, but given how familiar this issue is for RPBs, we were surprised that more had not taken action to jointly commission such a facility in their region.

[40] Children's Commissioner for Wales (2019) *Annual Report and Accounts 2018-19.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Annual-Report-2018-19.pdf

Part 4: No Wrong Door for children and young people with learning disabilities as they grow up

Young people, parents and professionals all agree that young people with learning disabilities are still expected to slot into services that already exist, with limited options if that doesn't fit their needs

Sally Holland, Children's Commissioner for Wales

Young people with learning disabilities far too often face a splintered set of services as they approach transition to adult services as they will often have multiple agencies involved in their care. RPBs are required to develop integrated transition arrangements for children with complex needs[41]. They should be playing a key part in ensuring that young people with learning disabilities have a care plan which integrates the various services they access and ensures that all of those individual services plan with adult services to ensure that young people do not lose out on the services to which they are entitled, and that they are not left without services as they move from children to adult services.

In 2018, the Commissioner published a report on the experiences of young people with learning disabilities and their transition to adult service called *Don't Hold Back*[42]. Key messages from our consultation with 99 young people with learning disabilities 187 parents and carers, and 43 professionals included:

- Young people's participation in planning and decision-making for their needs appears to be very low
- Parents often feel overwhelmed and anxious about the future
- Some young people face a considerable change in how much support they receive after the age of 18 due to different thresholds
- Every service has different ways of transferring to over-18s services. Having a key worker or transition service is very valuable
- Young people, parents and professionals all agree that young people with learning disabilities are still expected to slot into services that already exist, with limited options if that doesn't fit their needs

There was a specific recommendation within the *Don't Hold Back* report that:

> *The Welsh Government should ensure that Regional Partnership Boards are making substantial and effective progress on the integration of services for people with learning disabilities, children with*

[41] Welsh Government (2015) *Social Services and Well-being (Wales) Act 2014 Part 9 Statutory Guidance (Partnership Arrangements).* Available at: https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

[42] Children's Commissioner for Wales (2018) *Don't Hold Back – Transitions to Adulthood for Young People with Learning Disabilities.* Available at: https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Dont-Hold-Back.pdf

complex needs and transition services as required by the Social Services and Well-being (Wales) Act 2014: Part 9 Statutory Guidance (Partnership Arrangements).

Several other pieces of work have supported the findings of the *Don't Hold* Back report. The Welsh Government set out its *Improving Lives Programme*[43] in June 2018, which highlighted that children and young people with learning disabilities may also suffer from physical or mental health conditions, leading to confusion over which health team should be supporting the child. Relatedly, Healthcare Inspectorate Wales published a thematic review in 2019[44] which highlighted the differing experience of the coordination of services for children with complex health needs as they make the transition from child to adult services.

As has been suggested to us by stakeholders, there should be a regional approach to transition to adult services, for all children and young people who require support. However, we did not see enough evidence that sufficient region-wide change was taking place in any of the regions. One board told us that there are 'no clear answers yet' to the barriers of having smoothly-managed multi-agency transitions to adult services. I am concerned that more is not being done at RPB level to address this issue, despite several Boards highlighting both the *Don't Hold Back* report, and the *Improving Lives Programme*.

Negotiating the maze

RPBs and stakeholder reflected much of what we found in our *Don't Hold Back* report. They told us that young people transitioning to adult services face a complex maze of differing arrangements across regions. We were told that there are multiple transition pathways across services, and between different local authorities. They told us that different local authorities have different structures for discussing joint health and social care packages, and that within regions different local authorities have different eligibility criteria for disabled children's services.

In relation to the care of children and young people with learning disabilities more generally, we were told that health, social care and education services use different approaches for behaviours that challenge, meaning that families are confused by the differing approaches. This highlights yet again the need for a shared language to discuss what we mean by children with complex needs, and our responses to those needs.

Resource and Information Sharing

The RPBs shared with us some situations which they see as blocking an integrated transitions process. One RPB told us that they were unable to implement key working effectively, as there has been no agreement to share information between health and social care disability service teams through the Welsh Community Care Information System (WCCIS). Boards also shared their frustration that Statements of Special Educational Need are not transferrable between local authorities and can mean that if a young

[43] Welsh Government (2018) *Learning Disability Improving Lives Programme.* Available at: https://gov.wales/sites/default/files/publications/2019-03/learning-disability-improving-lives-programme-june-2018.pdf
[44] Healthcare Inspectorate Wales (2019) *Thematic Report – How Are Healthcare Services Meeting the Needs of Young People?* Available at: https://hiw.org.uk/sites/default/files/2019-06/290319thematicyouthen.pdf

person's service changes to be delivered in another local authority area, their Statement doesn't follow them. These are the sort of barriers that hold back the work of RPBs to integrate services, and should be surmountable.

Access and provision

> RPBs should be ideally placed to broker arrangements between child and adult services for children and young people with learning disabilities
>
> *Sally Holland, Children's Commissioner for Wales*

Boards and stakeholders told us that access to and provision of services was also a major issue. Some described the lack of dedicated facilities for young people, as youth services are not available equitably across Wales, for example. They felt that this is particularly the case for young people with disabilities aged 18-25. One of the regions also told us that while children's learning disability services are provided 'in-house', adult learning disability services are provided by another health board in another part of Wales, which does not even border their health board area. We understand that adult learning disability services will be brought back under that health board's control soon, but that this situation has led to difficulties in terms of accessing the other health board's pathway planning, leading to families not being fully informed, and potentially to unnecessary delays. Boards and stakeholders also told us that the commissioning of specialist therapeutic interventions can be problematic if the children and young people with a learning disability do not meet the eligibility for Continuing Care.

While these barriers are clearly difficult, RPBs should be ideally placed to broker arrangements between child and adult services for children and young people with learning disabilities, but also for services across health and social care, as they are in the unique position of being able to operate regionally. We did identify some early signs that this is starting to be tackled in some regions. The following case studies demonstrate some regional approaches to this issue:

Case Study:
Cardiff & Vale RPB

The region is developing a regional protocol for transition to adult services for young people with learning disabilities. The protocol will include the need to identify transition key workers, and a dedicated Transition Team. There will be a 'support planner' role who will identify children earlier to provide planning support for the transition to adult services. The RPB is also working to improve the information available to young people and their families so they have a better idea of what to expect from the transition process. ICF funding has been used to increase capacity in the workforce to support this work. The implementation of this work will be overseen by a Disability Future Partnership which will cover both children and young people with complex needs and adults with learning disabilities so that these services are better coordinated across the age of transition in services.

Case Study:
Powys RPB

Powys RPB have recently secured ICF funding for a 2-year project looking at transitions to adult services for children and young people. This work is led by the Transition Partnership Steering Group. The project aims to develop an integrated pathway for young people including, but not limited to those experiencing disability, mental health issues, Autistic Spectrum Conditions, vulnerability, and leaving care.

Powys also have an Integrated Disability Service which hold weekly triage meetings to consider referrals and facilitate information sharing, multi-agency meeting planning, signposting and any onward referrals.

These examples are welcome, but we have not seen examples of real change on the ground, despite several Boards telling us that they were reflecting on responses to the findings of *Don't Hold Back, Improving Lives*, and HIW's thematic review. There were pockets of good practice in local authorities in several of the regions, but we saw little evidence that there was enough ambition from the regions to provide an equitable service across their region which addressed the concerns outlined in my *Don't Hold Back* report.

Overall, we remain concerned that this group of young people have not seen improvements to their transitions experience across Wales and, with the exception of the case studies above, there is not enough evidence of regions taking a lead on this issue.

Part 5: Some Further Challenges for RPBs

How do RPBs see their role?

> RPBs need to be doing some of the doing
>
> *RPB member*

All Boards saw the value in having regional strategic partnerships. Some commented that partnership working means that services can truly have ownership of the issues facing their populations. There were also comments that these partnerships provide the forum to step back a bit and focus on improvements to preventative services, that it can mean the avoidance of duplicating work, and that it should lead to a better working relationship between services as they are joined by a set of underpinning key principles. Some members of RPBs told us that health and social care are getting better at 'picking up the phone to each other', and that conversations have shifted from 'what can I or my local authority area do' to 'what can we do collectively'.

RPBs were keen to tell us that they are a 'bringing together' of organisations, not a delivery body. This was reflected in some comments from the RPBs such as "RPBs are not decision making bodies; they do not have delegated authority or powers"; they are a "mechanism not an organisation". There was also the suggestion from one RPB member that Welsh Government are "not really sure what they have with RPBs", and that they see them as solid entities, not a coming together of agencies despite this not being reflected in their funding and governance/structural arrangements.

However, as one stakeholder pointed out, "it isn't early days anymore" and if things aren't working "RPBs need to be doing some of the doing". We would share this view. While RPBs are not direct service-delivery bodies in the same way as health boards or local authorities, we believe it is a fundamental part of their role to intervene as far as they can if services are not integrating. They have the power to do this through pooled funding and joint commissioning arrangements, for example.

Transformation and scaling up good practice

The Transformation Funding from Welsh Government is specifically designed to encourage the scaling up of good practice across the regions. There were few examples of where scaling up of good practice 'from local to regional and national level, and out to other teams and organisations' as envisaged by *A Healthier Wales*[45], has happened or is happening. While the funding is certainly welcome and has been invested in several exciting projects, just one RPB specifically told us that Transformation Funding had been a catalyst for the scaling up of a service. The ambition is the right one, and there have certainly been movements in the right direction, but Welsh Government will need to consider how they create truly transformational change, as providing short-term kick-starter funding does not appear to have been enough. We certainly believe that some of the examples highlighted in this report have the potential to become embedded practice beyond the individual region where it has been trialled.

[45] Welsh Government (2018) *A Healthier Wales: Our Plan for Health and Social Care.* Available at: https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

Are all partners on an equal footing?

> [Our RPB] has a very good third sector forum which allows organisations to feed into and contribute to overall priorities of the board
>
> *RPB third sector representative*

Because the geographical footprints of the RPBs align with health board areas, some members of RPBs shared an anxiety that some of the work of the board can feel very much health-led, rather than truly integrated. This can be compounded if regional funding is distributed via the health board, rather than being held by the RPB itself. This was a view expressed by several RPB members.

Some Boards told us that the bringing together of different areas within the region can cause tensions. In one RPB, for example, we were told of tensions over which local authority area the Chair of the Board should come from within the region, and tensions between the different local authorities over funding, resource and capacity.

Concerns were raised with us over the involvement of third sector partners in the work of the RPBs, as has been highlighted by the Welsh Council for Voluntary Action[46], and was reflected in responses to this project from the third sector. There was a sense from third sector respondents that the power at the Board sits with the statutory bodies. Some third sector representatives did express frustration at feeling like they attended the board in order to 'rubber stamp' decisions that had already been made by statutory partners. There is also the issue that third sector members are not paid to attend the Boards and may not be sufficiently incentivised to attend.

However, some RPBs were keen to emphasise that they involved and valued their third sector partners, with one member of an RPB telling us that "there are some things that statutory services are very good at, and some things they are terrible at". This RPB had a specific commitment in their work plan to working directly with third sector partners. One third sector stakeholder told us that one region had a "very good third sector forum which allows organisations to feed into and contribute to overall priorities of the board".

Some stakeholders shared concerns that RPBs aren't hearing from a wide enough pool of voices. One charity told us that while their client group is relatively niche, they believe they could provide expert insight into experiences and services for children with complex needs. This charity believed that insight from professionals working with children with the most complex needs can help to 'cut through' overly complicated situations, and they expressed regret that they had not been approached by any RPBs.

At the time of writing, one of the seven RPBs is chaired by a third sector representative. All the other RPBs are chaired by either local authority cabinet members or senior Health Board members.

[46] Welsh Council for Voluntary Action (2017) *Delivering Transformation in Wales: Social Services and Well-being (Wales) Act 2014 Interim findings.* Available at: https://wiserd.ac.uk/sites/default/files/documents/eng_sswba_briefingpaper_wcc_final_27.11.17_1.pdf

Information sharing

This issue has been highlighted throughout this report – effective information sharing between relevant agencies continues to be a struggle across regions. One board told us that in their recent citizen engagement exercise, families told them that they wanted to see services working more closely together, and specifically raised that they wished to see better and more efficient information sharing. Getting this right is essential if we are to see the 'no wrong door approach' we are calling for.

The integrated IT system for health and social services (WCCIS) is welcome, and the Boards were able to demonstrate activity on implementing this integrated IT system. However, it does not include other services such as education. RPB members told us of their frustration at not being able to share data between services. They said that there are examples where services do not know that they are involved with the same family as another agency. Indeed, in one multi-disciplinary panel we observed, not everyone in the room was able to see details of referrals being discussed, as not all partners could access this information through their agency.

Transparency, accessibility and accountability of the Board's work

How can we be accountable if people don't know we exist or what we do?

RPB Member

How can we find the services we need, or what the Regional Partnership Boards are doing well?

NYSG Member

RPBs must improve their transparency. This was reflected by several stakeholders we spoke to. At a basic level, it is not straightforward to access minutes from meetings or annual reports, or indeed any information for those outside the Boards to understand the mechanisms of how the RPBs work and how to access them. These should be clearly accessible online and kept up to date. At the time of writing, one of the RPB's websites does not appear to have published minutes of meetings since 2018, for example.

In addition, we would also like to see a commitment from every board to creating accessible versions of all of their major documents, including annual reports. We would like to see the RPBs detailing where initiatives are designed to benefit children and young people, and how they will explain this work in a language suitable for children and young people.

Culture change and honesty with families

We heard from a member of a board that they felt there is a mind-set of 'protecting specialists from demand' by making referral processes complicated and difficult, and by not sharing systems and information smoothly. It is understandable why we would want instinctively to protect specialists from

demand, but we need to do that in an open and honest way which recognises that specialist mental health interventions aren't always the answer, and to manage the expectations of families. This culture change cannot begin until we have more transparency from our public services. Indeed, representatives of individual services on Boards told us that there are also issues with expectations of their service from other services (all of which would sit around the RPB table). RPBs have a key part to play in facilitating open and honest conversations both between services, and with the citizens they serve. We should have the ambition of integrated pathways for children with complex needs, which are responsive to the needs of the child or young person, not just to their diagnoses.

Families should be able to access information on care pathways across health and social care straightforwardly where these are in place in their region. Not only would this help inform families more broadly, it would also mean that they have a better understanding of how integrated care should be designed around the child or young person, and their family, rather than necessarily seeing a CAMHS appointment or a diagnosis as a 'golden ticket' to getting the help they need. A professional involved in an early help panel model described the challenge of persuading families that the integrated response would be more beneficial to them than signing up for a waiting list for a CAMHS appointment. This is a cultural shift which will be difficult to achieve, but is necessary in order for integrated services to be successful. RPBs are uniquely placed to drive this shift in how we view our health and care services.

Relationships with other strategic partnerships

The issue of cross-over of priorities and objectives, and clarity over governance boundaries between strategic partnerships has also been raised, particularly in relation to children's issues, and for preventative and early help initiatives aimed at improving wellbeing. From the perspective of children and young people's services, this is particularly relevant to the role of Public Services Boards (PSBs), established under the Wellbeing of Future Generations (Wales) Act (2015)[47].

The membership of each Board is important here as, while there are senior decision makers on the RPBs, it is often the case that Chief Executives attend PSBs, and it has been suggested by some that Chief Executives may be in a better positon to 'sign up' to something 'there and then' whereas a Director, for example, attending the RPB may not be in a position to do so.

There was a mixed response to the suggestion of confusion over the governance and roles of the different Boards when the Commissioner wrote to every PSB and RPB in a joint letter with the Future Generations Commissioner for Wales in 2019. However, it is clear that there are concerns which included several members of each board attending both Boards, and of the potential for duplicating pieces of work. Some of these concerns have also been raised by the Wales Audit Office[48]. The issue of funding has also been raised with us, as the largest pots of funding are distributed through RPBs, not through PSBs. However, as

[47] National Assembly for Wales (2015) *Well-being of Future Generations (Wales) Act.* Available at: https://www.legislation.gov.uk/anaw/2015/2/contents/enacted
[48] Wales Audit Office (2019) *Review of Public Services Boards.* Available at: https://www.audit.wales/system/files/publications/review-of-public-service-boards-english.pdf

outlined above it is likely that priorities may at times be shared, and we see this as a further incentive for closer collaboration between the Boards when this is appropriate.

We have been told of RPBs and PSBs collaborating in a productive way, for example developing joint proposals to the Prevention and Early Years Grant and the Early Years Pathfinder Grant, where priorities complement each other. Where there are shared objectives between the Boards, it is important that the relationship between the two bodies is developed sufficiently so that either a joint response is taken forward, or when one is better placed than the other to take this work forward (for example through the RPB's access to transformation funding), the bodies work together to support that work, and set out clear expectations of how that relationship will function.

The Welsh Government and Welsh Local Government Association (WLGA) are currently reviewing the strategic partnership arrangements in Wales, which includes RPBs, as well as Public Services Boards (PSBs)[49], safeguarding partnerships and others. We await its conclusions and recommendations.

A whole-school approach to mental health and emotional wellbeing

There is also a decision which will need to be made over the relationship between the RPBs and the Regional Education Consortia in terms of coordination and accountability for the Welsh Government's whole-school approach to mental health and emotional wellbeing framework guidance. It is our view that while there are encouraging signs, RPBs are some way off being in a position where a whole system approach to children and young people's emotional wellbeing and mental health is 'business as usual'. However, we believe that it makes most sense for oversight of the whole-school approach to eventually sit at RPB level as Regional Consortia do not share their geographical footprint. The whole-school approach is a key element of the whole-system 'no wrong door' approach the Commissioner is calling for, and should complement the work ongoing at a regional level for children with complex needs as far as possible.

[49] Established under the Well-being of Future Generations (Wales) Act - National Assembly for Wales (2015) *Well-Being of Future Generations (Wales) Act 2015.* Available at: http://www.legislation.gov.uk/anaw/2015/2/section/29/enacted

Conclusion: Have RPBs been transformational in integrating services for children with complex needs?

> Being good at innovation doesn't always lead to transformation. There must be system change
>
> *RPB Member*

Regional Partnership Boards are seen as key to the Welsh Government's 10-year strategy for integrating health and social care, A Healthier Wales. The Welsh Government has invested large sums of money with funding incentives tied to demonstrating a scaling up of good practice to create transformation across the regions. It is envisaged that this in turn will lead to a transformation of services system-wide.

This report has focused on the experiences for children and young people with complex needs in relation to emotional wellbeing and mental health, and transition to adult services for young people with learning disabilities. We are pleased to see progress in specific governance arrangements being put in place to focus on children and young people, but in some regions these are at a very early stage and little has changed on the ground for children and young people in those areas. While there are some particularly encouraging examples in relation to supporting children with complex needs with their emotional wellbeing and mental health needs, these are not as advanced (with the exception of arrangements in the Gwent region) as we would expect, and plans for children with learning disabilities, particularly around transitions, are also not advanced far enough.

Most of the RPBs are thinking regionally, and we believe are committed to learning from their own good practice examples, and good practice from other regions. However, we also came across several examples of RPBs who would provide an example of what they viewed as good practice in one local authority, but where there was no evidence that funding had been bid for, or work was being undertaken, to scale up that good practice across the region.

Some of the issues outlined in this report have been addressed by recent action from Welsh Government, in response to our calls for change. However, while the Welsh Government's recent amendments to the Part 9 statutory guidance and ICF guidance are very welcome, regions will need more support from Welsh Government to get this right. Many are moving from no focus whatsoever on children and young people to, in a majority of regions, having a major part of their work plan dedicated to children and young people. This is a welcome improvement on the previous situation, but it is clear that this process will take time, and Welsh Government will need to be proactive in supporting RPBs both in terms of strategic and governance issues, and importantly in long-term sustainable funding which allows RPBs the opportunity to prove the

worth of their innovative integration models and to upscale these into transformative change across their region.

The context of the current crisis of course raises concerns over the sustainability of the funding available to RPBs for this agenda, as well as the RPBs' ability to focus resources on this agenda during this very difficult time.

Nevertheless, the statutory role of RPBs is to respond to their population assessment and implement plans to meet the health, well-being, care and support needs of their populations, and we must build on the progress they have already made, utilising this important, statutory, multi-agency body to drive this forward and plan services for the future.

Recommendations

I will meet with all Regional Partnership Boards during the 2021-22 financial year to follow up on this piece of work, specifically to check in on progress against the following recommendations. I will invite young people to come with me to every Board meeting so that they have the opportunity to scrutinise each Board's progress.

A pledge from the Children's Commissioner, Sally Holland:

Sustainable funding and support for transformation

While I have seen good practice examples, the intended effect of the Transformation Funding has not yet been realised in relation to integrated services for children and young people with complex needs. In light of changes to the funding arrangements for RPBs due to the Covid-19 crisis, it is vital that the Welsh Government considers how RPBs will be supported financially to upscale existing pockets of good practice from their region or to learn from the practice of other regions.

Ring-fenced ICF funding has been used to support some transformation projects already and consideration needs to be given to ensuring that momentum is not lost and to support RPBs to address clearly identified gaps in provision for our most vulnerable children and young people. These gaps will only be exacerbated by ongoing changes to how services operate and therefore new ways of working need to be found as these children's needs will not simply disappear because of the Covid-19 lockdown arrangements.

I therefore call for the Welsh Government to revisit how financial incentives can be used to support RPBs in upscaling pockets of good practice in their regions. The Transformation Fund and ICF have both clearly incentivised RPBs to think about providing for children and young people with complex needs, particularly the ring-fenced ICF funding. This momentum cannot be lost. Nor can it be sustained solely by core funding following an injection of monies. Welsh Government must be in a position to provide funding for transformation projects when these can demonstrate addressing a clear gap in integrated provision for our most vulnerable children and young people.

While it is difficult in fixed-term parliaments to have truly sustainable funding, the Welsh Government must do more to extend the life-cycle of funding where good practice, and ability to upscale across the region, is demonstrated.

Engagement and coproduction with children and young people

In addition to having groups dedicated to children and young people's issues, Boards must engage with a diverse range of young people from across the whole of their region. The dedicated sub-groups of the Boards should also be responsible for ensuring that, wherever possible, children and young people are given the skills and the platform to co-produce elements of its work. They should ask young people how they wish to be involved in the Board's work in a way which is engaging for them. No Board should be in a position where they are taking decisions without having heard directly from children and young people.

Transitions for Children and Young People with learning disabilities

There needs to be a conscious effort by RPBs to focus on transition to adult services as I have seen little evidence of region-wide approaches which sufficiently plan for children and young people with learning disabilities. Transition arrangements for children with complex needs more broadly should be part of the core business of RPBs, and I am pleased to see this recognised by the new statutory guidance. What we need to see is multi-disciplinary pathways involving health, education and social services. This will usually be most efficient and effective if the same processes are in place across the region. This would mean that there is more consistency for health board staff, and could be more efficient in commissioning voluntary sector support, accommodation or training opportunities, for example.

Recommendation 1: As part of our national response to children and young people's mental health and well-being needs following this period of lockdown, all Regional Partnership Boards should plan and implement a 'no wrong door' approach to mental health and well-being which could include integrated teams, panel and hub models to provide timely joined-up help, drop in centres and plans for integrated residential provision where needed. All Boards should review their current Area Plan to ensure they are taking sufficient action to address the needs of children and young people with complex needs, and that local authorities and local health boards are truly working in partnership towards this. This should include consideration of the Plan in light of the Covid-19 pandemic and how this impacts on the remaining years of the Area Plan, and longer term strategies.

Recommendation 2: Welsh Government will need to support Regional Partnership Boards with their long term strategies. This support will be needed more than ever because of the current circumstances, and should make clear how Welsh Government will make funding available to achieve better experiences and outcomes for children and their families. This should include system change that will help families experience a 'no wrong door' approach in every region such as integrated teams, panel and hub models to provide timely joined-up help, drop in centres and plans for integrated residential provision where needed.

Recommendation 3: Regional Partnership Boards must ensure they are compliant with the newly amended Part 9 statutory guidance by:

- Ensuring funding is not seen as 'held' by either the health board or the local authority, and that these arrangements are subject to a written agreement between partners. The funds should be owned by the whole region and all services should feel they have an equal stake.
- In light of the new statutory requirement for section 12 duties to extend to Regional Partnership Boards, all Boards should review their current arrangements for engagement and coproduction with children and young people. RPBs should use my *The Right Way* framework for taking a children's rights approach to working with children and young people[50] to guide their approach, alongside the National Participation Standards[51]. This must include the Board itself hearing directly from children and young people, and for children and young people to be empowered to shape the work of the Board.
- As part of their duty to support effective, integrated transition arrangements from children's to adult services, Regional Partnership Boards should publish multi-agency transition protocols, if they have not already, for children and young people with learning disabilities, considering how they deliver an approach so that the current multiple and pervasive issues of cross-local authority border and cross-sector disparities in transition arrangements are integrated as far as possible.

Pooled funding and joint commissioning

More must be done to encourage and facilitate pooled / shared funding and joint commissioning. We shouldn't be seeing situations where local authorities don't agree on sharing resources for a regional service when it clearly benefits the entire region. Welsh Government should take action to require pooled funding and to encourage joint commissioning.

Recommendation 4: Welsh Government should amend the *Partnership Arrangements and Population Assessments Regulations* to require pooled funding for a 'no wrong door' approach for children and young people.

Residential provision for children with complex needs which provides care and support for both mental health and social care needs

If they have not already, RPBs should undertake a full analysis of provision and provide a position statement for the whole region so that plans can be made based around providing the best possible integrated model. The Welsh Government should begin creating this vital provision here in Wales as soon as the safe accommodation review team have completed their work. This work must now accelerate at pace. The current crisis has highlighted the lack of this provision, as inpatient units have struggled to provide a service for all those children and young people who require admission. Some RPBs indicated when we met with them that they are 'ready and willing' to begin work on these facilities. I urge Welsh Government to engage with the regions to turn plans into action as soon as the review has concluded.

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[50] Children's Commissioner for Wales (2018) *The Right Way.* Available at: https://www.childcomwales.org.uk/resources/childrens-rights-approach/right-way-childrens-rights-approach-wales/

[51] Welsh Government (2016) *Having a Voice, Having a Choice: Children and Young People's National Participation Standards.* Available at: https://gov.wales/children-and-young-peoples-national-participation-standards

Recommendation 5: The current Welsh Government review of 'safe accommodation' must lead to concrete action being taken to develop new residential provision in Wales for children with complex needs upon reporting.

Transparency and accountability

Children and young people and their families should be able to easily access documents telling them about what work their RPB is doing for them. In addition, families should be able to access information on care pathways across health and social care straightforwardly. Not only would this help inform families more broadly, it would also mean that they have a better understanding of how integrated care is designed around them, rather than seeing a CAMHS appointment or diagnosis as a 'golden ticket' to getting the help they need.

Recommendation 6: As the responsible body for the administration of funding for Regional Partnership Boards, Welsh Government need to demonstrate leadership by clarifying their responsibility for the framework within which Regional Partnership Boards operate. Welsh Government should ensure that robust accountability mechanisms are in place for Regional Partnership Boards to report on their work on multi-agency arrangements for children with complex needs, including transitions to adult services. This should include proactively reviewing Regional Partnership Boards' Area Plans and monitoring progress against their ambitions through Annual Reports and meetings.

Recommendation 7: Regional Partnership Boards should work with the Together for Children and Young People Programme (2) to explore how they can better organise and publicise the role and work of the Regional Partnership Boards to make it more accessible to families. This should include accessible descriptions of multi-agency pathways for children with complex needs, as well as those projects which are of direct relevance to children and their families.

Citizen and third sector representation on the Boards

Citizen representatives and third sector stakeholders told us there isn't enough representation of children and young people's issues on the Boards, or enough representation of or engagement with the third sector, which provides input as they have a view across children's services. Every RPB should review its current membership from the third sector in relation to children with complex needs, and from professionals working specifically with children and young people with complex needs and their families. They should also review their approach to involving citizen representatives.

Recommendation 8: Regional Partnership Boards should work with citizen and third sector representatives who work with children and young people with complex needs to make sure they are sufficiently involved in meaningful work as part of the Board, and feel fully valued as equal partners by the statutory members on it.

Opportunities for shared learning

Further opportunities should be created for RPBs to learn from each other on their approaches to integrating services for children with complex needs. This exercise would allow for a comprehensive review of the

barriers facing RPBs, and what would help to overcome them. This shared learning exercise could be based around the recommendations of this report.

A shared language

While Boards will prioritise approaching issues for children with complex needs in different ways, it is important that there is a shared understanding across regions, and across services (particularly health, social care and education), of what is meant by complex needs and how we respond to those needs, and to emphasise that it must be a broad definition which is based on the experience of the child and their family. Welsh Government will need to engage with RPBs on how to embed this shared understanding across services.

Information and resource sharing

We should not be in situations where services are brought together to give a multi-agency response to an individual child's needs, but cannot all access the same information. Nor should we still be having disputes over using resources which should be viewed as shared regionally, not the property of individual agencies.

Recommendation 9: Welsh Government and the Together for Children and Young People Programme (2) should work with their partners and with Regional Partnership Boards to organise further shared learning events to focus specifically on a 'no wrong door' approach for children and young people with complex needs.

These shared learning events should include discussions of barriers between services' use of language (particularly but not confined to health, social care and education) around children with complex needs, in order to promote the new broader definition under the revised Part 9 statutory guidance, as well as being guided by the National Commissioning Board Wales' definition. The events should also include discussions of the issue of how information is shared and resources are pooled, and whether the current information sharing system needs improvement.

Relationships with other strategic partnerships

There should be a closer working between RPBs and PSBs where this is not already in place to avoid duplication of work, and to ensure that where funding is available it is put to best use based on the needs of the population of that area.

Recommendation 10: Regional Partnership Boards should develop a memorandum of understanding with Public Services Boards on potential cross-over issues where these related to children and young people, which includes an agreement on how to approach those issues which would benefit from joint working between Regional Partnership Boards and Public Service Boards, such as having arrangements in place for funding applications or joint commissioning.

Appendices

Appendix 1 – Glossary

Children with complex needs: This refers to the complexity of the services required to meet a child's needs, rather than the child themselves being described as 'complex'.

Children with learning disabilities: A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life. More context to issues affecting children with learning disabilities and the support they may need are available from Mencap[52]

Neurodevelopmental services: These are services to support children and young people with a neurodevelopmental disorder, which includes Autistic Spectrum Disorder (ASD), Attention-Deficit / Hyperactivity Disorder (ADHD) and Tourette's Syndrome.

Behaviours that challenge / behavioural issues and trauma: For those children with complex needs, which can often be linked to trauma, which can lead to what is often referred to as 'emotional' or 'behavioural' issues. The term 'behavioural' can be problematic as it can be seen to place the responsibility with the child and their 'behaviour'. However, it is a term which describes actions by the child or young person which are difficult to respond to safely, and can be a danger to themselves and others. This report will tend to refer to 'emotional wellbeing' which should be read to include 'behaviours that challenge' or 'behavioural issues'.

[52] https://www.mencap.org.uk/learning-disability-explained/what-learning-disability

Appendix 2 – Example of letter sent to all Regional Partnership Boards August 2019

Comisiynydd
Plant Cymru

Children's
Commissioner
for Wales

To: Chair Regional Partnership Board

Via email only

6 August 2019

Dear Chair,

Thank you for agreeing to meet with me and members of my team this autumn.

As you know, we are visiting every Regional Partnership Board to find out more about every board's work in delivering the priority to establish integrated services for 'children with complex needs due to disability or illness and for children and young people with mental health problems', as set out in the Social Services and Well-being Act 2014 - Part 9 Statutory Guidance (Partnership arrangements) .

I am looking at the work of Regional Partnership Boards in this area because I know that the offer for children and young people with complex needs looks different across Wales, and I want children and young people to get the best care possible wherever they live in the country.

My aims for this work are to:

a) Build a picture of challenges and opportunities in developing multi-agency services that are responsive to the needs of children with complex needs including learning disability and mental health problems.

b) Discover examples of promising developments that can be shared in other regions of Wales

c) Explore the current arrangements for discussing and making decisions regarding children's services in each RPB

d) Encourage the prioritisation of establishing integrated services for 'children with complex needs due to disability or illness and for children and young people with mental health problems'

Tŷ Ystumllwynarth/Oystermouth House
Llys Siarter/Charter Court, Phoenix Way
Abertawe/Swansea SA7 9FS
01792 765600

post@comisiynyddplant.cymru
post@childrenscommissioner.wales

comisiynyddplant.cymru
childrenscommissioner.wales

This letter goes on to discuss in more detail the information I would like to request is shared with my office in advance of our meeting, and a set of discussion points to inform the meeting itself.

Below are three cases studies which illustrate some of the experiences faced by young people and their families. These are real, but fully anonymised, case studies handled by my independent Investigations and Advice Service.

Examples of recent cases

Case Study A

Child A was just turning 18 when they contacted our office. They have a life limiting condition, and had been in the same foster placement (out of county) for a significant number of years. The lead social services team was the children's disability team.

The plan was for this young person to remain with the foster carers who would become Shared Lives carers. The foster carers de-registered as foster carers to allow for them to be assessed as Shared Lives carers to enable the young person to remain in their care. The assessment did not take place and this young person was now in a placement with unregistered carers.

The added complication to this case is that the young person has significant health needs and the two Local Health Boards involved were now disputing who has the responsibility for the health needs of this young person as they are now an adult.

Case Study B

Child B had taken an overdose which resulted in the young person being admitted to hospital. Since being discharged from hospital, Child B received no support, although the family were told that the young person would be able to access support in the community.

The family called the local CAMHS service and were told Child B is on the waiting list for an appointment with CAMHS but they were unable to provide a date.

The school were aware of the situation, but there was also a waiting list for their counsellor.

Social services told the family that it is CAMHS' responsibility to support Child B and as a result they did not offer any support.

Child B told their family that the thoughts that resulted in the overdose are back and the family were extremely concerned as they were unable to get any support for Child B. The family told us that Child B was discharged from hospital with no information about what they should do should the young person's symptoms return before the CAMHS appointment came through.

Case Study C

Child C, aged 16, contacted our Investigation and Advice service from a hospital where they had being detained under section 2 of the Mental Health Act. Child C had not been diagnosed with a mental disorder. Child C had been moved to the hospital following an incident at a child and adolescent mental health in-patient unit where the young person had broken doors in an attempt to get out, assaulting a police officer when police arrived to remove them.

Child C was placed at the hospital on an adult ward and supervised by two agency staff from the mental health unit they had been at. Child C was unable to return to the unit as they were unable to manage the young person's behaviour.

Child C was moved to another hospital, again on an adult ward, was segregated, and has the same agency staff they've had all along. A multi-agency meeting was arranged to agree next steps. The meeting was attended by 16 professionals, including one from the child's local CAMHS, the relevant social services department, and one of their lawyers. The meeting was chaired by the Clinical Director for CAMHS in the child's health board. Social Services maintained that they were not able to secure Child C in any form of secure accommodation as the young person was about to turn 17, and not subject to a Care Order.

My request to you

In order for me to determine whether the Boards are making substantial and effective progress on the integration of services for children with complex needs, due to disability or illness and for children and young people with mental health problems, including transition arrangements as required by the aforementioned statutory guidance, I would be interested in hearing more about the following in relation to the case studies above:

1. Your RPB members' assessment of the likelihood of such scenarios occurring in your region currently. What provision do you have in place that could assist these young people? How would you assess the current and future effectiveness of your board in terms of ensuring that young people do not 'fall between the gaps' because of service thresholds? If a decision cannot be agreed on a plan for care, what is the outcome for the young person?

2. Information about the governance structures you have in place to plan and deliver services for this group's needs, and the more particular arrangements designed for this group, particularly those with learning disabilities or mental health issues.

3. Information in relation to integrated service arrangements to support children with learning disabilities in their transition to adulthood, as well as general holistic care arrangements (as highlighted in my 2018 report, *Don't Hold Back*.)

4. Details of the structures of support in place to cater for children and young people with mental health, emotional and behavioural issues, which may be part of wider complex needs, for both:

    a. the 'Missing Middle' of those who do not reach the threshold for specialist CAMHS but require therapeutic and other interventions; and

    b. the care and mental health needs of the small number of young people with very challenging behavioural and emotional difficulties, for whom there is currently very little suitable residential provision in Wales

We envisage that there will be an opportunity for discussion when we meet. To free up time at our meeting, therefore, I would like to request that a summary document addressing elements of the above questions, of no more than 4 sides of A4, is shared with us in advance of the meeting. You may also wish to follow up the meeting with further written information about the RPB's work and future plans in relation to the 4 requests above.

As well as visiting each Board, I'll be working to gather experiences from children, young people and their parents/carers. All the information collated will be analysed and I am planning to issue my findings in early 2020 along with any relevant recommendations.

Comisiynydd
Plant Cymru

Children's
Commissioner
for Wales

I hope that this information is helpful in advance of our meeting. Thank you once again for accommodating us. I look forward to our visit.

Yours sincerely,

Sally

Sally Holland
Comisiynydd Plant Cymru
Children's Commissioner for Wales

Appendix 3 – Summary of Recommendations

A pledge from the Children's Commissioner, Sally Holland:

"I will meet with all Regional Partnership Boards during the 2021-22 financial year to follow up on this piece of work, specifically to check in on progress against the following recommendations. I will invite young people to also meet with the Boards so that they have the opportunity to scrutinise each Board's progress."

Recommendations for Regional Partnership Boards:

1. As part of our national response to children and young people's mental health and well-being needs following this period of lockdown, all Regional Partnership Boards should plan and implement a 'no wrong door' approach to mental health and well-being which could include integrated teams, panel and hub models to provide timely joined-up help, drop in centres and plans for integrated residential provision where needed. All Boards should review their current Area Plan to ensure they are taking sufficient action to address the needs of children and young people with complex needs, and that local authorities and local health boards are truly working in partnership towards this. This should include consideration of the Plan in light of the Covid-19 pandemic and how this impacts on the remaining years of the Area Plan, and longer term strategies.

2. Regional Partnership Boards must ensure they are compliant with the newly amended Part 9 statutory guidance by:

    - Ensuring funding is not seen as 'held' by either the health board or the local authority, and that these arrangements are subject to a written agreement between partners. The funds should be owned by the whole region and all services should feel they have an equal stake
    - In light of the new statutory requirement for section 12 duties to extend to Regional Partnership Boards, all Boards should review their current arrangements for engagement and coproduction with children and young people. RPBs should use my *The Right Way* framework for taking a children's rights approach to working with children and young people[53] to guide their approach, alongside the National Participation Standards[54]. This must include the Board itself hearing directly from children and young people, and for children and young people to be empowered to shape the work of the Board.
    - As part of their duty to support effective, integrated transition arrangements from children's to adult services, Regional Partnership Boards should publish multi-agency transition protocols, if they have not already, for children and young people with learning disabilities,

[53] Children's Commissioner for Wales (2018) *The Right Way.* Available at: https://www.childcomwales.org.uk/resources/childrens-rights-approach/right-way-childrens-rights-approach-wales/
[54] Welsh Government (2016) *Having a Voice, Having a Choice: Children and Young People's National Participation Standards.* Available at: https://gov.wales/children-and-young-peoples-national-participation-standards

considering how they deliver an approach so that the current multiple and pervasive issues of cross-local authority border and cross-sector disparities in transition arrangements are integrated as far as possible.

3. Regional Partnership Boards should work with the Together for Children and Young People Programme (2) to explore how they can better organise and publicise the role and work of the Regional Partnership Boards to make it more accessible to families. This should include accessible descriptions of multi-agency pathways for children with complex needs, as well as those projects which are of direct relevance to children and their families.

4. Regional Partnership Boards should work with citizen and third sector representatives who work with children and young people with complex needs to make sure they are sufficiently involved in meaningful work as part of the Board, and feel fully valued as equal partners by the statutory members on it.

5. Regional Partnership Boards should develop a memorandum of understanding with Public Services Boards on potential cross-over issues where these related to children and young people, which includes an agreement on how to approach those issues which would benefit from joint working between Regional Partnership Boards and Public Service Boards, such as having arrangements in place for funding applications or joint commissioning.

Recommendations for Welsh Government:

1. As the responsible body for the administration of funding for Regional Partnership Boards, Welsh Government need to demonstrate leadership by clarifying their responsibility for the framework within which Regional Partnership Boards operate. Welsh Government should ensure that robust accountability mechanisms are in place for Regional Partnership Boards to report on their work on multi-agency arrangements for children with complex needs, including transitions to adult services. This should include proactively reviewing Regional Partnership Boards' Area Plans and monitoring progress against their ambitions through Annual Reports and meetings.

2. Welsh Government will need to support Regional Partnership Boards with their long term strategies. This support will be needed more than ever because of the current circumstances, and should make clear how Welsh Government will make funding available to achieve better experiences and outcomes for children and their families. This should include system change that will help families experience a 'no wrong door' approach in every region such as integrated teams, panel and hub models to provide timely joined-up help, drop in centres and plans for integrated residential provision where needed.

3. Welsh Government should amend the *Partnership Arrangements and Population Assessments Regulations* to require pooled funding for a 'no wrong door' approach for children and young people.

4. The current Welsh Government review of 'safe accommodation' must lead to concrete action being taken to develop new residential provision in Wales for children with complex needs upon reporting.

5. Welsh Government and the Together for Children and Young People Programme (2) should work with their partners and with Regional Partnership Boards to organise further shared learning events to focus specifically on a 'no wrong door' approach for children and young people with complex needs.

   These shared learning events should include discussions of barriers between services' use of language (particularly but not confined to health, social care and education) around children with complex needs, in order to promote the new broader definition under the revised Part 9 statutory guidance, as well as being guided by the National Commissioning Board Wales' definition. The events should also include discussions of the issue of how information is shared and resources are pooled, and whether the current information sharing system needs improvement.

North Wales Regional Partnership Board

‘NO WRONG DOOR’

A Community-based Regional Strategy for Child and Adolescent Mental Health

2022 -2027

Executive Summary

DRAFT

1 Executive Summary

1.1 Background

The Children's Commissioner for Wales has highlighted the need for transformation in the way services work together to support children and young people whose needs are not deemed severe enough to require specialist support but, who are emotionally distressed and/or have behavioural issues. The aim is to produce a strategy that enables the North Wales Local Authority and Health Board partners to support the emotional resilience and mental health of children and young people in this group, across the region. The strategy proposes how agencies can best work together to respond to the full spectrum of needs of children and young people who are experiencing mental health problems. It identifies opportunities for the future development of services drawing on models of good practice in Wales and beyond.

The Regional Partnership Board commissioned Alder Advice to assist with this project. Alder Advice are a group of independent professionals who work within the health, social services and supported housing sectors, specialising in working with statutory organisations to improve outcomes for people. Their approach is always strengths based, appreciative and co-productive, seeking to build on the things that are working well and using these to tackle the issues that need to be addressed.

1.2 Introduction

The North Wales 'No Wrong Door' strategy was developed through a collaborative process using Appreciative Inquiry methods. These are strengths-based and seek to: discover what is working well in the current system; develop a joint vision for the future; design a future delivery model; propose and implementation plan.

The process took place over a period of 5 months and consisted of:

- Work with the regional team and Children's Services Managers to clarify the scope of the project and work collaboratively to initiate the work programme
- Quantitative data research
- An examination of national and international good practice relating to integrated children and young people's mental health and well-being services
- A series of workshops with professionals from partner agencies across the region
- Engagement with children and young people who have had contact with relevant services
- Iterative drafting of a strategy document and revision based on feedback form senior managers

The completed strategy proposes a radical revision of existing arrangements that offers an ambitious model for working together that will improve mental health and well-being outcomes for children and young people aged 0 to 25 years old. It builds on the strengths of the current system and is specifically designed for the local context.

The strategy recognises that children and young people's mental health and well-being is supported by multiple inputs delivered by a complex network of services and interventions, both formal and informal. This strategy has implications for all partners and agencies that

contribute to the health and well-being outcomes of children and young people, enabling them to live their best possible lives. At the heart of the strategy there is a requirement for agreement on funding the model. Each agency will need to interpret and align their own strategies and plans to this 'No Wrong Door' strategy.

The strategy proposes a regional approach based on a shared vision, an agreed set of principles and a common delivery model that will apply across the whole of North Wales. It however recognises that there are significant differences across the region reflecting culture, language, population density, and economic factors, amongst other things. The delivery model is therefore flexible and implementation can be tailored to local circumstances. The RPB will ensure that there is local accountability for compliance with the principles and system performance. We refer to this approach as Tight – Loose – Tight:
Tight adherence to the principles and outline service model
Loose (flexible) implementation of the service model
Tight accountability and monitoring of performance against the strategy.

1.3 Agreed Vision for the Future

This vision statement was developed from the key themes identified during the professionals' workshops and consultation with children and young people.

We want the children and young people of North Wales to enjoy their best mental health and well-being.

We will do this by ensuring the organisations that support them are easily accessed, work effectively together, and aim to deliver outcomes in a timely way, based on children and young people's choices and those of their families.

1.4 Principles

The strategy is based on the following principles, again derived from the collaborative development process and research into good practice.

1. Children and young people will be valued for themselves, and their worth appreciated.

2. We will listen to children, young people, and their families to understand their world and experiences. Their opinions will help us to shape and evaluate our services.

3. We will reduce the numbers of children and young people requiring targeted support by investing in preventative measures.

4. We will reduce the number of children of young people requiring more intensive support through timely, early intervention.

5. We will make it easy for children and young people and their families to find information about mental health and, if required, to obtain help that is accessed using simple and convenient arrangements.

6. There will be better support for mental health in schools.

7. All the children and young people will have access to co-ordinated help from a range of professionals, when this would be in their best interests.

8. No child should be excluded from a service because of their family circumstances

9. All children and young people will have the opportunity to form a trusting relationship with appropriate professionals. They, and their families, will have the support of a co-ordinator who will manage their case and help them to navigate the system.

10. Intervention will be timely, avoiding long waits for services and will be based on needs not diagnosis. Services will be child-centred, evidence based and flexible to ensure that needs are met and provided in ways that are suitable and convenient, including on-line.

11. The pathway will operate seamless across health and social services, education, community provisions and the criminal justice service.

12. We will have effective governance of system resources and professional activity.

1.5 Summary Model

The new service model developed to implement the North Wales 'No Wrong Door" strategy is designed to be flexible and responsive to different levels of need, with each level providing treatment and support tailored to, and proportionate to the child or young person's need, with a focus on providing timely help and preventing problems becoming more severe. This approach, in common with good practice models replaces a model consisting of service tiers based on diagnosis and a hierarchy of access criteria.

The new system is for children aged 0 - 25 years and aims to get the right help to the baby, child or young person as quickly as possible. In a complex multi-agency network of services this is best achieved through a managed process characterised by good joint working, information sharing and mature partnerships. The strategy therefore involves a multi-disciplinary service model which operates as if it were a single agency. This demands a change in culture, new systems and processes and funding arrangements. Where necessary there will be flexibility between children's and adult services.

We recommend that the model is given a distinctive brand identity. This has been done to good effect in other service redevelopment projects. It will mark a new beginning of collaborative working between the partners, make it more attractive to children, young people, and their families and facilitate the change in culture necessary for its success. Ideally Children and Young People will be involved in naming the brand.

The model is designed to respond quickly to mental health problems and find early resolution in the community where the baby, child or young person lives. Ideally this would be without the involvement of formal mental health services, other than to provide advice, if required. Universal services, and especially education, have an important role in nurturing children and young people's mental health and the early identification and support of those with developing issues. Training and support to these services is therefore essential to reducing the demand for formal mental health services, this should include mental health first aid.

The proposed formal mental health system is designed to respond to 4 different levels of need:

Low Needs - These are experienced by babies, children and young people who have had a wellbeing concern and have made good overall progress using preventative and non-specialist channels. There are no additional, unmet needs or there is/has been a single need identified that can be/has been met by support from educational support services, or a universal service.

Additional Needs – Babies, children and young people in this category have needs that cannot be met by universal services and require additional, co-ordinated multi-agency support at an early stage. It also includes those whose current needs are unclear.

Complex Needs – Babies, children and young people with an increasing level of unmet need, and those who require more complex interventions and additional, coordinated support to prevent concerns escalating.

Acute/Specialist Needs, including Safeguarding - These occur when babies, children and young people have experienced significant harm, or who are at risk of significant harm including those where there are significant welfare concerns. These children have the highest level of need and may require an urgent or very specialist intervention.

1.6 The New Service Model

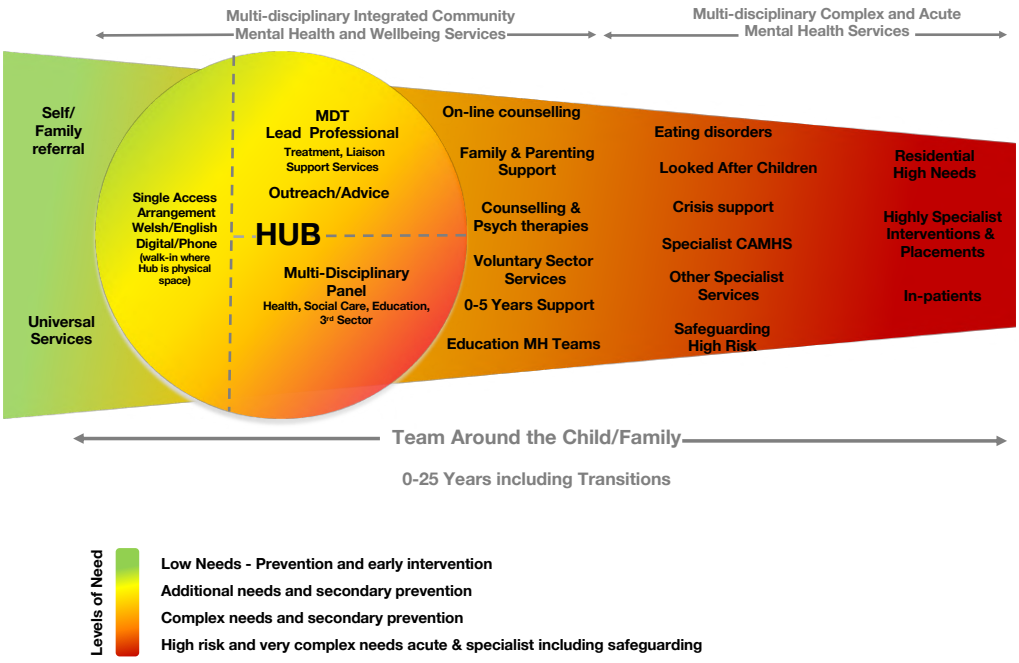

Figure 1: The New Service Model (Executive Summary)

The new model has open referrals (from any agency or individual, including self and family), multi-channel (letter, email, telephone or in person) access provided through a Single Access Arrangement (SAA). The SAA is the unique gateway into all mental health services for children and young people within the formal system.

Mental health 'Hubs' are a key feature of the system. These provide several functions including receipt of enquiries, triage, signposting to other services, assessment, treatment and support to children and young people and their families, outreach, and training for staff in other parts of the system. Hubs will be multi agency, bringing together staff from all relevant disciplines and services and operate using an agreed governance framework.

Hubs will ideally include (but are not necessarily limited to) physical entities with reception facilities, therapeutic spaces, and meeting rooms. They may also have the capability to operate peripatetically, using community facilities on an occasional basis or, if appropriate, a mobile resource. Hub operations will be supported by an ICT infrastructure and data sharing agreements to facilitate effective joint working and access/service delivery for children and young people.

Hubs will operate a Team around the Child (TAC) /Team Around the Family (TAF) practice model and every child or young person will have their treatment and support co-ordinated by a lead professional. The lead professional will be responsible for making arrangements

for access to any service provision required. The model includes a crisis response provision, which is available at any point in the pathway.

It is essential that the use of resources in the system is optimised, and this will be the responsibility of a multi-disciplinary, multi-agency resource panel. This is formed of the operational managers of key services within the system, schools' representatives and may also include housing and 3rd sector organisations. It will advise on which are the most suitable resources to meet the child or young person's needs in the most cost effective, timely and child-centred way. Importantly, it will have the authority to ask for flexibility in service access/eligibility and to adjudicate on disputes, where necessary.

The Resources Panel provides operational level (central tier) management and performance of the health, care and support system. It is part of a governance model consisting of three inter-connected levels of activity. The other levels are the services level (lower tier) and the strategic level (upper tier).

The service level governance has responsibility for service delivery. In the proposed "To Be" model this consists of two elements: the mental health hubs and all provider services (both directly managed and commissioned services)

The Strategic Level of governance is responsible for setting strategy and policy, holding the operations level to account for performance and resource use and is itself being accountable to The North Wales Regional Partnership Board and the Boards of each partner organisation.

1.7 The Case for Change

There are 3 key drivers for change in North Wales:

1) Economic and quality case: The current system offers limited opportunity for prevention and early intervention and is over reliant on high-cost specialist provision. Unaddressed mental health needs then lead to increasing morbidity and avoidable crisis which then fuels demand for yet more services. Investing in the mental health and wellbeing of children and young people will not only make the lives of children young people and their families better, research evidence suggest it is also likely to be more cost effective in both the short and longer term across a whole lifetime. The economic and quality case for change is based on the research evidence, system performance measures and local intelligence summarised in Figure 2. Below.

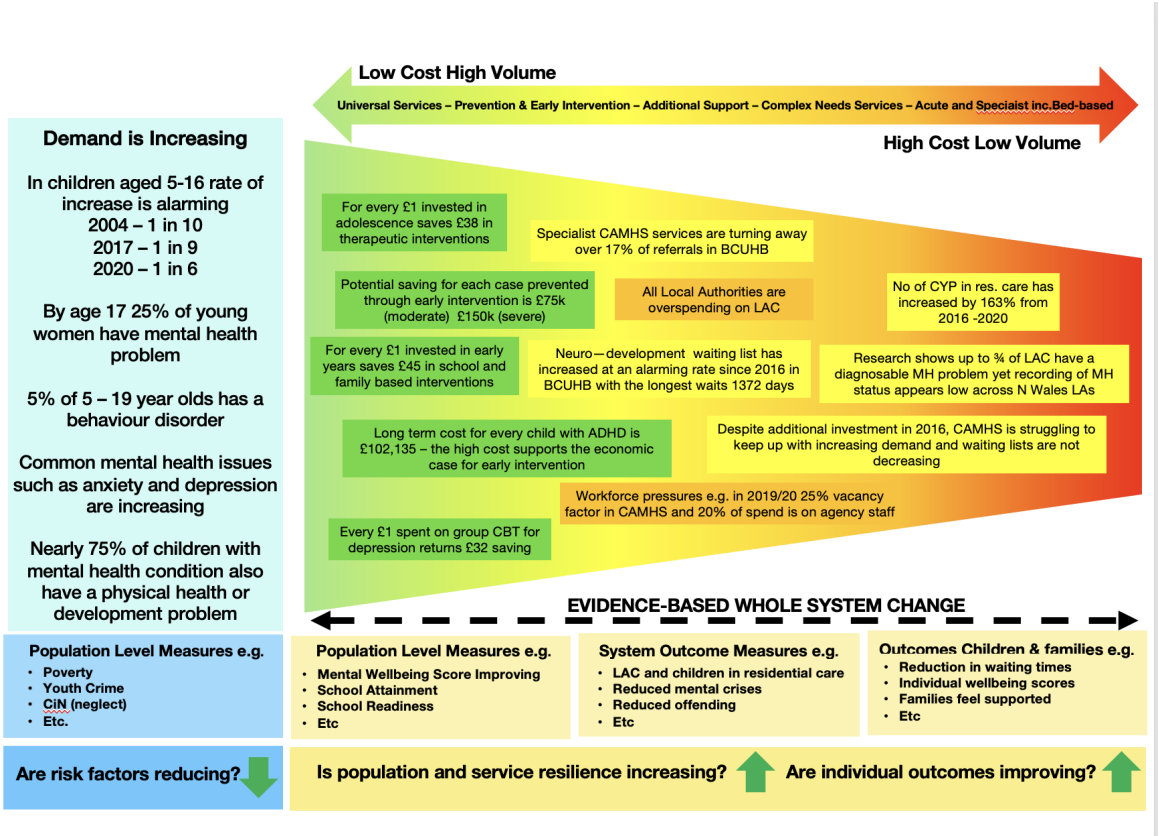

Figure 2: The Case for change Summary (Executive Summary)

2) Feedback from children, young people and their families: Children, young people and their families have told us there are multiple barriers to service access; waiting times are long and their experiences of services and outcomes are poor. This leads to children and young people's life changes being limited in both the short term and the longer term across their lifetime. Just one example of this is Gareth's story:

> "From a young age I felt something was different about me and when I started school my Mum and teacher noticed I was struggling to learn and got upset about going to school. My GP referred me to the neurodevelopmental team for an assessment and I waited 2 years to be seen. During the wait I was falling behind with schoolwork, feeling more upset and finding it hard to make friends at school. I was eventually told I had borderline autism and due to the diagnosis being borderline I didn't get any help at school I was in. It felt like nobody cared. I struggled through school, struggled to make friends and did not achieve any qualifications. When I was 17 I finally got a diagnosis of autism, but it was too late, I ended up homeless and felt a complete failure. I know I could have done much better because I receive support now but it's too late."

Children and young people told us they want to feel hopeful and particularly want to have services that are integrated, accessible and focus on prevention and early intervention. Feedback demonstrates that participants were pleased to see the range of concepts developed in the professional workshops.

3) Feedback from professionals: Recruiting and retaining the workforce is a major issue across North Wales. Attracting sufficient Welsh speaking staff is a particular problem. Staff are under relentless pressure to maintain capacity levels, meet ever increasing demand,

manage waiting lists and overcome multiple barriers to deliver services. Professionals have told us service delivery could be improved by organisations working together to deliver integrating services, making services more flexible, improving access, and really listening to and delivering what children and young people say they need. Professionals emphasised that they want to feel hopeful this time and want leaders to be brave, radical and deliver change at scale and pace.

10. Implementation

This is a radical and complex strategy that will require a substantial and well-resourced implementation programme to address the necessary culture change, development of an aligned/blended budget, structural changes, infrastructure requirements and development of the operating frameworks. The recommended 'Tight – Loose - Tight' approach allows for local solutions to realise the strategies ambition and its principles. Some of the implementation programme will require a regional approach, as the change requirements will be common across all areas, whereas some will require local development of those elements that are 'loose'.

The full strategy document outlines a five-year implementation plan, with the main changes taking place in years 1 -3. It will require organisational commitment and commitment of resources by all partners, strong programme management and external specialist support to the transformation process. It proposes an overarching regional approach, supported by local implementation groups, which would include some staff seconded from operational roles to undertake the necessary development work. These released operational staff will require temporary replacement. Implementation should align with, and contribute to parallel change process, for example the Betsi Cadwaladr University Health Board: Mental Health Maturity Matrix.

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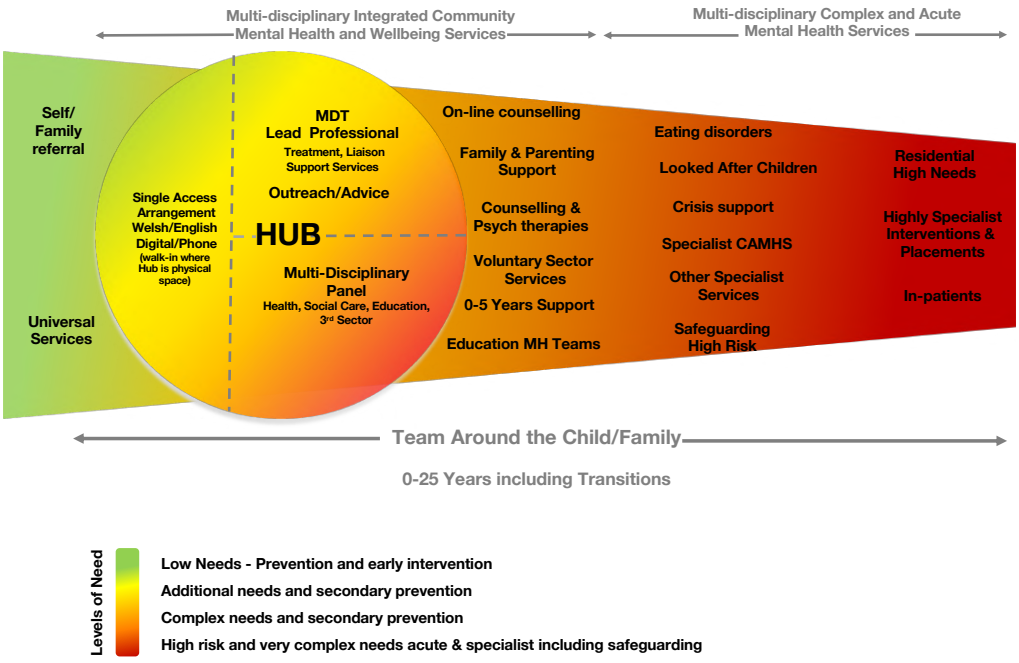

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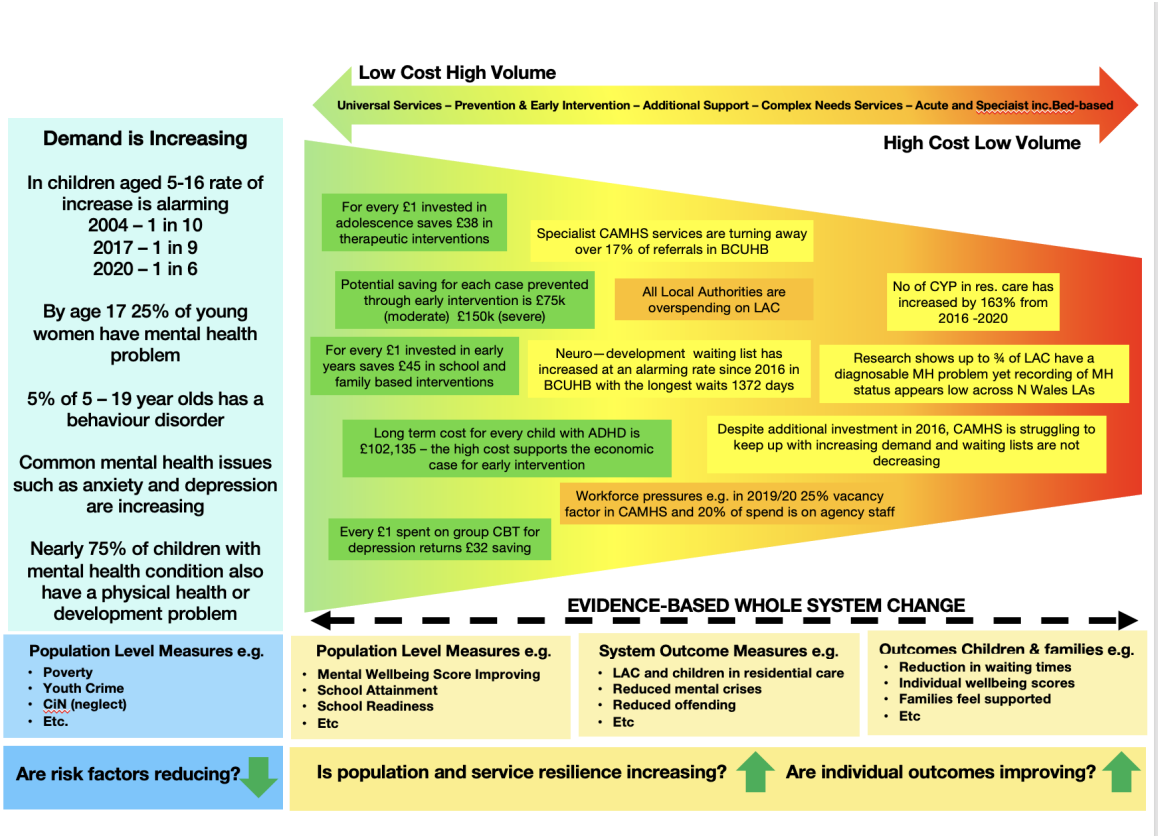

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Matrics Plant Implementation Plan

GWELLIANT CYMRU IMPROVEMENT CYMRU

GIG CYMRU NHS WALES

Commissioned by Improvement Cymru on behalf of the National Psychological Therapies Management Committee.

September 2021

Introduction

This plan has been designed to support the implementation of Matrics Plant: Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales[1]. It is anticipated that it will assist health boards and partners in ensuring that both the spirit and detail of Matrics Plant are transferred into action. It has not been designed as a performance management tool but rather a process to recognise existing practice and plan for improvement, if needed. It offers the opportunity for health boards and partners to consider the needs of all children, irrespective of diagnosis or neurodevelopmental profile; identifying examples of good practice and action needed to address gaps in current provision.

Both Matrics Plant and this implementation plan should be considered in relation to children's human rights under the United Nations Convention on the Rights of the Child[2] and in particular, every child's right to express their opinion freely about all matters affecting them and the principles of participation as set out in the national participation standards[3]. The Children's Commissioner for Wales has produced materials to support the implementation of the Convention in your work[4]. They also sit within the overall policy context in Wales which includes the Whole School Approach[5] and the NEST Framework[6].

Ensuring services are equitable to all those in need of them will be central to provision of effective psychological interventions. Reasonable adjustments for those with protected characteristics, including refugee and asylum seeking children, the ongoing development of services available in the Welsh language and more broadly culturally competent services will be essential.

1 https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/psychological-therapies/resources-psychological-therapies/matrics-plant/

2 https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

3 https://gov.wales/sites/default/files/publications/2018-02/Bilingual-Participation-Standards-poster2016.pdf

4 https://www.childcomwales.org.uk/the-right-way-a-childrens-rights-approach/a-childrens-rights-approach-in-wales/

5 https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-well-being

6 https://collaborative.nhs.wales/networks/wales-mental-health-network/together-for-children-and-young-people-2/the-nest-framework/

A Note about Evidence Tables

A process for reviewing the evidence tables, which are currently published as addenda to Matrics Cymru, is underway and new evidence tables will be published over the coming months. Evidence tables in respect of children and young people will be included in this work. These will be developed to encompass interventions in a variety of settings and services and include, but not be limited to, child health, children with additional needs, looked after children, children with learning disabilities and neurodevelopmental needs. In the interim, practitioners are referred to the Scottish Matrix[7] (which includes infant mental health) and National Institute for Health and Care Excellence[8].

Psychological Interventions

Within Matrics Plant, Psychological Interventions are defined as:

" ...purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing".

As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Interventions with main carers/parents
- Interventions directly with child or young person.

Whilst the formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who accesses our services, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of a psychological intervention.

7 https://www.nes.scot.nhs.uk/media/420chmra/matrix_-_children_youngpeopletablesfinal_2015.pdf

8 For example, possible depression: https://www.nice.org.uk/guidance/ng134/chapter/Recommendations

Purpose

This plan is intended to assist health boards and their partners in the delivery of Matrics Plant. Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children, young people and their families.

This requires an evidence-based theoretical framework to guide the provision of a range of interventions, in addition to the delivery of direct therapy specific interventions. Matrics Plant does not recommend specific models of service - accepting that models may vary according to local need and resource and change over time. It does, however, have a number of organising principles for services which recognise that children and young people:

- Live in their own specific circumstances
- Will have their own developmental needs
- Will have differing levels of control over their lives and/or the ability to seek support
- Should receive appropriate and proportionate psychological services based on distress/need rather than always requiring a mental health or other diagnosis
- May be best helped by services working with the people that the child or young person spends time with as well as offering individual work with them when this is needed.

Psychologically minded services for children, young people and families should therefore:

- Be able to engage children and young people in a way that supports their level of ability and communication
- Be able to offer interventions with children, young people and families' immediate and wider contexts/systems as well as with the identified child or young person
- Be trauma, attachment and ACE (Adverse Childhood Experiences) informed with appropriate competencies and skills
- Engage proactively with health, local authority, education, third sector and youth organisations in order to create conditions to foster positive child development
- Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments
- Help children, young people, their families and the systems around them to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework
- Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered
- Contribute to strengthening the evidence base, drawing on and developing practice-based evidence and evidence informed models.

And in direct psychological work with the child, young person or family be able to:

- Offer a service in Welsh
- Deliver evidence-based care via appropriately qualified, supported and supervised staff
- Provide an appropriate choice of evidence-based interventions
- Operate within a framework of values-based practice which places children's needs as central
- Communicate effectively according to the developmental needs of the child – this may include non-verbal interventions such as through play, music, art or drama
- Deliver measureable outcomes improving and/or associated with psychological health and wellbeing
- Help children, young people and families to achieve personally meaningful progress
- Evaluate and respond to feedback from children, young people and families about the appropriateness of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy.

In practice, this means having practitioners within the workforce who:

- Are able to deliver a service in Welsh
- Are trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work
- Are delivering interventions which make sense in respect of the presenting needs and are supported by the best possible evidence
- Are operating within a well-governed system which offers regular high quality, psychological supervision (model-specific, where appropriate) support and relevant Continuing Professional Development (CPD)
- Are monitoring the quality of the therapeutic relationship, recognising that this is an essential factor in achieving a successful outcome
- Have a role appropriate understanding of social, emotional, psychological, cognitive and physical development and the impact of acute, chronic or life limiting physical health problems on emotional wellbeing and mental health
- Have a role appropriate understanding of systemic case conceptualisation
- Have the ability to communicate effectively with children, young people, their carers and practitioners in their contexts, the systems and to maintain a compassionate approach

- Have an awareness of the impact of attachment, developmental trauma and ACEs with role appropriate competencies
- Have role appropriate training to appropriate standards with the competences required and the support necessary to deliver psychological interventions effectively within the service context in which they work
- Contribute to innovative and reflective practice.

A Note about Examples of Evidence

This plan sets out key questions in relation to the points above, gives examples of the type of evidence that may be provided, asks health boards to identify their local evidence and invites health boards to outline a plan for improvement, where needed. For some of these areas, local services will already be well developed and health boards will be able to demonstrate this through reports, data and appropriate up to date policies etc. This will give scope to identify and improve the less well-developed aspects of services.

Examples of the types of evidence that might be provided are included in the tables. These are examples only and not dimensions against which evidence must be provided. Health boards should not be constrained by these and may have other innovative approaches to achieve the required outcomes.

Section 1: Be able to offer interventions with children, young people and families'[9] immediate and wider contexts and systems as well as with the identified child or young person

Key questions	Health board evidence	Plan for improvement if needed
Are the following types of services[10] available? ▪ Targeted training ▪ Network consultation ▪ A range of consultative support ▪ Direct intervention with parents/carers ▪ Direct interventions with children and young people	All participating services reported delivery of targeted training for staff within the service and professionals working with children and young people across the wider system. All offer consultation. All include parents/carers in their interventions with children and young people, not all offer direct interventions for parents/carers if not working with child, All offer direct interventions with children and young people.	Clear definition needed of consultation. Agreed menu of interventions needed, with associated guidelines and information for young people families and referrers.
Is there an appropriate range of evidence-based 1:1 or group direct psychological interventions available at varying levels of intensity linked to current evidence tables?	There is a wide range of evidence-based interventions available for children and young people via community CAMHS teams and for children with health conditions although limited capacity. Some	Limited availability at Tier 4 due to lack of capacity. Very limited availability for children with learning disability. New SIF investment in place to develop this
Are a range of psychological interventions involving parents/ carers routinely available and linked to evidence tables?	Routinely available via specific interventions that include parents/cares e.g. Family-Based Treatment	Define parent/carer involvement in menu of interventions and outcome measures for
What is the capacity/provision for interventions for the system around the child?	Schools In-reach service, some practitioners have job plans with sessions for consultation work within the	System needed to reliably identify capacity allocated to different psychological intervention functions,

Examples of evidence could include: A menu of psychological interventions' is available and accessible for service users, families, staff and stakeholders; Agreed guidelines about when each type of intervention would be appropriate; A menu of quality assured targeted training modules available to meet common needs; An operational process for arranging, recording and following up on network consultation and consultative support including its impact on the child, young person, or family's wellbeing and goals; A menu of direct psychological interventions' is available and accessible for service users, families, staff and stakeholders; A menu of psychological interventions with parents/carers is available and accessible for service users, families, staff and stakeholders; Job plans/job descriptions/person specifications etc.

9 When this document refers to children and young people, it refers to all those aged 0 to 17 years. Family can mean very different things to different people at different times. In this document, family can mean the people with whom a child or young person lives with and who may or may not be related to them, as well as people to whom they are related.

10 Descriptions of these services can be found in Matrics Plant: https://phw.nhs.wales/services-and-teams/improvement-cymru/news-and-publications/publications/matrics-plant/

Section 2: Deliver measureable outcomes improving and/or associated with psychological health and wellbeing

Help children, young people and families to achieve personally meaningful progress

Evaluate and respond to feedback from children, young people and families about the appropriateness, accessibility and acceptability of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy

Key questions	Health board evidence	Plan for improvement if needed
How are the services offered reviewed and developed in relation to current and emerging evidence base?	Some services routinely disseminate and review NICE and other guidelines, others have adopted adhoc informal processes that are not captured or recorded. Individual job plans, CPD, regional and	Reliable systems for reviewing evidence needs to be introduced through the Emotional Health Clinical Advisory Group. Local processes needed to implement updates and reporting process to ensure
How are children and young people enabled to seek advocacy support, as needed, to promote and empower their participation in setting goals and aspirations they seek for themselves?	Routinely offered for children and young people in inpatient care through IMHAs. Routinely offered to children and young people with learning disabilities through Local Authorities and Special Schools and reviewed at annual reviews. Staff in community services variably aware of process and how to	Ensure all staff are aware of Advocacy when joining the service (induction) and that knowledge and skills are maintained. Case note audits to determine how often offer of advocacy occurs in goal setting.
How are outcome measures[11] routinely used to: ▪ Ensure goals are personally meaningful? ▪ Evaluate service user satisfaction? ▪ Demonstrate and support improvement in mental health and emotional wellbeing?	C-GAS, GBOS, ESQ mostly used routinely across CAMHS. Condition specific measures also used in addition. Outcome measures agreed for children with learning disability but not routinely implemented. Outcome measures used proactively in inpatient setting as part of progress and planning.	Outcome data collection and feedback systems urgently required so staff and young people benefit from learning. Staff training in use of R-CADS needed as WG have introduced Silver Cloud which relies on R-CADS (when R-CADS is not one of the required routine outcome measures). Need position paper and training plan on outcomes

Examples of evidence could include: Regular, documented review of interventions offered by service in relation to new and emerging evidence tables, gaps identified and training/development plan generated; Staff survey feedback; Service user feedback; Policy regarding monitoring of engagement, attendance and participation etc. to ensure that this indirect feedback as to acceptability, accessibility and appropriateness is used to improve services; Evidence of changes made where service user satisfaction has indicated they are necessary etc.

11 https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/outcome-measures/framework/

Section 3: Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments

Help children, young people and their families to understand the emotional and psychological needs of the child or young person within this framework

Be able to engage children and young people in a way that supports their level of ability and communication[12]

Be trauma, attachment and ACE informed with appropriate competencies and skills

Key questions	Health board evidence	Plan for improvement if needed
Do staff have a role-appropriate working knowledge and understanding of the impact of the following on emotional wellbeing and communication: ▪ Child development (physical, cognitive, emotional, social including neurodevelopmental differences)? ▪ Current attachment theory? ▪ Up to date knowledge of ACEs? ▪ The impact of developmental trauma? ▪ Learning disability?	Role-appropriate working knowledge is profession specific. Those without core training acquire basic knowledge through induction, and learning through exposure. Child Learning Disability staff are highly knowledgeable and skilled in child development and are a potential resource for others. West area CAMHS has maintained a learning disability arm to the service with three learning disability specialists within the CAMHS team. This is an area of good practice. It is expected that all clinicians have appropriate working knowledge of all listed areas but this is not easy to evidence or review within and across teams.	Record of required competencies needed in all services. Training Needs Analysis needed for all staff. There needs to be a link to training plans and available recommended training. Job plans and PADRs to be used as vehicle to achieve identified knowledge skill and competencies for individuals and the team. Newly funded SIF post recruited to starting October 2022 will focus of Training and Development in CAMHS. This role will contribute to defining and coordinating learning needs and training across the region.
Is there a process for determining what training or CPD will be necessary to enable staff to deliver appropriate psychological interventions in relation to the above?	Mainly PADR and Training Needs Analysis where in place. Targeted Intervention Improvement Plan addressing Recruitment Retention and Training as part of Workforce work stream.	Accessible database of staff skills and competencies and identified training needs. Psychological Intervention skills need to be mapped on to the plan. Job plans need to identify time for CPD. Where possible and appropriate share in-house training opportunities across all teams.

12 The importance of children and young people, especially those with mental health needs or a learning disability, being able to communicate in Welsh (or other first language of choice) is recognised as fundamental to their ability to express their thoughts and needs

How are services made accessible for children, young people and families who have mental health needs and may struggle to engage with traditional clinic-based services due to, for example, developmental trauma, presenting need, neurodiversity, learning disability?	Some services are highly responsive, flexible and needs led in order to reach young people by e.g. meeting local to home and at a suitable non-threatening environment; this is particularly apparent in Kite and Learning Disability service offers. Was Not Brought policy actively used in all services. Services are developing in primary care settings and in schools where some young people might prefer to meet. Offers include home visits, telephone, texting and remote access. Sone teams offer appointments outside traditional office hours to accommodate young people after schools and	Training Plans are in development and will be tied to Training Needs Analyses and Psychological Intervention Plan. Considerable work is needed on estates and accommodation. Teams need to review service offer in the evenings and weekends based on service user views. Review of training plans and adherence in area teams for future audit cycle.

Examples of evidence could include: Database/record of staff training; Database/record of staff competency; Review at annual staff appraisals (e.g. PDR, PADR etc.); Training plans including programme of staff development opportunities and knowledge updates, could include special interest groups; Policy around follow up for families who have struggled to engage; Allowances are made within capacity planning for establishment of rapport and relationship with these children, young people and families; A range of engagement methods are available, ranging from text messaging through to face to face.

Section 4: Engage proactively with health, local authority, education[13], third sector and youth organisations in order to create conditions to foster positive child development

Help the systems around children, young people and their families to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework

Key questions	Health board evidence	Plan for improvement if needed
What are the pathways/processes for relevant systems and organisations to access expert psychological/psychologically informed support in order to assist them to improve the appropriateness, accessibility and acceptability of their services?	Kite (Community Intensive Outreach) and Inpatient services are accessible through community CAMHS. Access to wider system only when open to Tier 4. Pathways into community CAMHS vary slightly	Clear and consistent pathways need defining documenting and implementing locally with regular reviews to ensure consistency in offer and outcome measures. Local area Service Level Agreements and Partnership Agreements where relevant and
What are the links/pathways for staff working with children, young people and families more broadly within the health board (e.g. health visitors, school nurses) and outside the health boards (e.g. local authority staff, family support workers) to access expert mental health advice/consultation/training?	As above. Some additional access via other joint agency service pathways where services have been developed and are being delivered in partnership e.g. Multi-systemic Therapy Team (East CAMHS); Meadow Lodge and LIFT Team (Central CAMHS); Early Years CAMHS (East	Service specification for early intervention and prevention including Schools In-Reach and Practitioners offering services through primary care will define access to consultation pathways. Staff training needs to be identified in relation to consultation-based working.
Where staff working with children, young people and families within and outside the health board are delivering psychologically informed interventions, how can they access psychologically informed supervision/support?	Within the Health Board, formulation-specific consultation and supervision is in place within teams, Capacity to provide for those in the wider systems around children is limited. Largely available through in-service supervision	Clear pathways to access consultation as intervention to be developed and delivered by staff with appropriate skills and competencies. Access to supervision will require partnership development and investment.
What is the capacity/provision for joint and multiagency working in order to provide the most effective psychological intervention?	Case-by-case and needs led via multi-agency meetings, engaging with schools and other relevant community settings; some named practitioners as	Where over-reliance on individuals identify risk management plan and address. Ensure support systems are in place to ensure adherence to

Example of evidence could include: Clearly identified points of contact for these staff within psychological intervention services; Clear, published and publicised pathway for accessing and providing this type of support; Proactive, published and publicised training offering is available to these staff; Agreed mechanism/procedure to capture non-direct intervention as meaningful clinical activity; Local partnership agreements; Job plans/job descriptions/person specifications etc.

13 https://gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-well-being

Section 5: Staff will receive the appropriate level of supervision – this should include mental health staff, other health board staff and staff in other agencies, as appropriate

Key questions	Health board evidence	Plan for improvement if needed
Is there provision for role-appropriate supervision of practitioners engaged in psychological interventions?	In community CAMHS and Tier 4 formulation-focused role appropriate supervision is available for all clinicians. Model-specific supervision is available where needed locally or regionally. Growing our own clinician skills and accredited supervisor skills is already underway - this is an example of good practice. Within child learning disability it is largely psychologists and assistant psychologists delivering psychological interventions - different levels of supervision are available depending on what is being	Review of supervision offer is needed. Some clinicians deliver several specific models each requiring model-specific supervision. This presents a challenge which needs to be reviewed and addressed. Recommendations to be developed disseminated and implemented. Policy / guideline to be developed. Guidance for other agencies on consultation and supervision also to be developed.
What are the links/pathways for staff working with children, young people and families more broadly within the **health board** (e.g. health visitors, school nurses) and **outside the health board** to access appropriately skilled supervision and support?	Not enough information to answer this and not clear where the responsibility for it lies. Access to external model-specific training and supervision is available for any agency. Trauma Informed Schools Network; Mental Health and Youth Mental Health First Aid; Friends Resilience; Video Interaction Guidance; Incredible Years; all have defined refresher/update and supervision requirements built in.	To discuss with partner agencies how to work together and offer support and recommendations within role.

Examples of evidence could include: Local supervision policies and compliance with these are monitored; There is an index of supervisors, to include capacity and the psychological therapy model(s) offered; Supervisory capacity will meet the needs of all staff; Job plans include time for regular clinical supervision and this is monitored at least quarterly; Jointly developed and agreed framework/policy for the provision of psychological intervention supervision/support etc.

Section 6: Contribute to strengthening the evidence base, drawing on and developing practice-based evidence and evidence informed models

Key questions	Health board evidence	Plan for improvement if needed
How are practitioners within the service involved in research?	Kite Community Intensive Outreach involved in national RCT - IVY trial. Several teams directly involved in audit and evaluation. Small and large scale research projects through Trainee Clinical Psychologists via North Wales Clinical Psychology Programme. Through partnership projects such as Adtrac, Schools In-reach pilot; MST. Mental Health Improvement funded Research Assistant in place and actively involved in supporting	Process for agreeing approval for sign up for national trials in Children's Services unclear. No capacity allocated for research and development in teams even when part of job description. Agreement in CAMHS to include protected time for specific roles to attract staff to the area. This needs to be adopted across other specialties. Process for seeking approval and evaluating practice-based evidence to be defined agreed and
How are practitioners supported to remain up to date with the current evidence base?	Various examples of good practice across services: Staff development forum (Kite); Regional Forum within specialties (learning disability, child health conditions); CPD time; PADRs; Communities of Practice; teaching preparation; assignment marking. MDT meetings. Peer case discussions. Consultation in-house. Clinical supervision including model-specific supervision. Reading group, Sharing information through Teams channel	No formal systems in place or recorded. Targeted Intervention Improvement Programme and Emotional Health CAG to direct. Academic Lead role funded though Mental Health Improvement funding to be recruited to as part of Recruitment Retention and Training and Psychological Interventions work streams. Staff publications to be shared through CAG and valued
How are the analyses of outcome measures audits shared appropriately, internally and/or externally in order to support the evidence base in relation to most effective outcomes?	Very variable across services and within services across the region. Some examples are in place but limited and largely adhoc: - C-GAS dashboard (Kite) - routine sharing of audits at Emotional Health Programme Team (East CAMHS) - highlight reports shared at Emotional Health Programme Team (Central CAMHS) - Quality Standards and Development Group	Complete plan for analysis of outcome measure in child disability services. Data sets and data collections systems need to be defined agreed and implemented. Regular sharing of audits at Emotional Health CAG and where agreed in Integrated Children's Services Board with partners.

Examples of evidence could include: Evidence of support for research activity; Links to local academic institutions; Research publications of staff; Evidence of sharing outcomes of audits appropriately etc.

Section 7: Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered

Key questions	Health board evidence	Plan for improvement if needed
How are the opinions of children, young people and families used to inform, co-produce and develop the service and the range of indirect interventions offered?	Patient Experience Officers have been appointed to CAMHS, Child Learning Disability and Child Neurodevelopment Services, and a Patient Liaison Officer to Tier 4 CAMHS; to focus on engaging and communicating with service users. Pockets of good practice in area teams continue -	Patient Experience Officers have focused on broader views of children and young people through the development of a Children's Charter. The specific needs of those who use the service will need to become the focus in the next 12-18 months.
How are children, young people and families fully involved in co-production of care plans and/or intervention goals?	Care Plans in primary and secondary care; Goal Setting; Care and Treatment Plans; multi-agency involvement and joined up planning.	Areas for development include training / refresher and update training in goal setting; how to set 'SMART' goals; and also how to manage the challenge of setting evidence-based intervention goals with young people when young person's goals are different. Training plans and on-going
How much informed choice do children, young people and families have around which psychological intervention is provided (both in terms of the type of intervention and the way in which it is delivered?	Wide range of types of psychological intervention are available from CAMHS and Child Health Psychology, both the model of intervention and how it will be accessed - face to face or remotely via digital platform, telephone if that is the only way to engage. Limited choice for children and young people with	Staff in-house may not always understand and / or recommend specific evidence-based interventions from assessment therefore need to ensure that the full offer is understood and applied by those in assessment roles. Good quality information needs to be developed

Examples of evidence could include: Services have conducted a review of youth and mental health organisations locally through which young peoples' views on current/future psychological intervention services can be accessed and have robust pathways to access and feedback these views to inform service development; Policies and procedures reflect current views of children and young people as published in relevant reports (e.g. Young Minds) and from local intelligence; Sample audit of assessments, care plans, or other relevant goal setting documentation for children and young people demonstrate informed engagement in goal setting; There is clear and accessible information proactively provided (perhaps in the form of a leaflet) which outlines for children, young people and families the range of psychological interventions available, the benefits of each and why services may recommend a particular approach (e.g. parent work rather than direct work with child); Where appropriate and available, children, young people and their families have a choice of evidence-based psychological interventions; *Where a choice is not available due to a lack of trained staff or other service constraints, this is recorded and plans are in place to reach a position of being able to offer this choice meaningfully etc.

Section 8: Equity and Accessibility

Key questions	Health board evidence	Plan for improvement if needed
Are there a range of psychological intervention services available to meet the needs of children, young people and families irrespective of diagnosis?	We do not work with diagnoses. Rather we focus on formulation-driven service offers - a range of approaches is available in all areas, some limitations in some teams e.g. lack of capacity for moderate to severe mental health interventions for children and	Good quality information needs to be developed including easy read versions. Pathways need to be clear. Offer needs to be levelled up across the region. Capacity to offer psychological interventions for children with learning disabilities needs to be
How is it ensured that all services and documentation are available in the Welsh language?	All bilingual documentation including some self help materials (CAMHS West). Variable across other teams beyond initial standardised WPAS appointment letters - needs to be reviewed. Some wait considerably longer for intervention through the	Limited access to Welsh speakers is a real issue. Welsh speakers work flexibly to try to meet the needs but there are fewer of them than is needed. Information needs updating/refreshing and using consistently across the region. Significant delays in
What are the mechanisms in place where the child, young person or family prefer or need to access services in a language other than Welsh or English?	Asked at referral and on joining the service their preferred language. Language Line translation Services referral process.	To ensure that all services meaningfully ask about preferred language and record in notes. Ensure all staff are familiar with Language Line referral process and how to conduct sessions via this service.
What reasonable adjustments exist to ensure services are accessible to people with protected characteristics and marginalised populations[14]?	A variety of approaches are taken - visit all wherever is appropriate; visit at home; visit more often for shorter periods of time; use adapted materials where needed; join another clinic e.g. outpatient paediatric clinic; use remote access methods such as Attend	Use expertise across teams where appropriate and meets the needs of young people; identify and record all those who can offer service in Welsh and share; establish how scarce resource can be flexibly delivered; develop focused recruitment campaign for
How is equity of service access ensured across the geographical area?	Kite and NWAS are regional services already, Services for children with learning disability are variable across the region - set up differently with different staff configuration and delivery; not equal or equitable for those who don't drive; not equitable for	Access to appropriate buildings is a priority. Access to appropriate space across the geographical patch is essential especially for rural communities. Some posts need to be identified as Welsh essential.

14 http://www.legislation.gov.uk/ukpga/2010/15/contents
https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equalityduty-wales
https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-248

Are services provided in accessible locations?	Mostly where possible. Child Health services are delivered from hospital only sites - this links with medical system of which they are an integral part. Space is not equal in accessibility or suitability across the region. West CAMHS - very accessible on public transport; East CAMHS Wrexham base good,	Significant improvement in availability of accessible venues of good quality especially needed for those in distant rural communities.
Are services available digitally[15] where appropriate?	Yes via MS Teams; Attend Anywhere; access to good quality web-based information signposted; Silver Cloud recent roll out of parent modules. Not offered for Tier 4 Inpatient service.	Connection to internet is patchy from some clinic bases. Not appropriate for some families - hardware, privacy/space.
How are children, young people and families supported to access digital services where there are barriers?	If appropriate work with school to enable access to machinery and confidential space where not available at home; same via other community setting where appropriate	Need to establish what support there is for those who may not have equipment and would prefer to use. Collate information locally on dialogue-firendly community environments for shared use.

Examples of evidence could include: Overview of services available to meet the psychological wellbeing needs of children, young people and families; Clear pathway to ensure children and young people can access appropriate psychological intervention (may not be with the service to which they have been initially referred); Record of practitioners who are able to deliver a service fluently in Welsh; Translators used have an appropriate level of psychological fluency; All bespoke written material available in Welsh without delays; All standardised written material available in Welsh; Evidence of compliance with current legislation on disabled access; Building and rooms appropriate for the developmental stage and age of the child or young person; Leaflets/reading materials appropriate for a range of developmental stages and ages and in an appropriate range of languages; Appropriate facilities and locations including waiting areas, access, clear signage to and within the building, confidential and safe consultation rooms etc.; Consideration of children, young people and their family's individual circumstances including rurality, access to transport and cultural context.

15 E.g. video conferencing via telephone or text

Table 1: Extract from BCUHB Children's Performance Report September 2022 – Mental Health Measure Part 1b

September 2022	Total Numbers Waiting (Measure and Non-Measure patients)				% Waited within target seen within month (Measure only patients)				Longest waiter (weeks)			
	E	C	W	BCUHB	E	C	W	BCUHB	E	C	W	BCUHB
CAMHS Part 1 Target 80%												
Intervention	290	126	152	568	25%	8%	50%	23%	49	32	47	49
Intervention > 28 days	252	88	140	480								

Teitl adroddiad: ***Report title:***	Review of the Audit and Pyott report for Ophthalmology services 2021.			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 May 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report has reviewed the recommendations of the Audit and Pyott reports published in 2021 and makes recommendations of their key findings and draws together an action plan (Appendix 1). It also makes 3 recommendations			
Argymhellion: ***Recommendations:***	*QSE are asked to support the following:* 1. Instigate an Ophthalmology steering group focusing on secondary care service 2. Align this work to the eye care collaborative 3. Review the risks associated to the service across North wales			
Arweinydd Gweithredol: ***Executive Lead:***	Gill Harris – Assistant Chief Executive			
Awdur yr Adroddiad: ***Report Author:***	Andrew Kent SME - Planned Care			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				

<table>
<tr><td>Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td></td></tr>
<tr><td>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP7 has an EqIA been identified as necessary and undertaken?</td><td>Report into Audit and Pyott report, therefore not applicable.</td></tr>
<tr><td>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP68, has an SEIA identified as necessary been undertaken?</td><td>Report into Audit and Pyott report, therefore not applicable.</td></tr>
<tr><td>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</td><td>See below current risks associated with service, further review of secondary care risks will be undertaken.</td></tr>
<tr><td>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith

Financial implications as a result of implementing the recommendations</td><td>There are no highlighted financial implications in the paper. However significant service change and modernisation is required and will be fed into both capital and IMTP streams</td></tr>
<tr><td>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith

Workforce implications as a result of implementing the recommendations</td><td>A full workforce review is recommended in the report</td></tr>
<tr><td>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori

Feedback, response, and follow up summary following consultation</td><td>Discussion with site management teams, Ophthalmology network lead and clinical lead have formulated this paper, prior scrutiny has been with the Deputy Chief Executive</td></tr>
<tr><td>Cysylltiadau â risgiau BAF:
(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)

Links to BAF risks:
(or links to the Corporate Risk Register)</td><td>
<table>
<tr><th>Current risk identifier</th><th>Descriptor</th><th>Score</th><th>Mitigated score</th></tr>
<tr><td>1986</td><td>Follow appointments for Glaucoma</td><td>15</td><td>6</td></tr>
<tr><td>2498</td><td>Follow appointments for Ophthalmology</td><td>16</td><td>4</td></tr>
<tr><td>3628</td><td>Insufficient clinical capacity</td><td>16</td><td>6</td></tr>
<tr><td>24999</td><td>Ophthalmology accommodation</td><td>9</td><td>1</td></tr>
</table>
</td></tr>
<tr><td>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)

Reason for submission of report to confidential board (where relevant)</td><td>Not applicable</td></tr>
<tr><td></td><td></td></tr>
</table>

Next Steps: ***Implementation of recommendations***
List of Appendices: ***Appendix 1- Ophthalmology secondary care action plan***

Introduction

Previous papers submitted to the Executives and Risk committee describe the risk to the Ophthalmology and eye care services.

The table below identify risks to elements of the service, however, they do not encapsulate the entirety, nor other key risks identified recently through the Audit and Pyott reports.

Current risk identifier	Descriptor	Score	Mitigated score
1986	Follow appointments for Glaucoma	15	6
2498	Follow appointments for Ophthalmology	16	4
3628	Insufficient clinical capacity	16	6
24999	Ophthalmology accommodation	9	1

The Pyott report (September 2021) and the Audit report (November 2021), highlighted good practice and risks in the delivery of the service. The Pyott report covered the eye care from a national perspective with organisational recommendations, where the Audit report reviewed BCUHB.

Although eye care services was covered, both reports focused on the issues within secondary care. The Audit report covered four particular areas:

- Waiting times
- Effectiveness and productivity
- Managing performance, accountability and leadership
- Service modernisation

The Pyott report used similar language and made ten recommendations, the Audit report made twelve. This paper has reviewed the twenty-two recommendations and has drawn them into an overarching action plan, providing a framework to ensure work can commence to improve the service, reduce harm and give a sustainable strategy going forward. (Appendix 1)

Report

The national GiRFT report on Ophthalmology in December 2019 highlighted the growing demand in Ophthalmology services over recent years with demand for this service rising fast – with referrals from primary care up by 12% since 2013/14 nationally. Repeated studies have indicated it will rise faster still, particularly in an ageing population. The paragraph below reflects the national findings and describes the challenges in this service as well:

"*While millions of patients every year benefit from high-quality care – including primary care provided by optometrists – many in the specialty are highly aware that the system is struggling to keep pace. The ophthalmology workforce has not grown in line with demand. Many hospital ophthalmology departments are cramped with little scope for expansion, and reliant on outdated or limited IT systems.*

Whilst many other specialties could point to similar challenges, in ophthalmology there is clear evidence of a deeply damaging consequence. A 2017 national investigation found that over 20 people a month lose their vision due to delays in receiving follow-up care in the United Kingdom."[1]

The Audit and Pyott reports have made a number of strategic recommendations related to the risks of the service, which echo the national GiRFT report. However little advancement has been made since their recommendations in 2021. The Deputy Chief Executive of the organisation has requested planned care to review the reports and give recommendations on the next steps. These are cited later in this paper.

The table below summarises the RAG rating of the recommendations and Appendix 1, is the combined action plan for both the Audit and Pyott reports.

The paper highlights the key recommendations that are "Red" and the actions being planned to commence further work and to mitigate the risks.

More detail can be found in Appendix 1.

Summary October 22			
	Audit report	**Pyott report**	**Total**
Red (not commenced)	7	3	10
Amber (some evidence of work in progress)	3	6	9
Green (clear work in progress or completed)	2	1	3
Total	**12**	**10**	**22**

The recommendations not yet commenced is listed below:

1. Working as a north Wales service not locality to reduce health inequalities
2. Strategic workforce plan
3. Strengthening the formal reporting line
4. Improving the estate
5. Introducing high volume low complex activity schedules
6. Improving service efficiency (implementing GiRFT)
7. Improving data at sub speciality level

[1] GiRFT –National review of Ophthalmology services 2019.

The seven points above cover the ten recommendations raised in both reports. Each point receives further detail below:

1. Working as a north Wales service not locality to reduce health inequalities

Although a significant amount of work has been undertaken to modernise eye care services, it has focused on moving elements and pathways into the community and joining, via those pathways, primary and secondary care. However, this has meant secondary care has not had the same focus. The recommendation is to establish an Ophthalmology steering group, to facilitate the recommendations of the reviews. This will move the service towards a pan North Wales approach; giving a framework and engagement to a renewed strategic view and establish a 3-5 year plan going forward. It is acknowledged that middle management on all sites have not received the Audit or Pyott reports and they have now been shared as part of the development of this paper.

Action- to instigate an Ophthalmology steering group to address both reports and to give a clinical strategic direction.

2. Strategic workforce plan

As highlighted in the Pyott report the Ophthalmology team in secondary care has an average age of 58 years. A strategic workforce plan covering new roles, non-consultant staff working to the high end of their licence, succession planning and linking into the education system to recruit staff for the future will be established as part of the steering group. This will focus the model of care to meet both the patients' needs and the service delivery. To date the service has focused on the parts, rather than the whole; management has not been consistent nor responsive to the service needs. The service now has clear clinical cohesive leadership covering North Wales. This incumbent has been successful in developing cohesion across the service. However, they are retiring in the near future, this will be a significant risk to service development made to date, with succession planning being difficult to attain. The current incumbent is working on their succession planning and is making progress. However West still has no clinical lead and continues to be covered by an Orthopaedic surgeon.

Action- To establish an overarching workforce work stream addressing recruitment, retention and differing roles thus developing a 3-5 year workforce plan for the whole of the service.

3. Strengthening the formal reporting line

Although eye care measures reports into PIFG, further work needs to be undertaken to ensure that the "golden thread" of governance is clear, ensuring Ophthalmology has a clear reporting line into the new operating framework. Previously it has been led separately from the mainstream operational management with at one point the Director of performance managing eye care to more recently the RTC Director. This service needs re-aligning with the new operating framework and have a clear reporting line to deliver the service for north Wales. This will include ensuring the Ophthalmology network manager has a clear role and professional objectives for the service.

Action – To review with operations and performance the golden thread of governance and reporting lines for the service.

4. Improving the estate

The long-term vision for the secondary care component of the service is within the regional treatment centre. However, the opening time is 2027 following a 40-month construction period. The current estates does not facilitate a High volume, low complexity (HVLC) approach, with poor waiting areas, aging estate and inadequate flow. Also the Abergele site has significant risks to the building infrastructure and West continues to undertake AMD procedures in theatres, where it is now a well-established out-patient procedure both locally and nationally.

Further work is required to see what can be achieved to improve the estate over the next 5 years with a plan facilitating a model of care, such as a hub and spoke model within North wales. The hub could be all general anaesthetic surgery, with the spokes providing Local anaesthetic cataract HVLC, as an example.

Action – to develop a capital and equipment risk log for the whole service and establish what can be done to the estate whilst awaiting the development of the RTC, this may include modular theatre units or “pop up” AMD clinics off the hospital sites.

5. Introducing high volume low complex activity schedules and Improving service efficiency (implementing GiRFT)

It is known that neither sites undertake high volume low complex operations/procedures; culturally this is something that has never been adopted although previous test cycles have shown an increase in productivity. Both of the above are covered by adopting the GIRFT programme, which can be undertaken in December of this year. However, there is still work to be undertaken regarding the clinical and managerial leadership of the programme, to ensure effective implementation

Action- Increase clinical and managerial engagement in the GiRFT programme and undertake the review in December 2022. Review all job plans.

6. Improving data at sub speciality level

Although data is collected on the Primary Targeting List (PTL) there are a number of patients who are not yet placed into a clinical condition (e.g. centre is 1,130 patients) this places the patients at risk of not being clinically triaged to understand the time of wait and could cause harm. These backlogs exists at the Centre and East site and are scheduled to be completed by end of November with a new process being implemented to ensure this backlog does not occur again.

Action- develop further the dashboards for ophthalmology and move towards a North Wales PTL at sub speciality level

Summary

A number of recommendations, issues and risks have been identified through the Audit and Pyott reports and in turn set out clearly what needs to be done to support the improvement of the service. A significant amount of work is being undertaken to improve the eye care service but a focus on secondary care ophthalmology now needs to be commenced. It is recognised that the independent sector will be seeing 2,500 cataracts to support reducing the backlogs; however, this facility is not delivered locally for the population, can only deliver “simple procedures” and is not sustainable for the future of increasing aging demographics. The formation of a steering group will lead the strategic direction, by looking at the whole of the service and what is necessary to sustain it going forward.

The BAF does not articulate all risks, as again it focuses on the parts, rather than the need to look at the service from a north Wales approach. Therefore, a review of the risk register is being undertaken to identify and mitigate a number of key issues that are recommended in the reports and are highlighted in this paper, the reader is directed to the Appendix for the whole of the action plan and recommendations, which supports the sustainability of the service going forward.

Conclusion

Twenty-two recommendations have been identified in the Audit and Pyott reports of which ten need to be commenced urgently as they will underpin the service going forward. The recommendation of instigating an Ophthalmology steering group has been made to the Director of Regional Delivery and the Deputy Chief Executive, aligning to other pan north Wales services. This will take time to mature and develop but will give a consistent approach to the service and a number of work streams can be

established to mitigate the risks quickly. The risk entries need to be more comprehensive, reflecting these recommendations and to support, manage and mitigate this high-risk service.

Recommendations

1. Instigate an ophthalmology steering group focusing on secondary care
2. Align this work to the eye care collaborative
3. Review the risks associated to the service across North Wales

Summary October 22			
	Audit report	**Pyott report**	**Total**
Red	7	3	10
Amber	3	6	9
Green	2	1	3
Total	**12**	**10**	**22**

	Audit report Dec 2021 - Action plan	baseline review -October 2022
R2	Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	the organisation uses a BCUHB PTL, which allows the organisation to see ophthalmology waiting times by site. However we are unable to review this by clinical presentation, it has been explored by the all wales informatics team and deemed not possible. however backlog of clinical condition needs to be completed by end of November to ensure a full risk evaluation can be undertaken of patients on the waiting list
R3	For as long as variation exists, include performance data on sub-regional variation in waiting times within existing performance reports to the Executive team and to Performance Finance and Information Governance Committee.	requires update speak to Kate Spargo
R5	Service efficiencies – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.	talks to recruitment for key staff, now in post but no evidence of a efficiency improvement plan , particularly around cataract surgery and secondary care improvements

Internal 1 (AK view)	implement Girft review	Q4 implementation date has been suggested but there is no clinical lead for Girft identified and requests from the national team for data is not being responded to
Internal 2 (AK view)	Appointment of ophthalmology GiRFT managerial lead	no single managerial lead is appointed to secondary care services across north wales, current eye network lead has focused on "eye care measures" and this work has been successful moved forward, possibly to the detriment to secondary care efficiencies and moving the ophthalmology service forward
R8	ensuring effective integration of services across acute sites; eliminating inappropriate sub-regional variation of service delivery and improving service efficiency. Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	clinical lead appointed but has now taken retirement

R10	Develop a single medium-term workforce plan for eye care services (acute and NHS funded community services) that:	now being rolled into the IMTP process and therefore closed, need to seek evidence of the workforce plan is part of the IMTP
	links to the future intended models of care	now being rolled into the IMTP process and therefore closed, need to seek evidence of the workforce plan is part of the IMTP
	builds further opportunities for working with training providers	now being rolled into the IMTP process and therefore closed, need to seek evidence of the workforce plan is part of the IMTP
	includes succession planning	now being rolled into the IMTP process and therefore closed, need to seek evidence of the workforce plan is part of the IMTP
	develops a more strategic approach to recruitment.	now being rolled into the IMTP process and therefore closed, need to seek evidence of the workforce plan is part of the IMTP
R11	Ensure estate improvements and wider capital needs are included within Eye care business cases and plans. This should include investment to support improved efficiency and use of existing estate as well as any additional estate capacity to support the longer-term sustainability of services.	not updates since April 2022, links to Retch but stating 2025, the RTC's are now 2027, therefore re-fresh of an estates strategy maybe required as capital estates compliance and ability to improve efficiency is challenging
R12	Strengthen formal reporting into the corporate programme management structures on eye care business case milestones and impact of investment in eye care services.	programme reports into PIFG and therefore was decided not to report into EDG.

notes	RAG rating descriptor
	Red (not commenced) Amber (some evidence of work in progress) Green (clear work in progress or completed)

Owner	Senior lead	RAG rating	Actions required	Whom
Informatics	Kathryn Lang	Red	backlog of clinical coding in Centre has a deadline of November 2022. however it has already missed 2 previous deadlines. Locality management should now be monitoring on a weekly basis that it is being undertaken and completed within agreed timescales (end of November 2022 or sooner	site teams
performance team		Red	waiting times per location against specific eye measures should now be routinely monitored through the weekly corporate access meeting and at locality level and a north wales approach to the PTL should be adopted	
Jackie Forsythe	Phil Orwin	Red	a robust improvement of theatre efficiency needs to be pulled together with the service teams for each locality picking up HVLC surgery (cataracts) including complex cataract (GA). This can be facilitated by the commencement of an ophthalmology steering group	clinical lead/network manager

Roger Haslett/service improvement		Red	mobilisation of the Girft review needs to be undertaken, possibly supervised by the eye collaborative. The Girft review will only be looking at HVLC (cataract service) but would give a good baseline to understand opportunities of efficiency in the service, which could lead to a reduction in outsourcing and improvement in waiting times	clinical lead/network manager
Phil Orwin/Nikki foulkes	Phil Orwin	Red	appoint current centre manager to have north wales focus, potential opportunity of covering orthopaedic and ophthalmology at abergele (ii) re-align eye network manager to cover secondary care services in more detail than currently (iii) appoint fixed term or secondment opportunity to cover north wales ophthalmology secondary care service	Phil Orwin/Gill Harris
Roger Haslet,/Jackie Forsythe	Nick Lyons	Red	as above	
Roger Haslet,/Jackie Forsythe	Nikki Foulkes	Red	North wales PTL needs to be adopted and an approach where patients are offered the earliest appointment	Nikki Foulkes/networ k lead
Roger Haslet/Jackie Forsythe	Nick Lyons	Red	current clinical leader has desired to retire and return conversations needs to be undertaken on replacement of clinical lead	Roger Haslett/Nick Lyons

Roger Haslett/operational leads per locality	Nick Lyons	Red	No IMTP ophthalmology schemes have been submitted for 23/24	Roger Haslett/Nick Lyons
Roger Haslett/operational leads per locality	Nick Lyons	Red	No IMTP ophthalmology schemes have been submitted for 23/24	Roger Haslett/Nick Lyons
Roger Haslett/operational leads per locality	Nick Lyons	Red	No IMTP ophthalmology schemes have been submitted for 23/24	Roger Haslett/Nick Lyons
Roger Haslett/operational leads per locality	Nick Lyons	Red	No IMTP ophthalmology schemes have been submitted for 23/24	Roger Haslett/Nick Lyons
Roger Haslett/operational leads per locality	Nick Lyons	Red	No IMTP ophthalmology schemes have been submitted for 23/24	Roger Haslett/Nick Lyons
Neil Bradshaw	Sue Hill/CFO	Red	a review of current estate for ophthalmology to see what capital improvements could be made given an Retch development is now 2027, there is evidence that the poor estate limits theatre efficiency	locality teams/capital estates
performance and planning	performance team	Red	review of reporting structures will be undertaken as part of this action plan	Nikki Foulkes/Phil Orwin

When

Nov-22

Nov-22

Nov-22

Nov-22

Dec-22

Mar-23

Mar-23

Mar-23

Mar-23

Mar-23

Mar-23

Nov-22

P Recommendation 1:

P Recommendation 2:

P Recommendation 3:

P Recommendation 4:

P Recommendation 5:

P Recommendation 6:

P Recommendation 7:

P Recommendation 8:

P Recommendation 9:

P Recommendation 10:

notes

Pyott report September 2021 - Action plan

Data management – It is imperative that for services to run smoothly data needs to be accessed and managed in a straightforward way. Access to accurate and real time informatics should be at the forefront of managing ophthalmic services. This includes data on cancelation where health boards should be held accountable for the number of hospital cancelations and scrutiny mechanisms put in place to ensure that hospital cancellations are avoided where possible

Improved communication within the service – For an optimal multidisciplinary approach to care to be effective, issues with communication need to be resolved. Regular meetings with managerial and clinical colleagues should be implemented to ensure a resilient and efficient workforce can reach its potential. It is also advised that the sharing of best practice and the encouragement of new innovations should be instilled within the workforce.

Reduction of a reliance on Service Level Agreements with English Health Boards - Whilst it is recognised that a long term reliance on cross border support for Eye Services in Powys is inevitable, the number of patients transferring to Bristol and Liverpool should be reduced if it is in the patients interest to do so, and the service can be safely provided in NHS Wales.

Corneal Services – Consideration should be given to the expansion of specialist corneal services.

Cross-linking – Consideration should be given to how and when a service for cross-linking should be developed. Appropriate education needs to be given to community optometrists to ensure that the service is well managed

Integration of services – Over time, out of date practices have led to a disjointed patient journey through some services. This can be problematic for the patient and the workforce. The implementation of workshops with all relevant stakeholders to establish new, leaner ways of working should be established.

Appropriate use of non-medical staff - Wales has made good use of non-medical staff. It is important that everyone is encouraged to perform to the top of their licence. A unified approach is to be encouraged.

Cataract Services redesign – Centres need to be engaging in efficient high volume surgery on a regular basis.

Anaesthetic cover in theatre – The use of anaesthetic cover in Wales is variable and depends on both the surgeon and the procedure. A streamlined cataract pathway with agreed anaesthesiology cover is recommended for a sustainable cataract service.

Independent Prescribing and Ophthalmic Diagnostic Treatment Centres (ODTCs) – For both of these services to thrive, consideration should be given to rolling out independent prescribing initiatives to all ODTCs as well as expanding ODTC services to meet the needs of the population.

Planning - This vision of three ophthalmology hubs will require significant planning, and it is envisaged that the whole process from decision to opening would take at least five years. NHS Highland has recently gone through just such a process, and in October 2022 plan to open a purpose built facility to patients. Whilst originally conceived as part of the National Treatment Centres, (which are planned to meet cataract and orthopaedic waiting list pressures), the Highland approach is for the fully integrated re-designed model, as suggested above. There are a few important principles which we have found to be important:

1. All stake-holders should be involved with the architect in the planning and design process
2. A commitment to completely re-design patient pathways, rather than replicating old methods
3. A rapid move to being fully electronic
4. Integrated diagnostic hubs. Digital imaging is going to be central to the development of eye services, and in the future Artificial Intelligence will be involved in decision making rather than clinicians. The hubs will be a place which can handle an efficient throughput of patients, possibly over seven day working, but with some information being gathered from remote sites.
5. Flexible staffing. Acceptance that competence to the task is the important determinant of

RAG rating descriptor

Red (not commenced)

Amber (some evidence of work in progress)

Green (clear work in progress or completed)

Baseline review -October 2022

The organisation uses a BCUHB PTL, which allows the organisation to see ophthalmology waiting times by site. Not at sub speciality level

Interface with primary care optometry - North wales has a long history of good collaboration between community optometrists and the hospital eye service, starting with the PEARS scheme, and now with the programme of Ophthalmic Diagnostic Treatment Centres (ODTC). At the Centre site a matron has been appointed who will be based on the facility. Management have increased their presence from 2 days a week to 3-4 days per week from October 2022

The repatriation of patients, where appropriate, who currently have unnecessary journeys to English boards for treatment: Vitreo-retinal surgery, Uveitis, Electrophysiology, and to a lesser extent Cornea and some strabismus.

Discussion with the clinical lead will be undertaken to discuss whether specialist corneal services should be adopted in North wales and then feed into the IMTP process

Teach and Treat - The Welsh School of Optometry is well developed, and throughout the UK there is a realisation that there is a need for upskilling the next generation of optometrists to be able to recognise and manage disease. Uveitis - In North Wales there is currently an Associate Specialist undergoing Article 14 training, who has an interest in uveitis. There needs to be a work force strategy to fully understand further roles that can be developed within the service as a whole

Development of pathways and GiRFT needs to be implemented using benchmarking and national standards. The use or virtual follow up as described in the "all wales cataract pathway" needs full adoption. A once for north Wales approach using these pathways will reduce variation and ensure equity across north wales in relation to access times

Some progress has been made , particularly in the community in the use of non-consultant staff, however given the aging demographic of the consultant population, the recognition of training needs, further work needs to be developed and a clear workforce strategy needs to be developed going forward

Introduction of GiRFT for HVLC is due to be commenced in Q4, however a significant education and buy-in process needs to occur as GiRFT has not been fully socialised in the ophthalmology services

The all wales cataract pathway exists and further work needs to be undertaken regarding anaesthetic use.

Given the average age of the ophthalmology workforce is in the late 50's a full workforce review needs to be undertaken, identifying a longer term strategy in developing other workforce roles and recruitment and retention strategy going forward

Owner	Senior lead	RAG rating
informatics	Kathryn Lang	Green
clinical lead/network manager	Phil Orwin	Red
clinical lead/network manager	Phil Orwin	Amber
clinical lead/network manager	Phil Orwin	Amber
clinical lead/network manager	Phil Orwin	Amber
clinical lead/network manager	Phil Orwin	Amber

clinical lead/network manager	Phil Orwin	Red
clinical lead/network manager/transformation team	Phil Orwin	Red
clinical lead/network manager	Phil Orwin	Amber
clinical lead/workforce	Phil Orwin	Red

Actions required	Whom	When
non required	N/A	N/A
ophthalmology steering group needs to be established	clinical lead	Nov-22
establishing steering group will establish what could be brought back into north Wales and what could be brought back after the RTC's have opened in 2027	clinical lead/network lead	Mar-22
a strategic discussion regarding the service future needs to occur as part of the establishment of the ophthalmology steering group to understand which services may wish to be repatriated and the workforce required	clinical lead/network manager with clinical workforce colleagues	Dec-22
a strategic discussion regarding the service future needs to occur as part of the establishment of the ophthalmology steering group to understand which services may wish to be repatriated and the workforce required	clinical lead/network manager with clinical workforce colleagues	Mar-23
needs to be an agenda item in the newly forming ophthalmology steering group	clinical lead/network manager	Mar-23

further work needs to be developed and a clear workforce strategy needs to be developed going forward	clinical lead. Workforce team	Mar-23
Girft adoption programme needs to be implemented ready for Q4	clinical lead/network lead and transformation	Mar-23
Girft adoption programme needs to be implemented ready for Q4	clinical lead/anaesthetic lead	Dec-22
workforce review needs to be undertaken, given the aging demographic, as part of the ophthalmology steering group	clinical lead	Mar-23

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety and Experience
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Steering Group Update October 2022
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Jenny Farley Vascular Network Director
Craffu blaenorol: **Prior Scrutiny:**	Dr Emma Hosking
Atodiadau **Appendices:**	Updated Vascular Improvement Plan Risk Register

Argymhelliad / Recommendation:							
The committee is asked to receive the update from the Vascular Steering Group							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	**X**
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**N**	
Sefyllfa / Situation:							
This month summaries the progress against several the key actions of the Vascular Improvement Plan, remaining in the same format until the transition to the Maturity Matrix Approach to Transformation has been completed							
Quality							
Asesiad / Assessment & Analysis							

Vascular Steering Group Update for October 2022

Governance

IMTP funding has now been approved and the vascular network can recruit to a band 5 Clinical Governance Lead post. There is a need for a centralised vascular risk register and a central coordination of all incidents in order to identify trends and work with clinical teams to mitigate risk and share best practice. Closer working relationships need to be developed between the clinical teams and the patient safety teams, and this role will be pivotal in supporting a patient centred approach to clinical governance and care. Once recruited there will be monthly reports produced - with a focus on shared learning and improving compliance with Quality, Safety and Effectiveness Committee key performance indicators as well as all governance related actions from the Vascular Improvement Plan (VIP) and Vascular Quality Review Panel (VQRP).

The Vascular Network Nurse Director has started a thematic analysis of the key areas in the VIP and the VQRP reports, using the Systems Engineering Initiative of Patient Safety (SEIPS). This tool is strongly grounded in a “Human Factors” based approach and will support prioritising the key actions, transformation and service redesign needed to embed processes that optimise patient safety.

Work has also commenced on a review of all the Serious Incidents with the aim of theming them, understanding the root cause of the recurrent issues, putting actions and systems in place to reduce the top five incidents and ensuring the lessons are shared and change embedded.

Vascular surgery away day

A team building timeout workshop was held in early October with the vascular surgeons, ward manager and the senior management team to discuss key priorities and concerns. Several issues and key actions emerged from the meeting including:

1. Additional sessions to be created to support the RCS and VQRP recommendations in relation to medical staffing, education, training, workforce and governance
2. Job planning to commence as soon as possible with a designated consultant to lead on this supported by the Clinical Director and a review of the workforce model
3. IMTP investments and essential administrative support require
4. Theatre allocations will need to be reviewed as part of job panning
5. How to improve the vascular consultant of the week (VCOW) rota and support for spoke sites
6. Patient processes, communication and relationships with ward teams
7. Health Inspectorate Wales (HIW) and VQRP expectations

A further meeting will be held to firm up the actions and progress in the key priority areas which were highlighted.

Amputation Rates Comparison to Peers

Mr Gareth Griffiths, Vascular Consultant Professional Lead undertook a review of the amputation data from the National Vascular Registry from 2018-2022.

There was a perception that amputation rates have increased since the creation of the Hub and Spoke Model at the Health Board in 2019. Mr Griffiths reviewed the data before and after the Hub and Spoke Model implementation and compared it with amputation rates from other UK vascular units. Data was drawn from clinical coding.

The results of the review for **major amputation** only demonstrated that:

- BCUHB has a mortality rate that is similar to the national mean for major amputation
- BCUHB's case load is within the interquartile range (visual assessment)
- There is a major amputation rate of 8.9/100k/year
- The ration of Above Knee Amputation:Below Knee Amputation is 1.1:1

Hospital coding data for **major and partial foot amputation**:

- 24.9/100k/y between July 2020 and June 2022
- 21.5/100k/y for the 18-month period before the network was created

Discussion

The amputation incidence is now stable with mortality and caseloads that are centrally placed compared to other UK units. The annual incidence of major amputation is within reported norms of 5-25/100k/year. The data does not support the perception that the amputation rates have increased since the network was created, or that they are out of step with other UK vascular services.

Transport Delays

The intra-hospital transfer group has been established to address some of the key clinical risks associated with delays in WAST (Welsh Ambulance Service Trust) transfers between the three hospitals. It has been agreed that in the event of a time critical vascular transfer if WAST are unable to transfer the patient in a timely manner, then ACCT (Ambulance Critical Care Transfer) team will do so. All vascular and Emergency Department Teams have been made aware that the process is to contact both teams simultaneously and ACCTS will be stood down if WAST are able to support. In addition, as part of the Emergency Ischaemic Limb Process Mapping it was agreed that Heparin Infusions can be safely stopped while a patient is being transported to the hub site for surgery. This reduces the need for a paramedic crew and nursing escort and therefore speeds up the transfer process.

Communication

There has been little progress on the planned vascular newsletter or on the development of a vascular web page. This is due to a lack of capacity in the network team and the misconception that positive news stories would be seen as defensive practice. Confirmation from the Chairman at a recent meeting with the vascular consultant confirmed that it was acceptable to promote the positive outcomes and experiences from patients and developments within the vascular services such as procedures and treatments. Work will recommence on these once the network team is fully resourced.

Interventional Radiology

The Health Board has appointed a third interventional radiologist and is in the process of recruiting to further members of this department to meet the longer-term aim of doubling capacity to run dual lists in the hybrid theatre.

Primary Care Pathways for Vascular

A preliminary meeting has been set up with integrated care pathway editor (a GP) and transformation leads to discuss their training and education requirements for the relevant vascular and lower limb ischaemia (diabetic foot) pathways. A process mapping session for urgent referrals is planned for November subject to primary care teams' availability.

Diabetic Foot Summit 5h October 2022

The summit was well represented from all three service providers and all disciplines. There was some very positive feedback from each of the sites. All disciplines agreed that the same national standard of care should be adhered to but that each site would work in a way that was conducive to their service establishment, this is because estate is different on each site, the models of staffing are historically different and the populations they serve are also slightly different. Key issues that impacted on the optimal patient care were discussed with ideas and solutions to resolve the issues, supported where appropriate by IMTP funding. A larger transformational programme of redesigning current services on each site to deliver optimal care has now begun and there will be meetings established every six weeks to process map, understand the root cause of the issues and deliver the solutions required for our local populations.

Bed Modelling

Bed Modelling has been completed and as anticipated, it shows that there is a lack of capacity on the hub site. The current bed base is 18 but there is the ability subject to staffing to go up to 22 beds, this however is still insufficient for the demand. When the hub and spoke model was established it was assumed that the 18 plus beds in West would remain along with 15 beds in the East. However, these beds have merged into medical beds on both sites. This also impacts on the length of stay at the hub site as there is limited bed capacity which leads to longer length of stay when there are delays repatriating patients to East and West hospitals given that the vascular bed base is no longer in existence.

When the hub and spoke model was being designed pathways were not created for rehabilitation and therefore there are limited services to support patients close to home. Work needs to start to design rehabilitation pathways within the current resources available to the HBs integrated community services. This will begin once the vascular transformation lead and operational manager are in place between the end of October and middle of November. Wider Capacity and Demand modelling is being completed by Kendall Bluck Consulting and should be available by the end of November.

IMTP funding

A data entry clerk has been approved to support data entry to the National Vascular Registry and the job description is being designed. This will free up valuable consultant time and ensure that all data is entered in a timely manner to ensure accurate peer review of our vascular data. Therapy posts across the service are also being advertised, challenges remain on the ability to recruit to the organisation due to the relatively isolated location. A Diabetology post in West is in the process of being recruited to as is the Foot and Ankle Surgeon in the East. This post will have capacity to support both Central and West patients.

The network team will work with finance and HR teams to create a system which allows accurate tracking of the IMTP funding and to ensure where necessary, key performance indicators are attached to the posts to demonstrate improvement in patient care and value for money.

Trust Grade middle and junior medical staffing interviews are continuing throughout October, the additional IMTP funding will enable a vascular doctor presence on the spoke sites five days per week to support a more responsive and safer service.

Patient Engagement

In early October three Patient Carer Awareness Sessions were undertaken on the vascular ward. The sessions were well attended to support patients in the first instance to raise concerns if they are not happy with their experience and to also share their positive experiences. The vascular ward also has allocated iPads for patients to complete satisfaction surveys to tell us about their experiences. These are then fed back to the clinical teams for commendations and where necessary actions to rectify issues and concerns.

Digital Documentation

Documentation remains a manual process until the HB's wider digital case note strategy is implemented. The CiTo pilot could not be supported as it did not meet the needs of the vascular services and there is insufficient technology at this stage. In the interim, the network is exploring the possibility of creating a clinical summary page for all clinical professionals to contribute their clinical involvement with the patients.

Vascular Quality Review Panel Update

The Chair of the Vascular Quality Review Panel (VQRP) and her team have now concluded their review of the case notes. The final report and recommendations are now being prepared with an expected publication date of November 2022. Work continues in responding to the recommendations that have been highlighted each month and aligning them with the RCS recommendations.

Multi-Disciplinary Team Meetings

All aortic surgery decisions made in the vascular MDT are discussed with Stoke hospital's MDT for wider clinical opinion. This is an action following recommendations by the external, independent consultant of the Vascular Quality Review Panel.

Dual consultant operating for planned aortic surgery continues. At the time of writing discussions are ongoing as to when the right time will be to step down the dual on-call arrangements at consultant level. These are onerous for the consultants in terms of protected time off but have almost never been required. The timing of any change will depend on how soon we can establish a middle grade presence which will be resident in the evening and on-call for the night so that any vascular emergencies will have surgeons with vascular experience available to support the consultant on-call.

Theatre Productivity and Pre-Operative Care

Both theatre productivity and pre-operative pathways of care have been long standing items on the RCS report with slow progress. These actions will move to a wider HB programme; Journey to Excellence. This is because there is a HB capacity issue both for theatre and for pre-operative assessment, partly due to workforce issues and partly due to the backlog of urgent patients that need to be seen post Covid across all surgical specialties. The surgical specialties have prepared a business case for a digital preoperative assessment tool. For many patients this will negate the need to attend hospital and therefore free up capacity but will still facilitate safe pre-operative checks.

Audit

A retrospective audit of discharge medical records is being conducted by one of the vascular surgeons and will be reported in November.

Monthly summary of Case Note Audits

There has been further improvement in the quality of the note entries and the consenting process.

Opsiynau a ystyriwyd / Options considered

The need to ensure external validation and assurance of the effectiveness of actions within the Vascular Improvement plan is now through the Maturity Matrix approach

Goblygiadau Ariannol / Financial Implications
Over the coming quarter need to complete the evidence of the value of the investing in the service as part of the Integrated Medium-Term Plans (IMTP) will commence.
Dadansoddiad Risk / Risk Analysis
The risk register continues to be reviewed and has been updated. The risk associated with the vascular consultant workforce sudden shortages has been closed for now as business continues as normal including the ability to manage dual on call operating. This is reviewed throughout each week with daily escalations if required.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Any legal implications in relation to the quality of consent and other issues identified as part of the RCS report are currently being considered. The Health Board is working closely with regulators in relation to professional standards.
Asesiad Effaith / Impact Assessment
Currently under consideration.

Teitl adroddiad: ***Report title:***	PSQ – Chair's Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This paper presents the Chair's Report from the Patient Safety and Quality Group.			
Argymhellion: ***Recommendations:***	The committee are asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive of Nursing and Midwifery Matthew Joyes, Associate Director of Quality Amanda Blaynee-Roberts, Quality Business Support Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	BAF21-10 - Listening and Learning

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- PSQ Chair's Report	

1. **Alert –** include all critical issues and issues for escalation

East Health Community

In relation to Theatre Nurse and Anaesthetic Staffing levels, the service reports they are currently unable to safely staff all planned elective lists resulting in planned elective lists having to be stood down and patients cancelled. A theatre recruitment day is to be arranged. The anaesthetic department are not working above job plans and the hospital management team are working to resolve.

West Health Community

Stroke performance – this is currently low and not meeting performance targets. Additional support and education has been provided and improvement has been noted.

There were 75 patient falls reported in July 2022, which is an increase of 33% from last month. The site is reviewing each individually, thematically and is fully engaged in the wider improvement programme for falls reduction.

Central Health Community

There are currently concerns regarding high use and dependency of agency/temporary staff to cover shifts 24/7 within the ED. There are also concerns regarding the lack of substantive staff to support the frailty unit leading to a lack of consistent assessment of patients and 24/7 arrangements. To mitigate, there is increased senior oversight and daily reviews of rosters including skill mix. Block bookings of temporary staff is in place alongside active substantive recruitment.

There are currently 63 complaints open & 42 of those are overdue. The new leadership team are establishing improved ownership and oversight of complaint handling.

2. **Assurance** – include a summary of all activity of the group for assurance

Central Health Community

The Central Area Covid19 Vaccination Programme team have delivered 27,330 Spring Boosters this is 92% of the eligible cohort in the Central Area.

East Area

Datix reports – reduction of 22% of closures – Datix clinics were set up for review and closure which was very successful. Chirk Community Hospital remains a very proactive Datix incident-reporting environment with 52 reported, with only one incident of harm noted.

There has been successful recruitment to Band 6 CAMHS practitioner posts.

Infection Prevention & Control Sub-Group

Numbers of patients affected and numbers of outbreaks declined in Central and West. Associated staff sickness has also reduced.

3. Achievement – include any significant achievements and outcomes

Safeguarding

Corporate Safeguarding have worked collaboratively with Bangor University and BCUHB Nurse Education to offer 2nd year student nurses the opportunity to undertake a 5 day bespoke placement within the Safeguarding team. Also the Wales Safeguarding Training Framework will be launched to coincide with National Safeguarding Week – which is week commencing 14.11.2022

Central Health Community

The Covid19 Vaccination Team have also been shortlisted as finalists for the Team award, in the BCU Achievement Awards 2022.

Report title:	**Chair's Assurance Report - Clinical Effectiveness Group (CEG)**		
Report to:	**Quality, Safety and Experience (QSE) Committee**		
Date of Meeting:	Tuesday, 01 November 2022	Agenda Item number:	4.1
Executive Summary:	To provide advice and assurance to QSE in discharging it functions and meeting its responsibilities with regard to the Clinical Effectiveness of health services.		
Recommendations:	The Board is asked to: Note and provide feedback on the paper		
Executive Lead:	Dr Nick Lyons, Executive Medical Director		
Report Author:	Dr Karen Mottart, Acting Deputy Executive Medical Director (report submitted by Chair of CEG)		

Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Link to Strategic Objective(s):	N/A
Regulatory and legal implications	N/A
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	N/A
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	The Chairman's report has been prepared to present to Quality, Safety and Experience Committee for an update following the Clinical Effectiveness Group scheduled meeting on 4th October.
Links to BAF risks: (or links to the Corporate Risk Register)	-
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: Note and provide feedback on the paper	
List of Appendices: Quarter 1 Clinical Audit Report Appendix A	

QSE COMMITTEE MEETING IN PUBLIC

Tuesday 1st November 2022

Clinical Effectiveness Group - Chair's Report to Quality, Safety and Experience Committee (QSE)

1. Introduction/Background

The Chair will report formally to Quality, Safety and Experience Committee (QSE) from the Clinical Effectiveness Group (CEG) this includes verbal updates and the submission of regular written reports. The Chair will also ensure appropriate escalation arrangements are in place to alert QSE of any urgent/critical matters that may affect patient and carer experience.

2. Body of report

1. Alert – include all critical issues and issues for escalation

Review of CEG Terms of Reference (TOR)

The group is reviewing its current function to refocus on patient outcomes and identifying areas within the health system that may need improvement. We are working with key stakeholders such as END, Transformation lead, head of quality.
It is anticipated that revised ToR will be available by end of Quarter 3.

Clinical Law and Ethics

There had been issues raised around consent in relation to procedures specific information; there was a view that the Health Board needed to have an understanding of all procedures, specific patient information leaflets in circulation, not just new ones produced.

This would be a large piece of work; and is technically, what is required by Welsh Risk Pool Management alert. This would fall Matthew Joyes, Associate Director of Quality, in terms of what would need to be a formal registry.

Locality Clinical Effectiveness Group

The issue of workforce recruitment and retention has been flagged across all IHCs and across a number of specialities. As Chair of CEG I have discussed directly within EMD team to ensure that workforce are aware of concerns and triangulate with other information available

2. Assurance – include a summary of all activity of the group for assurance

Standard Agenda Items

Following the decision in April's Clinical Effectiveness Group (CEG) meeting, that mandatory accreditation audits would be captured within the Cycle of Business (COB) quarterly for feedback to be given on progress and on target to complete both Radiology and Pathology submitted papers.

- **Radiology** remain compliant with regulatory compliance and will continue to share learning through the radiology audit meetings.
- **Pathology** remains compliant with regulatory compliance and accreditation standards.

Both areas through internal audit, provide a robust system to enable the departments to identify areas of practice that need to be improved and ensures continual monitoring and development of quality within the services provided.

Quarter 1 Clinical Audit Report for information (April – June 2022) had previously been sent to the group and then submitted to QSE, due to the layout being reviewed and amended, the group were ask to comment on template for future quarterly reports (copy is attached Appendix A)

The following Chairs reports were received. Nothing was raised by return email:

- Research & Development
- Reducing Avoidable Mortality Steering Group
- Clinical Law and Ethics
- Central Locality Clinical Effectiveness Group
- East Locality Clinical Effectiveness Group
- West Locality Clinical Effectiveness Group
- Quarterly Report from HCAI

The following Policies /Pathways/Standard operating procedures received for approval by consent were sent to the group with voting buttons to approve or reject each item, to prevent delays with updates to the individual submitting the document:

Approved:

- SOP03 – for Medical Emergencies V0.2
- SOP06 Training V0.2
- SOP07 Management of Volunteer Master File V0.2
- SOP08 Access to the Over Volunteering Prevention Scheme V0.1
- SOP09 Control and Use of the Consent 4 Consent Database V0.1
- SOP11 Monika Prime Temperature Monitoring System V0.1
- SOP13 Drug and Alcohol Testing V0.1
- SOP15 Accessing GP Records For Trial Participants V0.1
- SBAR for QSE Risk Assessment

(Not approved – more work to be completed, then resubmitted to CEG in November)

- SOP04 - Quality Assurance and Control V0.2
- SOP05 Risk Assessment and Applications V0.2

3. Achievement – include any significant achievements and outcomes

Research & Development (R&D)

In terms of alerts in the Health Board are no different from any other organisation in the UK in that the impact COVID had on research is continuing with a UK wide reset programme, with concerns about sufficient research resource and clinical research given their clinical challenges, so there is always a balance between clinical priorities and delivering research. Work is continuing with colleagues in Wales and across the UK.

In addition with wider implications, there are challenges with accommodation in that people in the District General Hospitals in particular think R&D do not need to be accommodated on the acute site and we absolutely do. It is down to the R&D team to educate and inform people about the clinical contribution that the research teams make, and actually supports our clinical teams so the care that's being delivered by the research teams is taking the pressures off the clinical team.

In terms of achievements, there are a couple of exciting achievements that have been collaborated with teams being successful in very large bids: one is with Imperial College and testing stethoscope that uses AI used to diagnose heart failure, and also an AI tool to support clinicians with decision making.

Reducing Avoidable Mortality Steering Group

The Learning from Deaths Group now meet on a regular basis. Implementation of a new DATIX module at the start of October 2022 will enable streamlining and tracking of all ME feedback and mortality reviews via a live dashboard. This will provide assurance and facilitate the ability to identify themes and triangulate with other DATIX modules. Current learning is feeding into the Health Board work streams linked to consent and end of life decision making

Clinical Law and Ethics

An All Wales e-learning package has been introduced

East Locality Clinical Effectiveness Group

The group was informed that an "expert patient programme for heart failure patients" had been created. This would be a 6 week 2-2.5 hour program run by expert patients who then deliver the training to other heart failure patients.

An International Medical Graduates (IMG) Handbook had been developed which acknowledges the unique challenges faced by international doctors making the transition to UK practice. This project was started by some of BCUHB IMGs to support and signpost IMGs to local, regional and national resources to form what would hopefully become a one-stop resource for incoming IMGs.

West Locality Clinical Effectiveness Group

Participation in Nocturnal Dialysis Study
Initial acceptance for Ysbyty Gwynedd (YG) to be included within a National Study for October 2022 start. Funding has been approved for the study but team need to apply to BCUHB Research and Development Department to ensure BCU approval (this has been enabled with the confirmation of funding for 6-day transport). YG would be the only renal service in Wales who will be participating in the study. Those involved are Dr Alejmi, Iwan Bonds and the wider renal service team. The wish is to do a press release and widely show support of the study (prestige for the service), however we will wait until Research and Development have given final approval.

Quarterly Report - HCAI Covid Death Review Process

The report was presented by Peter Morris, Project Consultant and he updated the group on work that had taken place in the last three months. The project plan was now developed and dedicated resources assigned to the project. These have recently been augmented with the appointment of a full time Project Manager, Business Analyst, Operational Manager, additional appointment of 2.2 whole time equivalents (WTE) Investigators providing a total investigating resource of 6.6 WTE, 3.0 WTE PALS Officers & 3.0 WTE Coordinators, supported by expert external consultancy. The establishment of the scrutiny panel and agreed Terms of Reference (TOR) provides the delivery unit with quality assurance required in relation to the agreed project outcomes. The first meeting of the scrutiny panel took place on 27th September 2022.There are currently no risks that need escalating to this level of the committee, there are some risks however controls are already in place.

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper.

4. Risk Management

4.1 N/A

5. Equality and Diversity Implications

5.1 N/A

Quarter 1

Clinical Audit Activity 2022-2023

1. The National Audit Programme and clinical effectiveness overview

Welsh Government (WG) or other regulatory bodies such as Medicines & Healthcare products Regulatory Agency (MHRA) mandate a number of clinical audits, these form our Tier 1 audit activity. Service and Clinical Effectiveness Team resources should be prioritised to support these audits. Relevant Tier 1 (National audits) must be incorporated within relevant Divisional/Directorate annual clinical audit plans

In February 2022 WG took the decision that while participation in the National audit program is mandated, submission to WG of assurance returns is no longer required. It rests solely with the Health Board to secure and track its own quality assurance

Within the Health Board we have taken the decision to retained the process of the 2 part assurance proforma: Part A identifies compliance with undertaking the audit, Part B outlines the variance from best practice and identifies local / HB actions required to close the variance.

2. Tier 1 Overview of Quarter 1 - Clinical Audit Activity 2022-2023

The tables below show the position on 30/06/2022 end of Quarter 1.

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2023/2024
Estimated publications due	10	10	14	5	4
Actual publications	13	0	0	0	-
Part A due	4	20	5	12	5
Part A received	4	2	0	0	-
Part A overdue	0	0	0	0	-
Part B due	0	4	19	10	10
Part B received	0	0	0	0	-
Part B overdue	0	0	0	0	-

2.1. BCUHB Assurance Returns

2.1.1 Part A returns for Q1 2022-23. Four (of four) were returned as follows. Part B responses to be received in Q2

i. National Paediatric Diabetes Audit: report published 14/04/22. All areas are contributing. SMART action plans from each area awaited
ii. National Diabetes Foot Care Audit: report published 11/05/2022. Response provided by podiatry who are leading for all 3 areas. Note some flags around re-establishing multi-disciplinary clinics post COVID. Await SMART action plans on completion of part B forms
iii. National Audit of Breast Cancer in Older Patients: report published 12/05/2022. Managed as single networked service. Awaiting SMART action plan with part B return, but early indication of need to increase use of frailty scores. Notes workforce issues particularly in radiotherapy
iv. National Confidential Enquiry of Patient Outcomes and Death: Physical Health in Mental Health Settings: report published 12/05/22. All 3 areas participating. Awaiting improvement plan with part B response. Early indication that there will be needs to address involving training, workforce and IT enablers

See Appendix 1 for additional detail on Part A submissions

2.1.2 Part B returns. These were received in Q1 for publication and part A forms received in Q4 2021-22. Eight of eight Part B returns were received.

These were for the following national audits noted below and narrative on detail will be captured within Annual Audit Report for 2021-2022

National Emergency Laparotomy Audit :Year 7 report
Renal Registry: 23rd UK RR Annual Report
All Wales Audiology Audit: 2019 National Report
National Lung Cancer Audit: Annual Report (2019 audit period)
National Prostate Cancer Audit: 2021 Annual Report

National Gastrointestinal Cancer Audit Programme: – Bowel Cancer Audit: 2021 Annual Report
National Neonatal Audit Programme (NNAP): 2021 Annual Report
National Audit of Cardiac Rehabilitation: Quality and Outcomes Report 2021

2.2 Benchmarking

When a National Audit reports includes Health Board specific data we benchmark BCU against National outcomes and against BCU data in previous reports

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

Thirteen National Audit reports have been published in Q1. Seven of these included BCU identifiable data. The table below outlines the benchmarking information. Of note while National Audit of Diabetes (adults) maintains a green RAG rating against national standards it is noted that we have performed less well than in previous reports.

It is also noted that cardiology audits identify amber status against both nation and previous reports. Work is ongoing with Cardiology Network to identify improvement plan needed.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Long Term Conditions					
NCAORP/2021/05	National Diabetes Foot Care Audit	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report		• Action plan in development, due to be completed August 2022
NCAORP/2021/08	National Diabetes Audit: Adolescent and Young Adult	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report		• Action plan in development, due to be completed October 2022
NCAORP/2021/08	National Diabetes Audit: Type 1 Diabetes	G	R	• Maintained compliance in line with national average, although performance compared to last reported period had dropped	• Action plan in development, due to be completed October 2022
NCAORP/2021/09	National Paediatric Diabetes Audit (NPDA)	G	G	• Maintained compliance in line with national average and when compared to previous reporting period • YG – Higher percentage of pump & CGM users with better outcomes. • YG – key health checks above national average • WXM – Key health check completion rates above national average • YGC – HbA1C checks. Implementation of high HbA1C Policy and continuation of HbA1C drive through clinics, local monitoring show in year improvements (70% compared to reported <10%)	• Action plan in development, due to be completed August 2022

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
NCAORP/2021/10	NACAP: Child & Young Person Asthma (2021 Organisational Report)	Organisational report no benchmarking	Organisational report no benchmarking		• Action plan in development, due to be completed October 2022 • Benchmarking data not available for comparison. There were 5 KPI's, Central not met 3 out of the 5; East not met 2 of the 5 & West not met 4 of the 5
NCAORP/2021/11 & 12	NACAP: Adult Asthma & COPD (2021 Organisational Report)	Organisational report no benchmarking	Organisational report no benchmarking		• Action plan in development, due to be completed October 2022 • Benchmarking data not available for comparison. There were 6 KPI's, Central not met 4 out of the 6; East not met 5 of the 6 & West did not complete (non-participation)
Older People					
NCAORP/2021/17	Stroke Audit (SSNAP) Acute Organisational Audit Report	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report		• Action plan in development, due to be completed October 2022
NCAORP/2021/22	National Audit of Breast Cancer in Older Patients (NABCOP)	G	No Comparative data available	• Maintained compliance in line with national average	• Action plan in development, due to be completed October 2022

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Cardiology					
NCAORP/2021/24	National Heart Failure Audit (NAHF)	A	A		• Action plan in development, due to be completed October 2022
NCAORP/2021/25	National Audit of Cardiac Rhythm Management (NACRM)	A	A		• Action plan in development, due to be completed October 2022
NCAORP/2021/26	National Audit of Percutaneous Coronary Intervention (NAPCI)	A	A		• Action plan in development, due to be completed October 2022
NCAORP/2021/27	Myocardial Ischaemia National Audit Project (MINAP)	A	A		• Action plan in development, due to be completed October 2022
Women's and Children's Health					
NCAORP/2021/34	National Maternity & Perinatal Audit (NMPA)	A	A		• Action plan in development, due to be completed October 2022
Mental Health & Learning Disabilities					
NCAORP/NP/2021/101	National Confidential Enquiry of Patient Outcomes and Death (NCEPOD)	Outcome review	No comparative data available		• Action Plan in development, due for submission September 2022

3. Tier 2 audit program

The tier 2 program is a suite of audits mandated across the Health Board, not reported nationally, related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms reviews, Concerns recommendations, Prevention of Future Death Notices, and Ombudsman reports. The CE team is working closely with the Quality Dept to ensure we have the correct Tier 2 audit program in place to provide assurance across the risks the HB holds. There have been no Tier 2 reports delivered in Q1

Project title	Reported	Objectives
Ward Manager Weekly Audit	IRIS - continuous	This audit complements the ward accreditation framework, monitoring standards across a number of areas; patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. The output from the audits are reported on IRIS. Ownership is locally by the ward manager and site nursing hierarchy.
DNACPR Audit	Q4	Measured against standards set out in the All Wales DNACPR policy. Previous improvement needs – communication between primary & secondary care, evidence of compliance with Mental Capacity Act Best Interest Decision making.
Audit of upper GI bleeding	Q2	National on line audit being run by host HB. Objective to measure the quality of clinical management, in particular the use of blood products.
Peer review of consent to examination and treatment processes	Q2	Continuous audit reported annually. Ensure compliance with the consent to examination or treatment processes. Previous audit identified improvement required to evidence quality of patient information provided and use of EiDO information leaflets, and compliance with the Welsh Language Regulations. Data collected via AMaT
Health Record Keeping	Q3	Continuous audit using AMaT, which enables clinical teams to track progress locally and implement a cycle of improvement. Currently rolled out using STAR audit tool for surgical specialties. Themes linked to poor MDT records, limited evidence of discussions with patient and / or families. Roll out to all non-surgical specialties including Paediatrics, Womens and Mental Health due in Q2 Medical.
Antimicrobial Point Prevalence Audit (Inpatients)	Q2	Annual point prevalence undertaken under the auspices of antimicrobial pharmacists

Project title	Reported	Objectives
Start Smart then Focus	Q3	Continuous on line audit via Public Health Wales tool, undertaken by prescribers in secondary care. Current compliance with undertaking the audit is poor across many departments. Action to address lies with local Antimicrobial Stewardship Groups. Where information is available compliance against standards is improving although step down from IV to oral as recommended is generally poor
2222 Audit	Q4	Continuous audit reviewing all cardiac and medical emergency arrest calls. At present some problems collecting the data in West and East due to technical difficulties. The data enables us to identify where areas may require additional support to recognize and escalate a deteriorating in a timely manner. Managed, lead and fed back to clinical teams via Resuscitation Teams.
LocSSIP	Q2	Local Safety Solutions for Invasive Procedures (LocSSIPs) are short checklists to ensure appropriate patient, procedure, consent and asepsis is undertaken for all invasive procedures undertaken outside the operating theatre (or equivalent). The audit is continuous and at present is purely to ensure a LocSSIP has been completed appropriately. The data is collated via AMaT, which enables continuous review of compliance, by each team.
Sepsis Six	Q4	Sepsis 6 is currently under review due to the imminent implementation of NEWS+. This work is being carried out under the auspices of the Chair of the recently formed BCU STEAR (Sepsis Triggers Escalation & Antibiotic stewardship Review). NEWS+ results in significantly less use of broad spectrum antibiotics, and provides a more flexible period for review. This would mean that our current Sepsis 6 data collection would be invalid. The plan it to have clear NEWS+ data set for auditing during Q2

4. Tier 3 local audits

This activity relates to those audits undertaken locally by clinical teams, with Division / Directorate approval.

The self-registration database was developed and launched in August 2020 (link below). 88 projects have been registered in Q1. Reports have been received for 8 (9%) projects.

http://7a1a1srvinforep/Tier3ClinicalAuditProjectSubmission

Quality, Safety and Experience Committee 1st November 2022	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Infection Prevention Sub Group (IPSG)
Meeting date:	13/09/2022
Name of Chair:	Rebecca Gerrard, Director of Nursing Infection Prevention and Decontamination
Responsible Director:	Angela Wood, Executive Director of Nursing and Midwifery
Summary of business discussed:	• Mandatory surveillance performance data. • C.difficile infections: learning from patient reviews and actions being taken to reduce the high rate. • Summary of MRSA bacteraemia reviews and learning. • Results of the MRSA screening audit. • A COVID-19 update. • Key Decontamination issues. • AAA reports from areas. • Learning from Corporate HCAI reviews. • New and updated IP policies and protocols. • An Infection Prevention Team Staffing Update. • Update from the Safe Clean Care programme. • A demonstration of the new blood culture dashboard. • A review of the risk assessments that need updating.
Key assurances provided at this meeting:	• Further training sessions arranged for IP Champions. • Good progress updating IP policies and protocols. • The Estates SCC revenue allocation for 2022/23 for improvements is being prioritised through Local IP Groups. • Pseudomonas blood stream infections have reduced this year: there are 18% less than the equivalent period in 2021/22. • COVID-19: the numbers of patients affected and numbers of outbreaks have declined. The updated Visitors protocol (V2) now uploaded on to Betsinet and the visiting guidance for maternity has also been amended. • Acute sites are proactively re-establishing Deep clean programmes with high level disinfection e.g. HPV to try to reduce the environmental bioburden including C.difficile. • Work has started on a CAUTI (Catheter Associated Urinary Tract Infection) database for community nursing. • The plan for Sleep Angel Mattresses was shared. The initial actions required by Mental Health are already in progress.

	Antimicrobial Stewardship: • The new Antimicrobial resistance dashboard is now complete; it allows timely scrutiny of resistance rates. • OPAT project and action plan developed. Expansion of elastomeric pumps to LLGH. • Despite recent increases in primary care, BCU are still meeting the target for reduced antibiotic prescribing. **Decontamination:** • The Strategic Review of The Decontamination of Medical Devices within BCU' has been received from Shared Services. • There has been improved engagement with members at the Decontamination Group meeting. • The protocol for Decontaminating beds and mattresses has been updated. • The 6 monthly BCU Decontamination Self-Assessment audits have been completed as planned. • Llandudno Theatres have been reinstated and the IP Environmental Audit attained a high score. **Safe Clean Care – Harm Free** • The 5S posters have been very popular and a great success with decluttering initiatives. • A Standard Precautions Awareness Campaign was held in September with a focus on the correct use of PPE. • Plans are progressing for both the Celebration Event and International IP Week in October.
Key risks including mitigating actions and milestones	• **C.difficile infections:** During August 2022 we saw 34 cases of CDI throughout BCUHB. So far in 2022/23, a total of 133 cases for BCUHB; this is approximately 43% more than the equivalent period in 2021/22. A Task and finish group has been established to review issues and take action: All wards have been asked to re-instigate a Deep cleaning programme; an SBAR to close bays where isolation has been delayed has been approved at IPSG; a new process for carrying out patient reviews for C.diff cases in primary care has been agreed; the Protocol for Faecal Transplant is being updated in line with new guidance; Toxin negative cases are being reviewed. • **MRSA:** There were 0 cases of MRSA during August 2022. There have been 8 cases for 2022/23. All cases have been fully investigated: there were 4 avoidable, 3 unavoidable, 1 unable to determine (lack of information from the Care home). The learning has been identified and shared. An MRSA Screening Audit has also been completed showing poor compliance with policy. Feedback has been provided to ward staff, to share at LIPGs. IPT continue to facilitate MRSA microteaching sessions and screening spot checks continue. • **IP team resource Risk 4241** 'Inability to deliver timely IP services due to limited capacity', scoring 15. Mitigating actions include recruiting to vacant posts, using IP Champions to promote IP, preparing a business case for expanding the

	current team, and promoting the Bangor University IP education programme amongst non-IP staff (the next intake for this course has now been postponed until the new year). • **Ward fridges**: very poor compliance; a high number of fridges inspected in June had high risk items left in there. A new leaflet is being designed titled 'Bringing Food into Hospital: Guidance for Visitors' to educate visitors and try and reduce the risk. • **PHW Microbiology resource Risk 1319** scoring 9; ongoing issues trying to recruit to vacant posts. This has been leading to a lack of representation at *C.difficile* ward rounds. Two new consultant microbiologists are due to start with BCUHB in the next two months. • **There is ongoing poor medical engagement with Corporate HCAI reviews**. • **Needlestick injuries/Body Fluid Incidents** remain on average 30 per month, a change in local behaviours is required to reduce this. • **Antimicrobial Stewardship**: Unable to provide information on prescribing in secondary care and compliance with Start Smart then Focus audits remain poor. Central to write to medical team about poor compliance with antimicrobial audits. **Decontamination:** • Decontamination Risk 4325 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16 unchanged. Action plan in progress. Agency Decontamination Consultant post now approved and he will start with BCU in November to develop a Decontamination strategy and options appraisal/business cases. • The 'Strategic review by Shared Services highlighted concerns with the built environment not meeting current guidelines and ageing machines. Engineering services and ventilation plants at SSD's, especially at YWM, are near or at the end of their original design life and will require replacement. In addition, there is no generator support at WM so in the event of a local power supply failure, the building would not be able to continue the sterilisation/decontamination processes. • SSD units need to procure new electronic track and trace system by Dec 22. This is on the risk register. • SSD at YGC was closed for 2 weeks recently due to issues with electrical panels and steam generation; work had to go to YWM. • Ophthalmology OPD Laser Lenses Decontamination at Abergele & YG are not complying with appropriate processes, SBAR in progress highlighting the need to consider the purchase of a "Low Temperature" Sterilisation Unit for the reprocessing of Choledochoscopes/Laser Lenses/ TOE and all Medical Devices which are not compatible with High Temperature Sterilisation – business case required.

	• IHEEM report for urology at YGC received with significant issues raised including training, COSHH, ventilation, and electronic track and trace. • WMH ENT currently decontaminating utilising immersion bath then Tristel 3 Stage Wipe. Clinicians have requested a risk assessment and review of processes. **Estates and Facilities issues**: • Cleaning for Credits (C4C) audits not being completed in all areas. An SABR was presented and approved that recommended the following: Review the C4C system in-line with the change to the upgraded Micad Asset Management System – this will take about 12 months to complete in full. To trial in East for 4 months doing 50% of the audit programme in each area one month and the other 50% the next month – to enable more areas to be covered. To feedback to IPSG before further roll out. To establish an external audit programme so staff are not just auditing their own areas.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	• A summary from IPSG is also sent to PSQ.
Matters requiring escalation to the Board:	• Nil
Well-being of Future Generations Act Sustainable Development Principle	• PHW are supporting BCU with assessment of risks and identifying short and long-term priorities in Decontamination. • Promoting IP education programmes at Bangor University. • Estates and IP trialling new technologies including ATP testing, hypochlorous acid, mobile air purification units, automated hand wash systems and joint working with the University of Sheffield on environmental cleanliness forensics. • IP are supporting the agenda to reduce waste and environmental impact.
Planned business for the next meeting:	Range of regular reports plus: • Short report highlighting where BCUHB is seeing the highest number of contaminants in blood cultures. • Agree spending priorities for the Safe Clean Care budget. • A comparison of Pseudomonas bacteraemia cases with water sampling data. • New leaflet, ‘Bringing Food into Hospital: Guidance for Visitors’ for approval. • The updated Christmas guidance for approval. • The updated protocol on testing for COVID-19.

Date of next meeting:	11 October 2022 Chris Lynes to Chair

V8.0

Teitl adroddiad: ***Report title:***	Public Interest Report from the Ombudsman			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This paper presents a Public Interest Report issued by the Ombudsman.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Associate Director of Quality Denise Williams, Senior Complaints Manager (Ombudsman)			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	BAF21-10 - Listening and Learning

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Ombudsman Public Interest Report Appendix B- Action Plan	

Introduction

Mr A complained about his care and management following his referral to an NHS Hospital Trust in England which was commissioned by the Health Board. Mr A complained that a Consultant Neurologist based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May 2018 and 19 September 2019. Mr A also identified that the Health Board should have explored a local referral option before sending him to the Trust. Finally, Mr A complained that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

The Ombudsman found that the investigation into and the time taken to diagnose Mr A's condition by the English Trust fell below the appropriate standard of care. The Ombudsman was satisfied that an earlier diagnosis would not have materially altered the outcome of Mr A's disease, but she was concerned the delay in diagnosis and the attribution of his symptoms to psychological or psychiatric factors caused Mr A unnecessary anxiety and uncertainty. This was a significant injustice to him and therefore this aspect of Mr A's complaint was upheld.

The Ombudsman was satisfied with the Health Board's explanation that although there are clinics available locally, the waiting list for a clinic appointment is often longer than at the Trust which is why patients are often referred to the Trust. This aspect of Mr A's complaint was not upheld.

In relation to complaint handling the Ombudsman was troubled that the English Trust, on behalf of the Health Board, did not identify the failings in care provided to Mr A by the Neurologist when considering Mr A's complaint. The Ombudsman also identified the Health Board failed to seek an independent clinical opinion to address Mr A's concerns. The complaint handling would have added to the stress and anxiety Mr A experienced, and this aspect of his complaint was upheld.

Action plan

The Ombudsman made a number of recommendations and these have been populated into an action plan, which is enclosed with this report (correct as of the time of writing at 16 October 2022).

The Senior Complaints Manager (Ombudsman) will monitor delivery of the plan and seek evidence of completion. This evidence is shared with the Ombudsman. The case will only be closed once internal and Ombudsman approval of the evidence has been given.

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202102604

Contents	Page

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr A.

Summary

Mr A complained about his care and management following his referral to an NHS Hospital Trust in England ("the Trust") which was commissioned by Betsi Cadwaladr University Health Board ("the Health Board") to provide care/treatment. (The Health Board having commissioned the care from the Trust, remained responsible for the monitoring and oversight of the care which the Trust provided). Mr A complained that a Consultant Neurologist ("the First Neurologist") based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May 2018 and 19 September 2019. Mr A also said that the Health Board should have explored a local referral option before sending him to the Trust. Finally, Mr A complained that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

The Ombudsman found that the investigation into and the time taken to diagnose Mr A's condition fell below the appropriate standard of care. The investigations following the first consultation were inadequate, despite the First Neurologist noting that Mr A's presentation in May 2018 was strongly indicative of underlying physical disease. Mr A had clear and ongoing physical signs which strongly suggested a neurological disorder from the first time he was seen in May 2018. The First Neurologist did not question or seek an explanation of Mr A's ongoing abnormal physical symptoms but attributed them firstly to an unrelated back problem and later to a psychiatric or psychological disorder. The First Neurologist also failed to discuss, recognise, and later review the significance of the ongoing abnormal physical signs that Mr A demonstrated on examination.

The Ombudsman was satisfied that an earlier diagnosis would not have materially altered the outcome of Mr A's disease, but she was concerned the delay in diagnosis and the attribution of his symptoms to psychological or psychiatric factors caused Mr A unnecessary anxiety and uncertainty. This was a significant injustice to him and therefore this aspect of Mr A's complaint was upheld.

The Ombudsman was satisfied with the Health Board's explanation that although there are clinics available locally, the waiting list for a clinic appointment is often longer than at the Trust which is why patients are often referred to the Trust. This aspect of Mr A's complaint was not upheld.

In relation to complaint handling the Ombudsman was troubled that the Trust, on behalf of the Health Board, did not identify the failings in care provided to Mr A by the First Neurologist when considering Mr A's complaint. The Health Board also failed to seek an independent clinical opinion to address Mr A's concerns. The Ombudsman was concerned that the Health Board, both at a commissioning level and in its own right, had failed to ensure that the Trust fully acknowledged and recognised the extent of failings evident in this case together with the impact on Mr A. The Ombudsman concluded that the lack of an open and timely response to Mr A's complaint was not only maladministration but further added to the injustice caused to Mr A. It also meant that an important part of the Health Board's monitoring role, which requires it to have rigorous oversight and scrutiny of the commissioned body, was lost. Inevitably, this would have added to the stress and anxiety Mr A experienced, and this aspect of his complaint was upheld.

Mr A was awarded PIP (a benefit to help with extra living costs for people with a long-term health condition) following his diagnosis. The Ombudsman concluded, on balance, that he would have been awarded this had his condition been diagnosed earlier. She therefore calculated the payment Mr A would have received, together with interest at the rate of a County Court Judgment (8%)

The Ombudsman **recommend** that within **1 month** from the date of the this report the Health Board should:

a) provide an apology to Mr A for the failings identified in this report which extended to poor complaint handling

b) in recognition of the financial loss caused to Mr A as a result of the failings pay him the sum of £4,835.38

c) in recognition of the distress and inconvenience caused to Mr A as a result of the delayed diagnosis and having to pursue the matter rigorously himself, at a time when he was unwell, make a payment to him of £1,500

d) in recognition of the distress and inconvenience caused by the failures in complaint handling, make a payment to Mr A of £500

e) write to the Trust as part of its commissioning arrangements, to bring to its attention the concerns highlighted by the Adviser about the need to monitor the First Neurologist's working practices, including reminding him of the need to adhere to the General Medical Council Guidelines as part of his professional obligations

f) as part of its commissioning arrangements, ask the Trust to ensure that its Neurological Team discuss this case at an appropriate forum as part of reflective and wider learning

g) review its response to this complaint to establish what lessons can be learnt, particularly in relation to when it would be appropriate to seek independent clinical advice on a complaint, as set out in the PTR guidance

h) share this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

The Complaint

1. Mr A complained about his care and management following his referral to an NHS Trust in England ("the Trust") which was commissioned by Betsi Cadwaladr University Health Board ("the Health Board") to provide care/treatment. Mr A's concerns related to the following:

a) that a Consultant Neurologist ("the First Neurologist") based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May **2018** and 19 September **2019**

b) that the Health Board should have explored a local referral option before sending him to the Trust

c) that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and the Trust and considered those in conjunction with the evidence provided by Mr A. Clinical advice was obtained from Dr R A Grunewald, a Consultant Neurologist ("the Adviser"). The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. It is my role to determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. The Health Board has commissioning arrangements in place with the Trust. As a Welsh patient receiving treatment commissioned by a Health Board in Wales, the treatment falls within my jurisdiction as set out by schedule 3 of the Public Services Ombudsman (Wales) Act 2019.

4. Mr A, the Trust and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation, regulation and guidance

5. The General Medical Council's ("GMC") Good Medical Practice guideline 2013 ("the GMC Guidance") states that a doctor must "Listen to patients, take account of their views, and respond honestly to their questions".

6. The Welsh Health Specialised Services Committee ("WHSSC") holds the contract with the Trust, which covers all of the services provided by the Trust to patients in North Wales. There is a single contract in place through WHSCC which covers both the specialist services commissioned by WHSSC and the non-specialist services commissioned by the Health Board, which includes medical neurology services. As the funding body, WHSSC also holds the Service Level Agreement ("SLA") on behalf of the Health Board for the commissioning of neurology services from the Trust. WHSSC and the Health Board collaborate on the running of the contract. The Health Board has day-to-day management responsibility with the Trust which sets the practical operational arrangements for the monitoring of the quality of the commissioned services provided and the handling of complaints (see paragraphs 29-31).

7. The SLA sets out that all concerns will be managed in line with the Welsh Government's National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") and accompanying Putting Things Right guidance ("the PTR Guidance").

8. The Regulations set out specific actions that health bodies should complete when considering complaints, together with timescales for completion. Public bodies are expected to have regard to any guidance, and in the event that it is not followed, document the rationale for not doing so.

9. Section 10 of the PTR Guidance sets out Cross Border Arrangements for considering redress - in general, it states that concerns about care and treatment provided on behalf of the NHS in Wales by organisations outside Wales should be dealt with in accordance with the relevant concerns procedure which applies to that organisation.

10. The PTR Guidance says that there may be occasions when it is necessary to secure an independent opinion on a matter relating to a concern, with a view to resolving it. This may include, for example, obtaining a second opinion to aid a patient's understanding of the care they have received.

11. My predecessor issued guidance "Principles of Good Administration and Good Records Management" (2016 - an updated version was issued in 2022) ("the Guidance") to which bodies within my jurisdiction are also expected to have regard, in order to deliver good administration and customer service. The Guidance sets out the good administration principles that public sector providers are expected to adopt when it comes to service delivery and dealing with service users. These principles include, for example, the need to be open and accountable.

12. My predecessor issued a thematic report "Ending Groundhog Day - Lessons from Poor Complaint Handling 2017". Which was focussed on driving improvement in public services using learning derived from complaints.

13. The Social Security Regulations 2013 (Statutory Instrument 377) set out the main rules for Personal Independence Payments ("PIP"). PIP is a non-means-tested benefit to help with extra living costs for people with a long-term physical or mental health condition or disability, and/or difficulty doing certain everyday tasks or getting around because of their condition. PIP is paid every 4 weeks. PIP has 2 parts: a daily living component and a mobility component. A person might be able to claim one or both components. Each component can be paid at either:

- Standard rate – where the person's ability to carry out daily living/mobility activities is limited by their physical or mental condition.

- Enhanced rate – where the person's ability to carry out daily living/mobility activities is severely limited by their physical or mental condition.

The background events

14. Mr A was referred by his GP to the Neurology services at Ysbyty Gwynedd on 12 February 2018 and was seen by the First Neurologist at the Trust on 19 May. The First Neurologist's clinic letter noted that Mr A had a 2-year history of erectile dysfunction followed by urinary hesitancy and urgency. More recently, he had experienced mobility problems, felt tired and had jerks and spasms in his left leg. An examination carried out by the First Neurologist revealed unsteadiness, positive Romberg's sign (a tendency to fall when standing with eyes closed), brisk deep tendon reflexes (during a reflex test, a doctor tests deep tendon reflexes with a reflex hammer to measure response - quicker responses may lead to a diagnosis of brisk reflexes) and extensor plantars (reflex characterised by upward movement of the great toe and an outward movement of the rest of the toes, when the sole of the foot is stroked). It was noted that Mr A also had pain in his left leg. The First Neurologist arranged for Mr A to undergo a magnetic resonance imaging scan (("MRI") a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) of his thoracolumbar spine (parts of the spine supporting the chest and lower back and the nerves supplying these areas).

15. At the First Neurologist's follow-up outpatient clinic on 20 July, he advised Mr A that the MRI scan showed a left-sided disc bulge (protrusion) touching the left spinal (S1) nerve root and that he would be referring Mr A to a neurosurgeon.

16. On 23 July Mr A's GP wrote to the First Neurologist highlighting that Mr A was extremely concerned because he felt the MRI scan only explained the sciatica in his left leg, which had occurred in the period between his initial consultation and the MRI scan, and not his other symptoms. The GP noted that Mr A had been referred to a neurosurgeon and that Mr A had said that the First Neurologist had discharged him from his care. The GP said

that Mr A was worried about his ongoing presenting problems (see paragraph 14) and wondered whether he needed a brain scan which the First Neurologist had said he would arrange if there was nothing abnormal on the MRI scan. The GP requested the First Neurologist review Mr A's case record and answer his concerns.

17. On 25 July Mr A emailed the First Neurologist asking that the original plan of him having a brain scan be carried out. A few days later Mr A sent a further email to the First Neurologist repeating his request for a brain scan and noting that his symptoms were those of somebody with MS, including muscle spasms, balance issues, bladder and bowel issues, fatigue, and walking difficulties.

18. On 1 August the First Neurologist wrote to Mr A's GP advising that he had arranged an MRI head scan which he said appeared normal. He noted that he had made a referral to the Neurosurgeons for an opinion.

19. On 6 August Mr A sent a further email to the First Neurologist asking how he might obtain a second opinion.

20. On 21 September Mr A was reviewed at the Trust's spinal physiotherapy clinic by an extended scope practitioner (a specialist physiotherapist) who wrote to the First Neurologist noting Mr A's complaints of poor balance, lack of co-ordination, and inability to run. Following this, the First Neurologist again reviewed Mr A on 7 January **2019**. During this consultation the First Neurologist noted that Mr A had "severe anxiety and depression" as well as symptoms suggestive of restless legs or periodic movements of sleep. He reassured Mr A that he did not have a neurological illness, and that his symptoms were psychological or psychiatric in nature. The First Neurologist asked the GP to make an urgent referral to a general psychiatrist.

21. On 4 February Mr A wrote to the First Neurologist setting out his ongoing debilitating condition and noting that the 3 MRI scans in 2018 had not revealed any evidence of degenerative neurological conditions, which could be causing his symptoms. He urged the First Neurologist and his

team to re-read the scans and re-examine him or refer him to another NHS Hospital to look more deeply into the possible physical root causes of his symptoms. In his email Mr A said:

> "Whilst the ongoing nature of my symptoms has understandably affected my outlook, and I very much do want to have the psychological evaluation, I want to state that I am of sound mind, and I am certain that the cause of this constellation of very persistent symptoms is physical, and not psychological. It has been eight months since I first was seen at the [name of hospital], and whilst I am happy to have the psych evaluation done, I don't want this to end without the exploration of possible physical root causes".

22. Following an exchange of correspondence between the First Neurologist and Mr A's GP, Mr A was referred by his GP to another Consultant Neurologist ("the Second Neurologist") at the Trust, who saw him on 19 September. Mr A was diagnosed with MS on 14 November, 16 months after his initial referral.

23. On 3 April **2020** Mr A complained to the Trust about what he said was the First Neurologist's dismissive approach to his symptoms and his failure to undertake the necessary tests to rule out MS. Mr A said that had he been diagnosed sooner he could have been receiving the appropriate treatment. The Trust provided a response on 14 May, which concluded that the care and treatment provided to Mr A had been appropriate and acceptable given the timeliness of investigations carried out, the referrals made, and the plan for further review and investigations before Mr A sought a second opinion. Mr A remained unhappy with the response. His complaint was then considered by the Health Board and Mr A received a response on 28 May **2021**.

24. The Health Board, following a review of the investigation into Mr A's care provided by the Trust, said that its Clinical Director was assured that the investigation by the Trust had been conducted fully. The Health Board said that it did not employ its own neurologists who would be able to comment on the investigation from a neurological perspective. The

Health Board said that both the neurologists involved in Mr A's care provide services for its patients and were unable to investigate the case from an independent perspective, as Mr A had requested.

Mr A's evidence

25. Mr A said that he was not satisfied with the responses from the Trust or the Health Board as both failed to acknowledge that the First Neurologist did anything wrong. Mr A said the response from the Trust stated that when he saw the First Neurologist in January 2019 there was "no evidence" to suggest that he had MS. Mr A said that the First Neurologist stopped investigating before he could rule out MS and therefore his diagnosis was completely missed.

26. Mr A said that the Trust and the Health Board's responses stated that he "sought a second opinion" from the Second Neurologist; Mr A said that this was an inaccurate representation of how things happened (see paragraph 22).

27. Mr A said that once he asked for a different doctor, he was able to see the Second Neurologist locally. He questioned why he was not referred to the Second Neurologist in the first place. He added that this would have saved him much time, distress, and the expense of travelling back and forth to England for appointments.

28. Mr A said that he had lost a whole year of his life waiting for the diagnosis and it had been extremely distressing to be told that there was nothing wrong when he could see from his own experience that there was clearly something seriously wrong. Mr A said that this delay meant he was unable to seek further help both in managing his MS and obtaining financial help. Mr A said that he lost out on claiming the PIP (standard rate for daily living and mobility) which he had been receiving since his diagnosis.

The Health Board's evidence

29. The Health Board noted that to enable WHSSC to have oversight of the contract, the Trust is required to share all contract monitoring information with WHSSC. The Health Board set out the day-to-day processes that it has

in place with the Trust for monitoring the quality of the commissioned neurology services provided by the Trust. This includes quarterly SLA meetings with representatives from WHSCC, the Health Board and the Trust. The Health Board noted that these were supplemented with regular SLA meetings between itself and the Trust with the focus being on operational matters/issues relating to service delivery and patient experience.

30. The Health Board said that the Trust deals with all patient complaints relating to the commissioned neurology services. It said that such complaints are recorded and investigated in line with the Trust's Complaints Policy and Procedure.

31. The Health Board said any complaints that the Trust's Patient Experience Team are concerned about are escalated to its Chief Nurse and brought to the Health Board's attention. The Health Board said that as per the contract, the Trust would go through its own claims and legal process. Its processes around safety and quality are overseen by the NHS England Improvement Team.

32. The Health Board said that its referrals are triaged by the Trust, and patients are offered an appointment at the most appropriate clinic following this clinical triage. Although there are clinics available locally, the waiting list is often longer than those for a clinic at the Trust. Therefore, patients are often offered appointments at the Trust as they are available sooner than those locally.

33. The Trust provided nothing further in its response to that which it had provided to Mr A.

Professional Advice

34. The Adviser said that the First Neurologist's initial examination documented Mr A's unsteadiness, brisk reflexes and extensor plantar responses. He said that these were "hard" neurological signs - i.e., those which are strongly indicative of underlying physical disease. These signs were not explained by the nerve root compression noted on the MRI scan of Mr A's thoracic lumbar spine, and an alternative explanation should have

been sought. Given the presence of these neurological signs, most consultant neurologists would have ordered an MRI of the whole neuraxis (head and the total spine) at the initial consultation. The Adviser said that limiting neuroimaging to the thoracic and lumbar spine is considered poor practice. He added that whilst an MRI of Mr A's head was later undertaken and reported as normal, there was no evidence that Mr A was then appropriately re-examined by the First Neurologist to confirm or refute the presence of the hard neurological signs.

35. The Adviser concluded that the First Neurologist's management of Mr A was sub-optimal at the first consultation, that inadequate neuroimaging was initially requested, that no explanation for Mr A's abnormal physical examination was found, and that attribution of his symptoms to a psychiatric or psychological disorder was "inappropriate and rash".

36. The Adviser commented that whilst there are no relevant local or regional guidelines covering this presentation, nevertheless he was of the view that the First Neurologist appeared not to have met the requirements of the GMC Guidance to provide a good standard of practice, to assess Mr A's condition adequately and take into account his history, views and values, and where necessary examine him. He said that this implied that the First Neurologist's working practices should be scrutinised closely.

37. The Adviser noted that Mr A's presentation of demyelinating disease (when the protective coating that surround parts of the brain and the spinal cord, is damaged) was unusual and appeared to be consistent with a diagnosis of primary progressive MS. The Adviser said that unfortunately, as there is not yet any treatment for MS which has been shown to change the prognosis of the disorder, it was unlikely that more prompt diagnosis would have materially altered the outcome of Mr A's disease. He added, however, that the delayed diagnosis and attribution of his symptoms to psychological or psychiatric factors did cause Mr A unnecessary anxiety and uncertainty.

38. The Adviser said that there were inconsistencies between the Trust's response to Mr A's complaint and the entries in the clinical records. The Adviser commented that the Trust's complaint response suggested that the First Neurologist intended to undertake further investigations "if a patient

was to progressively present with more neurological signs" but did not get the opportunity so to do. However, the Adviser said that the clinical documentation implied instead that the First Neurologist recommended a second opinion at another health care setting in February 2019, despite Mr A writing to him pointing out his symptoms were worsening and despite the presence of physical signs on examination. The Adviser said that this was inaccurate and unreasonable.

39. The Adviser said that the Trust's response also stated that "When [the Second Neurologist"] saw Mr A, he had further abnormal neurological signs on examination. Hence after the initial scan, he undertook a lumbar puncture to look for evidence of the very rare form of MS that is not associated with scan abnormalities". The Adviser said that the clinical documentation indicated that abnormal physical signs were already present when the First Neurologist examined by Mr A in May 2018. The suggestion that further investigations were undertaken because Mr A's clinical examination had changed was therefore not reasonable.

40. In conclusion, the Adviser said that Mr A experienced delayed diagnosis of his demyelinating disease. Whilst the Adviser was of the opinion that this did not cause an adverse clinical outcome, it did result in a great deal of anxiety, frustration and uncertainty. The delayed diagnosis was partly attributable to failures on the part of the First Neurologist in investigation, interpretation and re-examination of Mr A.

Analysis and conclusions

41. I have been assisted by the advice and explanations of the Adviser, which I accept in full. The conclusions reached, however, are my own. I will address each of Mr A's concerns in turn.

That there was a failure to diagnose Mr A's MS between May 2018 and September 2019

42. My investigation has concluded that the investigations into, and the time taken to diagnose, Mr A's condition during this period fell below the appropriate standard of care. As the Adviser has highlighted, the investigations following the first consultation were inadequate, despite the

First Neurologist noting that Mr A's presentation in May 2018 was strongly indicative of underlying physical disease. I accept that Mr A's MS presented in an unusual way, in that there were no obvious indications on the scans carried out, as there usually would be for a patient with MS. It was not until a lumbar puncture was arranged by the Second Neurologist that a definitive diagnosis was made. However, as the Adviser has explained, Mr A had clear and ongoing physical signs which strongly suggested a neurological disorder from the first time he was seen in May 2018. It is concerning that the First Neurologist did not question or seek an explanation of Mr A's ongoing abnormal physical symptoms but attributed them firstly to an unrelated back problem and later to a psychiatric or psychological disorder instead. This was also despite Mr A contacting the First Neurologist on a number of occasions to set out the ongoing physical symptoms he was experiencing and the impact they were having on him.

43. For these reasons, I am concerned that the First Neurologist failed to provide an appropriate standard of care to Mr A, as required by the GMC Guidance. As set out above, he failed to discuss, recognise, and later review the significance of the ongoing abnormal physical signs demonstrated on examination and which Mr A was continuing to report.

44. Whilst I am satisfied that an earlier diagnosis would not have materially altered the outcome of Mr A's disease, I consider the delay in diagnosis and attribution of his symptoms to psychological or psychiatric factors caused Mr A unnecessary anxiety and uncertainty. Moreover, Mr A lost out financially as a result. I note that Mr A is now in receipt of PIP on account of his disability, (see paragraph 48). This was a significant injustice to him. I have therefore **upheld** this aspect of Mr A's complaint.

The Health Board should have explored a local referral

45. In relation to Mr A's concerns that the Health Board should have explored the option of a local referral before sending him to the Trust, I am satisfied with the Health Board's explanation (see paragraph 32) for this and that had he been seen locally, it might have delayed his initial consultation. I have therefore not upheld this aspect of Mr A's complaint.

The handling of Mr A's complaint

46. I am troubled that the Trust, on behalf of the Health Board, did not identify the failings in care provided to Mr A by the First Neurologist when considering his complaint. It is also disappointing that the actual clinical events were not always recounted as accurately in the Trust's complaint response as they should have been, based on the evidence. Further, the Health Board's investigation of Mr A's complaint appears only to have rubber stamped the investigation carried out by the Trust, despite the PTR Guidance providing a mechanism for seeking an independent clinical opinion to address Mr A's concerns. Had the Health Board properly considered the complaint response it should have identified the clear inaccuracies in the Trust's response as identified by my Adviser.

47. The Health Board, both at a commissioning level and in its own right, has failed to ensure that the Trust fully acknowledged and recognised the extent of failings evident in this case and the impact on Mr A. The lack of an open and timely response to Mr A's complaint was not only maladministration but further added to the injustice caused to Mr A. In this instance the Health Board not engaging with the PTR process or obtaining an independent clinical opinion on the complaint meant that an important part of its monitoring role, which requires it to have rigorous oversight and scrutiny of the commissioned body, was lost. As a result, there was a missed opportunity to properly learn lessons, and equally important, to put things right quickly and effectively, which is not in keeping with my office's guidance or the lessons from my predecessor's thematic report on complaints handling. This will inevitably have added to the further stress and anxiety Mr A was experiencing. I have therefore upheld this aspect of Mr A's complaint.

48. In considering the financial redress in this case, my initial starting point has been to put Mr A back in the position he would have been in, had he been diagnosed following his initial consultation with the First Neurologist on 19 May 2018. In doing so, I have taken into account the fact that Mr A's condition was not dissimilar during this period to what it was when he was awarded PIP, and on balance therefore, I consider it is more likely than not that he would have been awarded this earlier, had he been diagnosed sooner. In calculating the retrospective redress, I am of the view that it is

reasonable to assume that it would have taken 2 months to reach a diagnosis. I am also mindful that Mr A should not be disadvantaged by the delay, and therefore, I have applied the interest rate which the County Court awards on its judgements of 8%. Therefore, the PIP payment to which Mr A would have been entitled would have been £4,477.20 (made up of £319.80 per month at the rate applicable in 2018) (made up of both daily living allowance and mobility at the standard rate) for 14 months plus interest of £358.18, which makes a total figure of £4,835.38. I am also mindful that the mental anguish the uncertainty caused to Mr A about his physical symptoms, and having to fight to get a diagnosis, has caused him significant distress. I have therefore arrived at a distress figure of £1,500 to reflect the additional impact this has had on him.

Recommendations

49. I **recommend** that within **1 month** of the date of the final version of this report the Health Board should:

a) provide an apology to Mr A for the failings identified in this report which extended to poor complaint handling

b) in recognition of the financial loss caused to Mr A as a result of the failings pay him the sum of £4,835.38

c) in recognition of the distress and inconvenience caused to Mr A as a result of the delayed diagnosis and having to pursue the matter rigorously himself to get a diagnosis, at a time when he was unwell, make a payment to him of £1,500

d) in recognition of the distress and inconvenience caused by the failures in complaint handling, make a payment to Mr A of £500

e) write to the Trust as part of its commissioning arrangements, to bring to its attention the concerns highlighted by the Adviser about the need to monitor the First Neurologist's working practices, including reminding him of the need to adhere to the GMC Guidelines as part of his professional obligations

f) as part of its commissioning arrangements, ask the Trust to ensure that its Neurological Team discusses this case at an appropriate forum as part of reflective and wider learning

g) review its response to this complaint to establish what lessons can be learnt, particularly in relation to when it would be appropriate to seek independent clinical advice on a complaint, as set out in the PTR guidance

h) share this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

50. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Michelle Morris 21 September 2022
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales

REF: COM48302

Summary: The Ombudsman's investigation considered the care and management of Mr A following his referral to an NHS Trust in England which was commissioned by the Health Board to provide care/treatment. Mr A's concerns related to the following:

a) that a Consultant Neurologist ("the First Neurologist") based at the Trust failed to diagnose his multiple sclerosis ("MS" - a condition which affects the brain and the spinal cord) between 18 May **2018** and 19 September **2019**
b) that the Health Board should have explored a local referral option before sending him to the Trust
c) that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

Action Plan Lead(s)		Divisional Director Senior Concerns Manager (PSOW Single Point of Contact)			
Updated		Date Created 8.8.2022, updated 21.9.2022, updated 16.10.22			
Ombudsman Recommendations		**Leads**	**By**	**RAG**	**Comments/update**
a.	Health Board to provide an apology to Mr A for the failings identified in the Ombudsman's report which extend to poor complaint handling.	Senior Concerns Manager (Ombudsman Single Point of Contact)	21 October 2022		Action complete – apology letter sent from the CEO.
b.	In recognition of the financial loss caused to Mr A as a result of the failings pay him the sum of £4,835.38.	Senior Concerns Manager (Ombudsman Single Point of Contact)	21 October 2022		Action complete – redress payment issued.
c.	In recognition of the distress and inconvenience caused to Mr A as a result of the delayed diagnosis and having to pursue the matter rigorously himself, at a time when he was unwell to get a diagnosis, make a payment to him of £1,500.00.				
d.	In recognition of the distress and inconvenience caused by the failures in				

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	complaint handling, make a payment to him of £500.00.				
e.	Write to the Trust as part of its commissioning arrangements, to bring to its attention the concerns highlighted by the Ombudsman's Adviser about the need to monitor the First Neurologist's working practices, including reminding him of the need to adhere to the GMC Guidelines as part of his professional obligations.	Mr Matt Joyes Director of Quality Dr Steven Beaumont Asst Director Of Quality	21 October 2022		Action complete – letter sent to the Trust and confirmation received will be actioned.
f.	As part of its commissioning arrangements, ask the Trust to ensure that the Neurological Team discuss this case at an appropriate forum as part of reflective and wider learning.	Mr Matt Joyes Director of Quality Dr Steven Beaumont Asst Director Of Quality	21 October 2022		Action complete – letter sent to the Trust and confirmation received will be actioned.
g.	Review its response to this complaint to establish what lessons can be learnt, particularly in relation to when it would be appropriate to seek independent clinical advice on a complaint, as set out in the PTR guidance.	Dr Steven Beaumont Assistant Director Of Quality, Quality Directorate	21 October 2022		At the time of writing (16.10.22) this review is underway.

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b) that the Health Board should have explored a local referral option before sending him to the Trust
c) that the complaint responses received from both the Trust and the Health Board were not robust and were inaccurate.

		Mrs Carolyn Owen Acting Assistant Director of Patient and Carer Experience, Quality Directorate			
h.	Share this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.	Mr Matt Joyes Director Of Quality	21 October 2022		Action complete – report shared with key officers including the Chairman and tabled for the QSE Committee in November 2022.