Bundle Quality, Safety & Experience Committee 17 March 2020

AGENDA
9:30 Boardroom, Carlton Court, St Asaph LL17 0JG

0	Note - Pre Meeting of Independent Members to take place at 09:00
1.0	OPENING BUSINESS AND EFFECTIVE GOVERNANCE
1.1	09:30 - QS20/37 Chair's Opening Remarks
1.2	09:31 - QS20/38 Declarations of Interest
1.3	09:32 - QS20/39 Apologies for Absence

Mr Andy Roach, Director of Mental Health & Learning Disabilities
Mr Chris Stockport, Executive Director of Primary & Community Services

1.4	09:33 - QS20/40 Minutes of Previous Meeting Held in Public on the 28.1.20 for Accuracy, Matters Arising and Review of Summary Action Log

    QS20.40 Minutes QSE 28.01.20 Public v0.05.docx

    Summary Action Log QSE Public.docx

1.5	09:53 - QS20/41 Action Log from Joint Audit and QSE Committee - Mrs Lucy Reid

    QS20.41 Action log from Joint Audit and QSE Committee.docx

1.6	10:08 - QS20/42 Patient Story : Mrs Gill Harris

    QS20.42 Patient story SW 2019.docx

1.7	10:18 - QS20/43 Quality/Safety Awards and Achievements : Mrs Gill Harris

Verbal report

2.0	FOR DISCUSSION
2.1	Performance Reports
2.1.1	10:23 - QS20/44 Annual Plan Monitoring Report - Dr Jill Newman

The Quality, Safety & Experience Committee is asked to note the report.

    QS20.44a Annual Plan Progress Monitoring Report Coversheet.docx

    QS20.44b Annual Plan Progress Monitoring Report Appendix 1 January 2020 Final v0.2.pdf

2.1.2	10:33 - QS20/45 Integrated Quality & Performance Report - Dr Jill Newman

The Quality, Safety and Experience Committee is asked to scrutinise the report and to escalate any areas of issue to the Board.

    QS20.45a IQPR coversheet v3.docx

    QS20.45b IQPR v2.pdf

2.1.3	11:03 - QS20/46 Exception report on BCU response to audit report into postponed procedures - Dr Jill Newman

The Quality, Safety and Experience Committee is asked to note the additional information provided in the attached briefing paper

    QS20.46a BCU response to audit report into postponed procedures coversheet.docx

    QS20.46b BCU response to audit report into postponed procedures update.docx

2.2.1	11:13 - COMFORT BREAK
2.3	11:23 - QS20/47 Infection Prevention & Control Q3 2019-20 Report: Mrs Gill Harris

The Quality Safety & Executive Committee meeting is asked to note the Q3 report.

    QS20.47a Infection Prevention Control Q3 2019-20 Report v2.docx

2.4	11:33 - QS20/48 Ward Accreditation Update : Mrs Deborah Carter

The Committee is asked to support the ongoing Ward Accreditation process.

    QS20.48a Ward Accreditation coversheet.docx

    QS20.48b Ward Accreditation Appendix 1 Framework for support.pdf

2.5	11:43 - QS20/49 Serious Untoward Incidents : Mrs Deborah Carter

The QSE Committee is asked to note the report.
The QSE Committee is also asked to note the ongoing improvement work including review of various Health Board processes and implementation of the Datix IQ Cloud

    QS20.49a Serious Untoward Incidents coversheet.docx

    QS20.49b Serious Untoward Incidents report.docx

2.6	11:58 - QS20/50 Monitoring of actions from Internal Audit report into WAST Handover at Emergency Departments : Mrs Deborah Carter

That Quality Safety Executive Committee is provided with assurance that;
1\. Regular review of the ambulance handover performance and actions are embedded within existing process\.
2\. Structures are in place to effectively monitor patient safety within the ED particularly in times of escalation\.
3\. Systems are supporting data capture to identify harm and recording performance impact\.
4\. The Health board is engaged in programmes locally and nationally to support pathways\, processes and quality improvement to ensure that patient quality\, safety and experience is maintained within our Emergency Departments

QS20.50 Monitoring of actions from Internal Audit report into WAST Handover at EDs.docx

2.7.1	12:13 - LUNCH BREAK - members are reminded to bring their own lunch
2.8	12:33 - QS20/51 Mortality Reporting - Dr David Fearnley

The Quality Safety & Experience Committee is asked to note the content of this paper and support the proposed way forward.

QS20.51 Mortality Reporting.docx

2.9	12:43 - QS20/52 Draft 2020-21 Clinical Audit Plan - Dr David Fearnley

The Quality, Safety and Experience Committee is asked to approve the draft 2020/21 Clinical Audit Plan for BCUHB.

QS20.52a Clinical Audit Plan coversheet.docx

QS20.52b Clinical Audit Plan report.pdf

2.10	13:03 - QS20/53 Draft Annual Quality Statement (AQS) 2019-20 - Mrs Gill Harris

The Quality, Safety and Experience committee is asked to note the attached documents and is also asked to provide suggestions in particular, around the 'Forward Look' section.

QS20.53a Annual Quality Statement coversheet.docx

QS20.53b Annual Quality Statement Appendix A.docx

QS20.53c Annual Quality Statement Appendix B.pdf

QS20.53d Annual Quality Statement Appendix C.docx

2.11	13:13 - QS20/54 Patient Experience Report Quarter 3 2019-20 - Mrs Gill Harris

The Quality, Safety and Experience Committee is asked to receive this report for assurance.

QS20.54a Patient Experience Report Q3 coversheet.docx

QS20.54b Patient Experience Report Q3 report.docx

2.12	13:28 - QS20/55 Medicines Management Annual Report 2019-20 - Dr David Fearnley

The Quality Safety & Experience Committee is asked to note the report for information

QS20.55a Medicines Management annual report 2019_20 coversheet.docx

QS20.55b Medicines Management Annual report 2019-20.pdf

2.13	13:43 - QS20/56 Psychological Therapies Update - Mrs Lesley Singleton

The Quality, Safety and Experience committee is asked to receive this information and regular updates on improvement work for scrutiny and assurance.

QS20.56a Psychological Therapies coversheet.docx

QS20.56b Psychological Therapies Review 2019 FINAL.pdf

QS20.56c Psychological Therapies Programme Board ToRs.docx

2.14	14:03 - QS20/57 Thematic Review of Suicides - Mrs Lesley Singleton

The Quality Safety & Experience Committee is asked to note this report which provides additional data relating to deaths in the West locality and to note the work being undertaken to implement learning from deaths.

QS20.57 Thematic Review of Suicides.docx

2.16	14:23 - QS20/58 Primary & Community Care Quality Assurance Report - Mrs Clare Darlington

It is recommended that the QSE Committee:
• Reviews the core primary care Q&S indicators and assurances, and notes the actions taken;
• Notes the 'Focus on' topics and considers any future related reporting that is required;
• Considers any further 'focus on' topics that the Committee would find useful.

QS20.58a Primary Care Assurance Report coversheet.docx

QS20.58b Primary Care Assurance Report appendix 1.docx

QS20.58c Primary Care Assurance Report appendix 2.docx

QS20.58d Primary Care Assurance Report appendix 3.docx

2.17	14:43 - QS20/59 Quality Safety Group Assurance Report - Mrs Deborah Carter

QS20.59 Quality Safety Group Assurance Report.docx

2.18	14:53 - QS20/60 Primary Care CAMHS (Child Adolescent Mental Health Services) - Progress Update Against Delivery Unit Recommendations - Mrs Clare Darlington

The Quality, Safety and Experience Committee is asked to note the progress being made and advise of any future assurances required.

QS20.60 Primary Care CAMHS - Progress Update Against Delivery Unit Recommendations.docx

2.19	15:08 - QS20/61 Item deferred
3.0	FOR CONSENT
3.1	15:18 - QS20/62 Health & Safety Policy HS01 for Approval

The Quality Safety & Experience Committee is asked to approve the Health & Safety Policy HS01

QS20.62a Health and Safety Policy coversheet.docx

QS20.62b Appendix 1_Health and Safety Policy V2.docx

QS20.62c Appendix 2_EQIA.docx

4	FOR DECISION
4.1	15:33 - QS20/63 Committee Annual Report 2019-20 - Mrs Gill Harris

The Quality, Safety and Experience Committee is asked to:
1\. Review the draft Annual Report for 2019\-20
2\. Provide comments and feedback as necessary
3\. Agree that Chair's Action can be taken if necessary before submission to Audit Committee

QS20.63a Committee Annual Report_front template.docx

QS20.63b Committee Annual Report V0.03.docx

QS20.63c Committee Annual Report Appendix 1 QSE ToR V5.0.pdf

QS20.63d Committee Annual Report Appendix 2 QSE ToR V6.0.pdf

QS20.63e Committee Annual Report Appendix 3 QSE CoB.pdf

5.0	15:48 - FOR INFORMATION
5.1	QS20/64 Summary of business considered in private session

The Quality Safety & Experience Committee is asked to note the report

QS20.64 Private session items reported in public.docx

5.2	QS20/65 Documents Circulated to Members

27.01.2020 Psychological Therapies Review Report
18.02.2020 Annual Plan Progress Monitoring Report
02.03.2020 QSG January meeting notes
09.03.2020 Briefing note - Safeguarding Training Medical Staff in Emergency Departments

5.3	QS20/66 Welsh Health Specialised Services Committee – Quality & Patient Safety Committee Minutes 29.10.19

QS20.66 WHSCC Quality Patient Safety Committee Approved Minutes 29.10.19.pdf

5.4	QS20/67 Issues of Significance to inform the Chair's Assurance Report
5.5	15:53 - QS20/68 Wuhan Novel Corona Virus update - Miss Teresa Owen

Verbal update

5.6	QS20/69 Healthcare Inspectorate Wales Inspection Reports

The Committee is asked to note the attached reports and approve the new Corporate Nursing Tracker Tool for improvement actions and the revised approach to monitoring the implementation of the actions.

QS20.69 HIW Inspection Reports coversheet.docx

QS20.69a HIW Inspection Reports_Appendix A.docx

QS20.69b HIW Inspection Reports Appendix B - Maternity-YG report.pdf

QS20.69c HIW Inspection Reports Appendix C - CMHT Wxm report.pdf

QS20.69d HIW Inspection Reports Appendix D_HIW Standard Operating Procedure.pdf

5.7	QS20/70 Date of Next Meeting - 5th May 2020
5.8	QS20/71 Exclusion of Press and Public

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

Quality, Safety and Experience (QSE) Committee

Minutes of the Meeting Held in public on 28.1.20 in
The Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Mrs Deborah Carter	Associate Director of Quality Assurance / Interim Director of Operations
Dr Kate Clark	Medical Director for Secondary Care (*part meeting*)
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Steve Forsyth	Director of Nursing, Mental Health & Learning Disabilities (*part meeting*)
Mrs Sue Green	Executive Director of Workforce and Organisational Development (OD)
Mrs Gill Harris	Executive Director of Nursing and Midwifery (*part meeting*)
Mr Matt Joyes	Assistant Director of Patient Safety and Experience (*part meeting*)
Dr Melanie Maxwell	Senior Associate Medical Director / Improvement Cymru Clinical Lead
Dr Jill Newman	Director of Performance (*part meeting*)
Miss Teresa Owen	Executive Director of Public Health (*part meeting*)
Mr Sean Page	Consultant Nurse (*part meeting*)
Prof M Rees	Vice Chair, Healthcare Professionals Forum (HPF)
Mrs Lesley Singleton	Acting Director of Mental Health & Learning Disabilities
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Miss Emma Woolley	Director for Medical and Dental Education (*part meeting*)

AGENDA ITEM DISCUSSED	ACTION BY
QS20/1 Chair's Opening Remarks The Chair welcomed everyone to the meeting.	
QS20/2 Declarations of Interest Cllr C Carlisle expressed an interest in item QS20/13 in that the Conwy Community Mental Health Team came under her portfolio within Conwy Local Authority.	
QS20/3 Apologies for Absence Received for Mr G Evans, Mr A Roach, Mr D Harries, Mr M Thornton and Mr M Wilkinson	

QS20/4 Minutes of Previous Meeting Held in Public on the 19.11.19 for Accuracy, Matters Arising and Review of Summary Action Log **QS20/4.1** The minutes were agreed as an accurate record pending the following amendments: • QS19/165.4 to replace "although" with "despite" • To note that Mr A Thomas had rejoined the meeting by item QS19/168 **QS20/4.2** Updates were provided to the summary action log **QS20/4.3** It was noted that a briefing note on suicides had been circulated to members, although the Chair expressed concern that it did not provide a thematic review of the cluster of suicides within the West as previously requested and asked that this be provided for the March meeting. A typographical error was noted on page 4 of the briefing note in terms of the date reported. In response to a range of questions from an Independent Member, the Acting Director of Mental Health and Learning Disabilities (MHLDS) stated that retention of staff was a continued challenge but there was a workforce plan in place. She confirmed that the Division was reviewing its risk assessment process and associated training for staff, with significant improvements now being seen in how risk assessment was being carried out. The Executive Director of Public Health felt there were clear links to Public Health Wales reporting. The Executive Director of Nursing and Midwifery set out an ambition for zero tolerance towards mental health suicides and requested that the paper being prepared for the Committee in March went through the Quality Safety Group in February.	 LS LS
QS20/5 Minutes of Meeting of Joint Audit and Quality, Safety & Experience Committees Held in Public on the 5.11.19 The minutes were noted.	
QS20/6 Patient Story **QS20/6.1** The Associate Director of Quality Assurance / Interim Operations Manager presented the patient story which related to the ICAN urgent care centres for mental health support. She noted there were common links and themes in terms of language and the ability to recognise and meet individuals' needs. **QS20/6.2** The Acting Director of MHLDS felt the story gave a clear indication of what was meant by alternatives to admission and service provision, and that there were positives points to take away from the story. The Vice Chair of the Healthcare Professionals Forum highlighted the importance of asking the right questions of patients and service users eg; "what matters to you, what is important".	
QS20/7 Quality/Safety Awards and Achievements **QS20/7.1** The Associate Director of Quality Assurance / Interim Director of Operations indicated she had prepared a short written update and would circulate as a briefing note. The Chair also set out her intention to discuss with the Health Board Chair the potential of sharing such information at Board meetings.	 DC LR

QS20/8 Annual Plan Monitoring Report (APMR) **QS20/8.1** The Director of Performance presented the report and highlighted that it included some deep dives, and narrative on red and amber performance areas. She clarified that in general the actions relating to health improvement and care closer to home ones were allocated to the QSE Committee for scrutiny. An Independent Member suggested that links to APMR reports to other Committees might be helpful.	**JN**
QS20/8.2 A discussion ensued. An Independent Member noted that in terms of stroke there was no update since November 2019. The Executive Medical Director agreed there was a need to bring together a range of actions around the development of a business case for stroke services. Another member enquired as to progress with AP008 to develop a partnership plan for children with a strong focus on Adverse Childhood Experiences, and the Executive Director of Primary and Community Services indicated progress was being made at a good pace but was not meeting the timeline originally set. A formatting error was noted in terms of the colour of the RAG status against AP025 regarding endoscopy which should have shown as red as at December 2019. It was also noted that the rheumatology review had been completed and therefore AP024 should not be shown as red. In response to a point raised regarding medical workforce capacity the Executive Director of Workforce and Organisational Development set out a range of work around stress risk assessments and elements of workforce optimisation. The Chair reiterated a general concern that was expressed at the Health Board meeting that many areas within the report indicated "no update", which in some cases was incorrect and defeats the objective of providing the narrative	**JN**
QS20/8.3 The Chair suggested an amendment to the recommendation that the Committee receive the report for information and **it was resolved that** the Committee receive the report for assurance subject to the feedback provided on the importance of reporting accuracy and clear narrative.	
QS20/9 Integrated Quality & Performance Report **QS20/9.1** The Director of Performance drew members' attention to the executive summary of the report and highlighted areas of positivity including flu vaccination, a reduction in the backlog of serious untoward incidents and the achievement of the Child Adolescent Mental Health Services (CAMHS) measures. She went on to highlight the further work required around the psychological therapies and neurodevelopment indicators to move the organisation on. In terms of infection prevention and control she noted that the indicators remained out of line with national trajectories and it was becoming more unlikely that the organisation would be able to deliver these by the end of March. The Director of Performance recognised that performance in terms of sepsis indicator work in Emergency Departments (EDs) was lower than last year. The Associate Director of Quality Assurance / Interim Director of Operations confirmed that whilst the report stated there had been no new never events in-month, one had been reported after the IQPR had been produced and Committee members had been informed separately. The Chair highlighted the need to ensure the narrative provided in the reports link to the previous reporting period to enable the Committee to receive the complete picture.	**JN/DC**

QS20/9.2 A discussion ensued. A general point was made that there appeared to be a number of deteriorating trends that did not appear to be explained within the narrative. The Executive Medical Director noted the ongoing issue of a potential conflict between antimicrobial resistance and sepsis. The Executive Director of Primary and Community Services noted that solutions in a medicalised environment often would not work in primary care and that this was a live debate that remained a challenge.   The HPF Vice Chair felt that patients often didn't seek medical help when they should do so, and that the messages of 'Choose Well' needed to be sustained.

QS20/9.3 An Independent Member referred to the target to achieve 95% of children receiving second dose MMR by age five, and enquired how many children this related to in numbers. The Executive Director of Public Health did not have the actual numbers to hand but assured the Committee it would not be significant. She also assured members that Health Visitors continued to work hard to encourage uptake but there remained the element of choice.

QS20/9.4 An Independent Member noted that patient falls were increasing. The Associate Director of Assurance / Interim Director of Operations suggested that a focus on identifying falls would always mean an increase in reported numbers. She noted that those teams and wards with the highest numbers were being supported and the work of the collaborative being widened. The Executive Director of Nursing and Midwifery added that accelerated unscheduled care pressures often resulted in more patient moves which was also an inherent risk to falls. The Senior Associate Medical Director / 1000 Lives Clinical Lead reported that early work to monitor the impact of the collaborative was being carried out with some high level data being identified.

QS20/9.5 Members were pleased to note the CAMHS performance and assurance was given that the Children's Services teams would continue to monitor locally to ensure that any dropping off of performance was picked up and escalated as necessary.   An Independent Member noted that the Infection Prevention and Control section of the report confirmed 22% of infections were avoidable. The Associate Director of Assurance / Interim Director of Operations confirmed there was a large area of work being undertaken focussing on the avoidable infections, in particular around device care and catheter care to address this. The Independent Member (Trade Unions) enquired about staffing levels within maternity. The Associate Director of Assurance / Interim Director of Operations indicated that a further review was being undertaken. The Executive Director of Workforce and Organisational Development stated that the matter had also been raised at the Strategic Occupational Health and Safety Group (SOHSG). The Executive Director of Public Health would pick this matter up and ensure transparency of reporting and sharing of information with Trade Union partners.

TO

[Miss Teresa Owen left the meeting and Dr Kate Clark joined the meeting].

QS20/9.6 An Independent Member noted with concern the performance relating to psychological therapies waiting times in terms of the 26 week target. The Acting Director of MHLDS acknowledged the waits against this recently added indicator were unacceptable and that a paper was being prepared for the next Committee. She confirmed that a review of psychological therapies was identified in 2018 as a key piece of work in the Division's annual plan but that field work was not completed until August 2019, with the report having been received at the end of September 2019 and

was reviewed by the Division in October 2019. The report had been discussed in a range of forums and it had been agreed to identify project support via a Task and Finish Group to implement the recommendations. The Executive Director of Nursing and Midwifery suggested that the terms of reference for this group be shared for ratification with the Committee at the next meeting. It was further agreed that the resultant action plan would need to be approved and monitored via QSE.	LS
QS20/9.7 In relation to postponed procedures the Committee Chair noted that the Committee had not received the briefing note on the non clinical reasons for postponements referred to in the November Committee report. The Director of Performance agreed that this would be provided at the March meeting.	JN
QS20/9.8 The Executive Director of Primary and Community Services indicated that given the ongoing discussions about what should or should not feature within the IQPR, Executives would welcome explicit guidance from Committee members to allow them to focus on meeting the Committee's needs. The Chair advised that she had met with the Director of Planning and Performance recently to discuss the reporting requirements.	
QS20/9.9 It was resolved that the Committee receive the report and the feedback provided on the report would be actioned	
QS20/10 Endoscopy Update **QS20/10.1** The Executive Director of Therapies and Health Sciences presented the paper, confirming that work was still ongoing to identify trajectories and to work through risk stratification and the identification of harms. He drew members' attention to changes in operational management within the service and ongoing capacity and infrastructure challenges to meeting the needs of the endoscopy service. BCU continued to participate within the national endoscopy group which had four main workstreams, and in addition BCU had a fifth workstream around service redesign. It was noted that work continued towards achieving JAG accreditation with positive feedback having been received for Ysbyty Glan Clwyd (YGC) and Ysbyty Gwynedd (YG) with feedback awaited for Ysbyty Wrexham Maelor (YWM). In terms of diagnostics, the Executive Director of Therapies and Health Sciences indicated there were still issues with the water quality of the vanguard unit at YGC. There had been a reduction in waiting times for YG and YGC and the organisation was now looking to procure a unit for WMH. Overall it was felt that progress was being made and patient waits were decreasing. **QS20/10.2** A discussion ensued. The Executive Medical Director enquired whether the implications of a new diagnostic test had been built into assumptions as it may increase the number of endoscopies required. The Medical Director for Secondary Care confirmed this had not yet been worked through but was part of a workstream for the national group, as were the implications of changes to bowel screening testing. She added that the capacity and demand modelling tool had highlighted some issues with the organisation's data. The HPF Vice Chair referred to capacity and stress on clinicians and that different ways of working would indicate a broader workforce than medics. He noted that the report mentioned blocks in recruitment and the Medical	

Director for Secondary Care confirmed there was a related workforce strategy which included proposals to upskill endoscopy staff.

QS20/10.3 In response to a question regarding a modular room in Wrexham, the Executive Director of Therapies and Health Sciences confirmed this was additional to the Vanguard unit. A member noted that Appendix 1 was due for review in January and enquired whether all the phase 1 elements that were due in December 2019 had been achieved. The Medical Director for Secondary Care indicated that had been the initial target and there was a meeting the following day to review progress.

QS20/10.4 The Medical Director for Secondary Care added that the work that had been done nationally had helped quantify the size of the issue facing the Health Board. She reported that she had prepared a brief overview of harms attached to endoscopy waits and it had been encouraging to find that the vast majority were linked to other organisation risks.

QS20/10.5 It was resolved that the Committee continue to support the increased level of focus on the design and implementation of the recovery plan to address the core capacity improvement, backlog reduction and sustainable solutions for endoscopy services across BCUHB working closely with the National Endoscopy Programme Board and the Delivery Unit to deliver both shorter and longer tem plans.

[Dr Kate Clark left the meeting]

QS20/14 Development of Dementia Services
[Agenda item taken out of order at Chair's discretion]
[Mr Sean Page joined the meeting]

QS20/14.1 The Associate Director of Quality Assurance / Interim Director of Operations introduced the agenda item which had arisen from a previous patient story presented to the Committee.

[Miss Teresa Owen rejoined the meeting]

QS20/14.2 The Consultant Nurse outlined that it was known that numbers of people living with dementia were increasing and that sufferers often had other conditions which would lead them to have contact with a whole range of the Board's services. He reminded members that the Dementia Strategy for 2018-20 focused on 6 strategic areas with safeguarding at the very heart. He reported that the Board was now moving to articulate a different model via a dementia care pathway which focused on clinical aspects of care for those with dementia, and that a consultation was soon to take place.

QS20/14.3 The Consultant Nurse went onto highlight the challenges around Emergency Departments (EDs) and elements of training that were being delivered there. He reported that data on frequent ED attenders was collated and targeted work done around these patients. He also drew members' attention to a programme of work with care homes, work ongoing with the Ambulance Service and Macmillan and that a national audit of dementia had just been completed. He concluded by saying he felt there was evidence of increased awareness and ownership of actions, and that there

was a positive amount of activity and energy around this agenda which would be co-ordinated through the Dementia Strategy Group chaired by Mr Trevor Hubbard (Deputy Nurse Director).

QS20/14.4 A discussion ensued. In response to a question regarding the social care elements of dementia services, the Consultant Nurse confirmed that the new strategy was being developed in partnership and the traditional healthcare role whilst important, was part of a bigger picture. The Independent Member (Trade Union) asked about prioritisation of levels of training for staff as there could be areas or teams not normally associated with direct care of dementia patients that would still require the training. The Consultant Nurse clarified that the prioritisation was based on Welsh Government (WG) definitions focused around clinicians delivering care in 'dementia heavy' areas eg Care of the Elderly. A comment was made regarding alignment with Regional Partnership Board (RPB) work around dementia. The Acting Director of MHLDS confirmed that the RPB was developing a dementia strategy under Local Authority leadership and there would be a need to determine how the Health Board could specifically contribute to this

QS20/14.5 It was resolved that the Committee receive the report.

[Mr Sean Page left the meeting]

QS20/20 General Medical Council Enhanced Monitoring of Medicine Training and Wrexham Maelor Hospital
[Agenda item taken out of order at Chair's discretion. Miss Emma Woolley joined the meeting]

QS20/20.1 The Executive Medical Director reported that following concerns raised by HEIW regarding the medical education and training environment in medicine at WMH, the General Medical Council (GMC) had the programme under Enhanced Monitoring arrangements in July 2019 for failing to meet the required standards. The paper provided an update on actions taken to meet the required standards.

QS20/20.2 The Director for Medical and Dental Education indicated that the situation in WMH was being highlighted as there were leadership issues at the time, but the situation could easily be replicated in other departments across BCUHB. She added there were continued challenges in balancing educational training with capacity whilst ensuring delivery of a service. She felt the situation was compounded by how workload was currently allocated and there was a need to look at what tasks could be undertaken by clinicians other than doctors. She also suggested that the situation was compounded by digital and connectivity issues. She drew members' attention to the conclusions within the paper which sought funding to be agreed urgently for experienced physician associates working in the medical team to support and manage the current workload.

QS20/20.3 A discussion ensued. The Executive Director of Primary and Community Services observed that departments that had lost their trainee post were unlikely to easily attract senior doctors to come and work there. The HPF Vice Chair supported the view of the Director for Medical and Dental Education that the situation was urgent and a symptom of the levels of stress that many clinicians were under. The Director for

Medical and Dental Education confirmed that HEIW would be returning to undertake another review in the next few months and if the Health Board had not shown adequate improvement in the training environment, the training status was at risk. The Executive Director of Workforce and Organisational Development concurred that early resolution was required and that the appointment of physician associates to supplement teams was being investigated. She also reported that in terms of a service review some workforce optimisation work had already been done and related to the flow and acuity of patients. Services that were high cost and fragile would need to be prioritised alongside ensuring appropriate accountability and agreeing a systematic approach as an organisation as a whole. The Director for Medical and Dental Education felt there was a lack of understanding around the role of physician associates which needed to be addressed but she would wish to see their appointment in response to this immediate challenge. The HPF Vice Chair would support the use of physician associates. The Executive Director of Workforce and Organisational Development assured the Committee that this continued to be a live discussion for her with the appropriate leads, and that the opportunities within WMH would be shared with the group of physician associates and interns to seek expressions of interest. She confirmed that the immediate issue was in hand but the longer-term approach needed agreeing. In response to a question from an Independent Member regarding funding the Executive Director of Workforce and Organisational Development added that this was being addressed by herself, the Office of the Medical Director and the Hospital Management Team, within the context of the Board's financial position. She felt that a detailed financial discussion was the remit of the Finance and Performance Committee.

QS20/20.4 The Committee Chair noted the concern of Committee members and the risk to the Health Board and it was agreed that the matter should be escalated to the Board.

LR

[Cllr Cheryl Carlisle left the meeting]

QS20/13 Mental Health and Learning Disabilities Exception Report
[Agenda item taken out of order at Chair's discretion. Mr Steve Forsyth joined the meeting]

QS20/13.1 The Executive Director of Nursing and Midwifery noted that the report set out a range of areas where progress had been made, and asked the Division to share what they felt to be their key risks and opportunities moving forward, noting that there would be work coming out of the psychological therapies review.

QS20/13.1 The Director of Nursing MHLDS confirmed that the main risks centred around out of areas placements, staffing matters and environment aspects pertaining to doors within units. He noted that performance against the Mental Health Measure had dipped as expected but there were positive conversations with the Delivery Unit as to when actions would deliver to get performance back on track. The Committee Chair enquired regarding trajectories and the Director of Nursing indicated that the Division was committed to clearing the waiting list and hitting the target by April 2020.

[Mrs G Harris left the meeting]

QS20/13.2 The Director of Nursing MHLDS was referred to the Thematic Review of Suicides Report that had been circulated to members. He confirmed that there was no evidence within the report of cluster contagions. The Committee Chair asked about the review that had been undertaken on the cluster of suicides in the West, which had been previously requested by the Committee. The Acting Director of MHLDS agreed that a report would be provided to the Committee meeting in March 2020. An Independent Member noted that the report referred to an increase in bed based provision and the Acting Director of MHLDS clarified this related to remodelling and different provision and that overall there would be a reduction in bed based care. The Committee Chair referred to the statement within the paper that the number of incidents closed by WG had changed, and the Associate Director of Quality Assurance / Interim Director of Operations clarified that this related to WG having put in additional resources to allow the Board to receive their feedback in real time. In terms of learning from incidents previously reported, the Committee Chair felt this was not covered within the paper. She accepted that common themes had been identified from them but was keen to see an increased visibility around actual lessons learnt. The Acting Director of MHLDS would work to develop this for the next report. The Chair reiterated that she was not looking for an expanded report but one that was more targeted and focused; she gave an example of good practice as the primary care exception report. The Committee Chair also noted that the recommendations to the Committee included noting progress made relating to the risk register but that the report did not contain sufficient information in this regard and therefore could not be noted. Finally, the HPF Vice Chair enquired whether a watching brief was maintained regarding any suicides within the workforce. The Executive Director of Workforce and Organisational Development confirmed that none had been reported but any cases would be reported straight through to the Executive Team.	LS
QS20/13.3 It was resolved that the Committee note the report and that the Director of MHLDS would provide a report on the thematic review of cluster suicides in the West at the March Committee meeting and would act upon the feedback provided on the report.	LS
QS20/21.4 Mental Health and Learning Disabilities Division - Resubmission of Policies *[Agenda item taken out of order at Chair's discretion]* **QS20/21.4.1** The Committee Chair reiterated her concern that divisional policies such as these were coming to the Committee at all. It was agreed to have a wider discussion at the next Committee Business Management Group and to invite the Statutory Compliance, Governance and Policy Manager to the meeting. **QS20/21.4.2** In terms of the individual policies the Chair felt that they hadn't addressed fully the issues raised by the Committee previously and there were still issues with the equality impact assessments (EqIAs). The Director of Nursing MHLDS would review again with support from the equalities team for EQIAs and with Peter Bohan in terms of getting clearance through the SOHSG which the Executive Director of Workforce and Organisational Development felt was appropriate. **QS20/21.4.3 It was resolved that** the MHLDS Division further review the policies.	KD

[Mr S Forsyth left the meeting]

QS20/11 Occupational Health & Safety Q3 Report

QS20/11.1 The Executive Director of Workforce and Organisational Development presented the paper, noting it was a comprehensive report but that much of the context had been shared with the Committee on previous occasions. She confirmed that officers were moving forward with the Health and Safety Improvement Plan with the detail being discussed at Strategic Occupational Health & Safety Group (SOHSG), the meetings of which were very well attended.   She highlighted that the SOHSG had agreed to conduct a similar process for non-patient safety as for patient safety, particularly focusing on incidents. She also noted that there was an ongoing process to strengthen root cause analysis. Additional health and safety risks have been identified as requiring escalation to the Corporate Risk Register and would be considered by the Committee today.

QS20/11.2 A discussion ensued. The Independent Member (Trade Union) reported that a Health and Safety Representatives' Group had been established and that a key output would be to produce a document to remind managers of representatives' legislative rights. She also raised that the number of incidents relating to sharps was unacceptable.   In response to a concern regarding an ongoing vacancy for an Occupational Health physician, the Executive Director of Workforce and Organisational Development reported that this post had been out to advert twice. There was a similar position nationally in terms of a shortage and she indicated there may be a need to look at a contracted solution which was being explored. Another Independent Member felt that the report did not easily inform the reader as to whether the approach and management of health and safety had improved since the last report.

SG

QS20/11.3 In response to a query from the HPF Vice Chair, it was confirmed that a separate report on occupational health was provided to the SOHSG. The HPF Vice Chair referred to a valuable presentation on health and well-being and avoiding stress which Mr Jack Jackson (Team Leader in Occupational Health) had provided at recent roadshows. He noted the events hadn't been very well attended and also felt that the lack of an Occupational Health Physician would impact heavily on this agenda. The Executive Director of Workforce and Organisational Development suggested that low attendance would predominantly be due to capacity within teams to release staff. She assured members that a consistent approach to stress risk assessments was being developed.

QS20/11.4 The Committee Chair wished to acknowledge the progress made with Occupational Health and Safety within the last 12 months and **it was resolved that** the Committee note the position outlined in the Quarterly Report.

QS20/11b

The Executive Director of Public Health took the opportunity to provide a verbal update on the Corona Virus. She confirmed that this was a new virus and that there was now a test available within the UK. She is receiving daily updates from Public Health Wales who are linked in with WG and Public Health England colleagues who are leading

activity across the UK. She confirmed that to date the matter had not been declared as a pandemic, but if it was in the future then this would trigger a formal process. Current advice was that the impact was likely to be moderate with a low risk to population. In confirmed cases outside of the UK the virus was affecting older people with other underlying conditions. She assured the Committee that the organisation was well used to responding to new incidents such as this and that Welsh pathways were being followed.	
QS20/12 Patient Safety Report *[Mr Matt Joyes joined the meeting]* **QS20/12.2** The Assistant Director of Patient Safety and Experience presented the new style report which replaced the former 'CLICH' report and aimed to better triangulate data relating to patient safety. He acknowledged the format would continue to evolve and he would welcome feedback from members. He highlighted a notable increase in patient safety incidents which did triangulate with an increase in complaints, and that investigation of this trend had identified there was primarily low or no related harm. Secondly he referred to the open patient safety alerts and that one of the two reported had now been recommended for closure. Finally he reported on work ongoing to improve the complaints processes and that a workshop had been held and there were also discussions planned with the Community Health Council. **QS20/12.3** A discussion ensued. The HPF Vice Chair referred to the surgical Never Events detailed within the paper and noted these should easily have been avoided by the use of checklists. The Associate Director of Quality Assurance / Interim Director of Operations agreed that the latest event was still subject to an ongoing investigation but she agreed that the use of a checklist would likely be an outcome. An Independent Member referred to the section on claims and was concerned that an individual could possibly identify themselves from the detail. The Associate Director of Quality Assurance / Interim Director of Operations assured members that the level of detail within the paper was already in the public domain. The Committee Chair welcomed the helpful presentation of data in graphs, which enabled clear identification of outliers and would support this approach being replicated in other reports. The Senior Associate Medical Director / 1000 Lives Clinical Lead pointed out a challenge in terms of different software packages in use across the organisation that presented data differently. It was agreed that officers continue the conversation outside of the meeting to see if more consistency could be achieved. **QS20/12.4** The Committee Chair raised her continued concern that the 'golden thread' was yet to be achieved in terms of lessons learnt from Never Events and incidents being carried through into future reports. She also felt that the reporting profile for incidents did not match what she would expect an organisation such as BCUHB to have. She asked that the highest incident categories be expanded further rather than just reporting on the top 3, which are already the focus of other reports. **QS20/12.5 It was resolved that** the Committee receive the report, noting the highlighted areas and that the Committee's feedback on the report would be actioned.	JN DC MM MJ DC/MJ
QS20/15 Serious Incidents Report *[Agenda item taken out of order at Chair's discretion]*	

QS20/15.1 The Assistant Director of Patient Safety and Experience presented the report acknowledging there was duplication with the Patient Safety Report although this report attempted to pull out common learning points from completed incidents. He stated that 22 of the 100 identified no learning and all but 1 were patients known to mental health services who had died but that the deaths are not necessarily related. He confirmed that each action arising from the learning identified had a nominated owner and a target date and he would be looking to strengthen the review process.

QS20/15.2 The Committee Chair reiterated her wish for the organisation to demonstrate learning more clearly. The Executive Director of Workforce and Organisational Development referred to a discussion at the SOHSG around a potential unintended consequence of encouraging staff to close off actions and incidents within Datix and that there should be a mechanism to remind people not to compromise on quality when closing off an action. The Director of Performance noted her surprise that there were no incidents regarding eyecare within the report.

[Mr Matt Joyes left the meeting]

QS20/15.3 It was resolved that the Committee receive the report for assurance and feedback provided by the Committee would be actioned.

QS20/16 All-Wales Self-Assessment of Quality Governance Arrangements **QS20/16.1** The Committee Chair explained that this paper had been discussed with members outside of the Committee and was being shared formally in public session for completeness. The associated action plan that would be developed would be agendered at the next meeting. It was also noted that the All Wales QSE Committee Chairs had agreed to share each other's action plans. **QS20/16.2 It was resolved that** the Committee receive the report.	GH
QS20/17 Healthcare Inspectorate Wales (HIW) – the Health Board's position statement **QS20/17.1** The Associate Director of Quality Assurance / Interim Director of Operations presented the paper, which had been refreshed to try and meet the requirement to ensure the Committee was appropriately sighted on activity by HIW. The report detailed how the various actions arising from inspections are being monitored. **QS20/17.2** The Committee Chair welcomed the level of detail provided within the tracker tool and felt it provided much better detail on progress. Members also found it helpful to have the full reports appended and asked that this continue. **QS20/17.3** Members were concerned at the findings of the follow up inspection of Wrexham Maelor Hospital Emergency Department. The Associate Director of Quality Assurance / Interim Director of Operations reported that three of the concerns raised all related to the care of the same patient by the same nurse. Whilst inexcusable, this did make the data appear worse. She drew members' attention to the fact that when the matters were brought to the attention of the nurse in charge, their response was recorded as commendable. An Independent Member noted that it was pleasing to read about the improved relationships within the maternity department at YGC. **QS20/17.4 It was resolved that** the Committee note the report and appendices *[Mrs G Harris rejoined the meeting]*	DC
QS20/18 Corporate Risk Register and Assurance Framework Report **QS20/18.1** The Committee firstly considered the current risks as set out within the paper. The following was agreed: • CRR05 Learning from Patient Experience – members noted this had been referred back from the Audit Committee for review. The Committee accepted the current risk description and score. • CRR13 Mental Health – the Committee was being asked to approve a reduction in risk score from 16 to 12. It was noted that the Committee had not approved the previous reduction in score on the report and this is evidenced in the commentary. Whilst members felt the controls were much clearer, they did not yet warrant a reduction. There was also concern at the ability to achieve the target score by March 2020. Members also felt that the original risk description needed refreshing to take out reference to governance "at all levels". The Committee requested that	LS

the description be updated as discussed and did not approve the reduction in the risk score.

- CRR20 Security risk – noted that the target date of March 2020 had been revised in line with the improvement plan. The Committee accepted the current risk description and score but did suggest that a separate briefing may be needed at a future stage.
- CRR21 Health and Safety Leadership – the Executive Director of Workforce and Organisational Development explained that this group of risks had been identified through the gap analysis. Those relating to Estates were aligned with the improvement plan and had been through the SOHSG. She acknowledged the risk scores were high but felt it was an accurate reflection. The Committee accepted the current risk description and score.

QS20/18.2 The Committee then considered the risks for escalation as set out within the paper. The following risks were accepted to be added to the corporate risk register, noting the individual comments below:

- ID 3024 Non-Compliance of Fire Safety Systems – members noted that the target date was missing.
- ID3019 Asbestos Management and Control
- ID3020 Contractor Management and Control
- ID3021 Vibration Control
- ID3022 Electrocution at Work
- ID3023 Legionella Management and Control
- ID 2956 Potential to comprise patient safety due to large backlog and lack of follow-up capacity – members noted that "comprise" should read "compromise". The Executive Director of Nursing and Midwifery confirmed there had been clinical input into the development of this risk.

QS20/18.3 The Committee then considered the following risk which was recommended for de-escalation:
- ID 2950 Potential inability of Care Homes to provide safe quality care – it was noted that the Committee was being asked to de-escalate the care home element from the wider risk. The Executive Director of Nursing and Midwifery assured members that there was early intervention in place. The risk description was felt to be unclear as the issue was more around the ability of the Health Board to respond proactively to support care homes when concerns arose. It was agreed that this would be revised.

QS20/18.4 There was a suggestion that with the increased number of health and safety related risks, there should be some independent member input – perhaps through the SOHSG. It was suggested this be raised at a future IMs meeting.

QS20/18.5 The Executive Director of Workforce and Organisational Development noted that the officer risk group was to meet on the 31st January and feedback from this discussion could be given there.

QS20/18.6 It was resolved that the Corporate Risk Register would be updated based upon Committee's feedback.

SG

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GH CS

LM (KD)

QS20/23 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report : **HASCAS** *[Agenda item taken out of order at Chair's discretion]* **It was resolved that** the Committee note the progress of the recommendations to date.	
AT THE CHAIR'S DISCRETION THE COMMITTEE THEN WENT INTO PRIVATE SESSION TO DISCUSS ITEM QS20/35 HARMS REVIEW	
THE COMMITTEE THEN RETURNED TO PUBLIC SESSION *[Mrs D Carter and Dr J Newman left the meeting]*	
QS20/21 Policies, Procedures or Other Written Control Documents for Approval	
QS20/21.1 Review of Open Visiting Policy **QS20/21.1.1** Members felt that Appendix 2 was too harsh and directive, that the Welsh language aspect should be moved higher, and that as a revised policy tracked changes should have been used or a summary of changes provided. The Executive Director of Workforce and Organisational Development also stated that the EQIA had not been approved. **QS20/21.1.2 It was resolved that** the Open Visiting Policy be further reviewed.	GH (AMR)
QS20/21.2 Nurse Staffing Levels Policy **QS20/21.2.1** The Executive Director of Workforce and Organisational Development noted that Lawrence Osgood had made some suggestions to the draft policy which had not been included. **QS20/21.2.2 It was resolved that** the Nurse Staffing Levels Policy be approved pending the inclusion of Workforce colleagues' comments.	GH (AMR)
QS20/21.3 Clinical Audit Policy **QS20/21.3.1** The Committee noted that the policy would be reviewed again within the year due to a number of changes that will be implemented across the organisation's governance structure. Members felt that quarterly reports on the clinical audit plan was too frequent and should be amended, particularly as the ongoing governance review should create improved scrutiny through the Clinical Effectiveness Sub Committee. **QS20/21.3.2 It was resolved that** the Committee approve the draft policy and procedure document pending the amendment above.	MM
QS20/24 Health and Social Care (Quality and Engagement) (Wales) Bill : Mrs Gill Harris *[Agenda item taken out of order at Chair's discretion]* **It was resolved that** the Committee to receive the report.	

QS20/22 Quality Safety Group Assurance Report **QS20/22.1** The Vice Chair of the HPF noted the repeated messages about workforce. The Executive Director of Workforce and Organisational Development confirmed these were being picked up. **QS20/22.2 It was resolved the** Committee note the reports.	
QS20/26 Issues Discussed in Previous Private Session **It was resolved that** the Committee note the report	
QS20/27 Documents Circulated to Members It was noted that the following had been circulated: 5.12.19 APPMR for October 19.12.19 QSG Notes of November meeting 21.1.20 QSG Notes of December meeting	
QS20/28 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting.	
QS20/29 Date of Next Meeting Tuesday 17.3.20 @ 9.30am in Carlton Court, St Asaph.	
QS20/30 Exclusion of Press and Public **It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

BCUHB QUALITY, SAFETY& EXPERIENCE SUB COMMITTEE - Summary Action Log Public Version				
Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
21st May 2019				
D Carter	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of category 'abuse of staff by patients', for next submission	Sept	24.9.19 discussions between teams ongoing as part of gap analysis. 30.10.19 The new Assistant Director of Service User Experience (who started with BCU in mid-October) is meeting with the Assistant Director of Health, Safety and Equality and will discuss how patient safety and staff safety incidents will be separated in the reports submitted to the committee, ensuring information to the committee is not lost and remains triangulated where appropriate. 19.11.19 The Chair confirmed she had met with the new Assistant Director for Patient Safety and this action would be addressed within the Patient Safety report in January. 28.1.20 The Committee were content that this action could be closed.	January Closed
~~E Moore~~ M Maxwell	**QS19/74.2** Reflect on comments regarding format and flow of mortality report including the need to ensure a single author/owner for next submission.	Sept	17.9.19 A revised format has been submitted and agreed at Quality Safety Group, and will inform the next report to Committee. 24.9.19 Committee agreed to re-open the action until next mortality report received. 12.11.19 Mortality report agendered for discussion at November Committee meeting. Members' feedback invited on format and flow.	~~Closed~~ ~~November~~ ~~January~~

			19.11.19 Further report requested for January. Meeting set up for January between QSE Chair and Office of Medical Director. 6.1.20 Meeting held and clarification/steer provided on how to improve and strengthen mortality reporting, with agreement the paper be deferred to the March meeting. 28.1.20 QSE Chair confirmed her expectation that the paper in March will be a plan of action as to how mortality will be addressed and reported. 04.03.20 Mortality Report submitted for March meeting	March
16th July 2019				
D Carter	**QS19/99.2** Include patient story re Welsh Language in the next Welsh Language monitoring report		13.9.19 As recommended by QSE, Head of Patient and Service User Experience for BCUHB has produced a Quality Assurance for Patient Stories Framework Sept 2019 to ensure that all Patient Stories are monitored. BCUHB has ensured adequate resources are in place to sustain the growth and development in capturing, monitoring and measuring quality improvements from patient stories. The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. The Listening and Learning Strategic forum for Patient and Service Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture the correct attendees in alignment with QSE and	~~Closed~~

			QSG). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements. The LLG will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. This includes Patient Stories. Patient Stories will be integrated into the Clinical Harm Dashboard along with all other feedback methods. Quality improvement actions will be captured, monitored and measured in triangulation with incidents and complaints. The one system approach strengthens the service improvement management.	
			24.9.19 Committee requested action be re-opened as response did not confirm if the patient story had been included into the Welsh Language monitoring report or not.	November
			19.11.19 Noted that the qualitative report re Welsh Language came to QSE as part of the IQPR reporting process. Timeframe for next report to be confirmed and whether the patient story had been included.	January
			28.1.20 The Committee were content that this action be closed.	Closed
C Stockport	**QS19/102.2** Work to provide a heat map summary in future primary care reports	By next report (March)	Summary provided in the primary care report for March QSE	Closed
C Stockport	**QS19/102.4** Ensure that future reports include narrative on lessons learned from incidents	By next report (March)	Detail of how 'lessons learnt' are collated and shared with Primary Care colleagues is included in the report for March QSE	Closed

A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept	24.9.19 AT reported that there was a lack of clarity. The CHC Chair accepted that the information was difficult to unpick retrospectively but was assured that the intention to appoint a Medical Devices Safety Officer was still ongoing. Committee agreed to keep action open. 19.11.19 AT confirmed there was a robust system around medical devices and this was an operational issue that should back through QSG, however, the Chair reminded members that the action had originated from the report from QSG. AT would take this action away again. 20.1.20. AT has had confirmation from the DGM of NWMCS that the MDSO function will be assigned to a member of staff within the Medical Devices team by the end of June 2020. 28.1.20 The Committee were assured that day to day work continued whilst the nominated MDSO function was ongoing, and that tracking was undertaken via the Assistant Director Patient Experience. The Committee were content that the action be closed.	November January Closed
24th September 2019				
J Newman	**QS19/129.1** Revisit the briefing note (against action QS19/101.1) on mapping of indicators to reflect members' comments re appropriateness and mapping to SPPH	Oct	19.11.19 JN indicated that there was a list within the IQPR of annual plan issues that came through QSE. The Chair reiterated that the action relates to having the briefing note refreshed to give the Committee confidence that it was monitoring the right annual plan elements. JN set out challenges in that whilst an overall action may be attributed to QSE there may be multiple milestones within that action which	

			relate to another Committee – for example clinical coding. SG felt that an action shouldn't need to be deconstructed in order for it to be fully monitored. It was suggested that the Executive Director of Planning & Performance take the discussion through Exec Team.	January
			28.1.20 The Chair of QSE has discussed this with the Executive Director of Planning and Performance. The committee with overall responsibility to scrutinise each Action in the operational plan will be added to the IQPR from the next report. This will reflect that some of the actions are being scrutinised through committees over than QSE.	Closed
D Carter T Owen	**QS19/139.1** Ensure that next report from Women's Division includes detail of the reported clinical complex cases.		19.11.19 TO suggested that six months would be appropriate for next report.	May 2020
19th November 2019				
J Newman	**QS19/164.1** Review the sequencing and reporting of APMR reports to committee to ensure as timely as possible.	January	28.1.20 Review took place immediately after the QSE meeting resulting in timetable for report completion being brought forward. Updates from Executives are now requested at month end to enable earlier sign off of the report by the Exec Team. The completed report is issued to all relevant secretaries of the Board Committees so as to enable the latest report to be included in next Committee meeting and for QSE members to receive reports relating to month end progress during the months that the committee does not meet.	Closed

L Singleton	**QS19/165.3** Ensure that future MHLDS exception reports within IQPR provided an explanatory narrative where a major outlier was identified, together with timelines to address.	January	21.1.20 S Forsyth confirmed this has been taken on board and actioned. 28.1.20 The QSE Chair did not feel the narrative sufficiently set out the current position and asked that this action be reopened. 09.03.20 comments in relation to the IQPR have been acknowledged and work is underway with Head of Ops to improve narrative which will be completed for future reports.	May
J Newman	**QS19/165.5** Consider reviewing an existing performance team reporting schedule to include information for committee members as to what data goes where and when	January	28.1.20 Director of Performance confirmed this had been actioned and she would provide the necessary narrative to enable the action to be closed 28.1.20.The list of when each measure is reported and the committee reported to was circulated to members ahead of the January 2020 QSE meeting by the committee secretary	
D Fearnley	**QS19/171.2** Look at uptake against safeguarding training within various staff groups and provide a briefing note for circulation outside of the meeting.	January	19.1.20 Site Medical Directors have been asked to review safeguarding training for medical staff and report performance to the Executive Medical Director before end of January 2020. A briefing note will then be circulated to QSE members. 28.1.20 The Executive Medical Director confirmed this related to EDs and he would ensure the outstanding briefing note was circulated before the next meeting 09.03.20 Briefing note circulated	Closed
M Denwood	**QS19/171.3** Provide details of referrals by both area and referrer in future reports.	May 2020	Work in progress to complete action by May deadline	

M Denwood	**QS19/171.3** Work to ensure future reports are less numbers-focused and concentrate more on outcomes and learning.	May 2020	Work in progress to complete action by May deadline	
L Reid	**QS19/175.1** Send a letter of congratulations on Nursing Time award for Team of the Year to the MHDLS Division	December	20.1.20 Committee Chair has drafted correspondence 28.1.20 The QSE Chair confirmed this had been action. Point was raised that there were numerous other awards that could be recognised similarly. Noted that these were acknowledged directly at Executive level.	Closed
D Carter	**QS19/180.4** Arrange for amendments to be made to the Levels of Enhanced Care In-Patients Policy for submission for Chair's Action	December	21.1.20 revised policy received and will be submitted to Chair for approval 06.02.20 policy submitted to Chair for approval	March
D Carter	**QS19/182.1** Work to refresh the HASCAS / Ockenden reports to ensure more manageable	January	Refreshed report submitted for January meeting	Closed
28th January 2020				
L Singleton	**QS20/4.3** It was noted that a briefing note on suicides had been circulated to members, although the Chair expressed concern that it did not provide a thematic review of the cluster of suicides within the West and asked that this be re-provided for the March meeting.	March	Report submitted for discussion at March meeting	Closed
D Carter	**QS20/7.1** Circulate briefing note already prepared on awards and achievements.	February	Verbal update on awards and achievements will be provided at the meeting	

L Reid	**QS20/7.1** Discuss with the Health Board Chair the potential of sharing information on awards and achievements at Board meetings.	February	This has been discussed with the Chair as part of the Board development programme	Closed
Jill Newman	**QS20/8.1** Link APMR reports to other committees	March	09.03.20 The APMR has been amended to include an additional column to show which committee has responsibility for scrutinising which action	Closed
Jill Newman	**QS20/8.2** Amend reports to remove 'no update' and ensure accuracy in reporting	March	09.03.20 The narrative has been refined to ensure there is a distinction between 'no update being received from the sponsor', and 'no further progress on implementation of the action' to provide greater clarity.	Closed
Jill Newman	**QS20/9.1** ensure narrative in IQPR reports links to previous reporting	March	09.03.20 Retrospective lookback on a sample of reports commenced and will be completed for the May report	May
T Owen	**QS20/9.5** Follow up maternity staffing issues to ensure transparency of reporting and sharing of information with Trade Union partners.	March	Compliance is reported at the annual WG Maternity Performance Board and submitted to HIW as part of their Review of Maternity Services. The current full Birth Rate Plus audit is being carried out by the Birth Rate Plus Consultancy Team and final report is awaited. The 2016/17 report has been shared with the local RCM Representative and a meeting is scheduled (in the next week) to explore/discuss the report further. Finalised report will be reported via the Women's Committee/Meeting Structure. The Head of Service meets with RCM Representatives regularly, and will brief all IMs as appropriate.	

L Singleton	**QS20/9.6** Provide paper on psychological therapies update to next meeting including the terms of reference for the Psychological Therapies Programme Board.	March	Report submitted for the March meeting	Closed
J Newman	**QS20/9.7** Briefing note to be circulated In relation to postponed procedures which focused on the specified non-clinical reasons.	March	09.03.20 Included as additional slides in the IQPR for March 2020	
Sue Green	**QS20/11.2** Provide an update on the exploration of a contracted solution for the Occupational Health Physician vacant post	March	Two Occupational Health Physicians (OHP) have expressed an interest for the OHP post within the Occupational Health and Wellbeing Department. Interviews are planned for early May 2020. It is anticipated the post will be filled by September 2020.	May
D Carter J Newman M Maxwell M Joyes	**QS20/12.3** Meet to discuss how more consistent data reporting could be achieved across various department from different software packages and systems.	May	Work in progress – update to be provided at May meeting	
D Carter M Joyes	**QS20/12.4** incident reporting to be expanded to include the highest incident categories rather than just reporting on the top 3	March	SI report updated to include all themes – report submitted to March meeting	Closed
L Singleton	**QS20/13.2** Work to develop increased visibility around actual lessons learnt for the next routine report from the MHLDS Division.	May	09.03.20 Work is underway to include lessons learnt within May report	May
G Harris	**QS20/16.1** Provide action plan against the All-Wales Self-Assessment of Quality Governance Arrangements at next meeting	March	Deferred to May meeting	May
D Carter	**QS20/17.2** Continue to provide full inspections reports as part of HIW updates	March	Reports submitted for information at March meeting	Closed
L Singleton	**QS20/18.1** Refresh risk description for CRR13 Mental Health	February	Refreshed narrative will be presented at the Risk Management Group Meeting in May	May

S Green	**QS20/18.2** Provide target date for ID 3024 Non-Compliance of Fire Safety	February	17.02.20 Target risk date for ID 3024 Non-Compliance of Fire Safety has been set to 01/11/2020.	Closed
S Green	**QS20/18.2** Change "comprise" to "compromise" on ID 2956 Potential to comprise patient safety due to large backlog and lack of follow-up capacity	February	11.2.20 Workforce Optimisation Business Manager / Programme Manager contacted Datix support to enact this change. Completed. 17.02.20 Wording "comprise" has been amended to "compromise" on ID 2956	Closed
G Harris C Stockport	**QS20/18.3** Refresh risk description for ID 2950 Potential inability of Care Homes to provide safe quality care	February	The Risk Description ID 2950 has been de-escalated and reviewed in line with discussions at the previous meeting and the risk now states …."*The ability of the Health Board to respond proactively to support care homes when concerns are raised*".	Closed
L Meadows	**QS20/18.4** Raise issue of IMs input into H&S risks – via next IMs meeting	March	09.03.20 LM emphasising the importance of health and safety to IMs	
L Reid	**QS20/20.4** Escalate quality, safety and strategic aspects of the General Medical Council Enhanced Monitoring of Medicine Training and Wrexham Maelor Hospital**,** to the Board through Chair's report.	March	This has been discussed with the Chair and a report has been requested for the March Board meeting.	Closed
G Harris	**QS20/21.1.1** Further amend and submit Review of Open Visiting Policy for Chair's action	February	09.03.20 Executive Director of Nursing seeking assurance that the Visitors Charter, appendix to the Open Visiting Policy, is being reviewed with wider stakeholders prior to Chairs Action.	May
G Harris	**QS20/21.2.2** Add W&OD colleagues' comments to Nurse Staffing Levels Policy and resubmit for approval under Chair's Action	February	WOD colleagues confirmed they had not previously commented on the policy during consultation period. Comments have now received, added and forwarded 10/02/20 for policy final ratification	May
M Maxwell	**QS20/21.3.1** Amend frequency of reporting within the clinical audit policy	February	Reporting amended quarterly to CAESG and annually to JAQS	Closed

K Dunn	**QS20/21.4.1** Arrange for discussion around submission of policies at next CBMG and invite Bethan Wassell.	March	5.5.20 Invitation sent to Bethan Wassell, and notification to CBMG secretariat to include on March agenda.	Closed

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Actions from meeting held on 9.11.17				
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Future reports to take on board the suggestions put forward by the Committee namely:- • Intended outcomes to be captured as well as progress on specific recommendations • Summary of main headlines to be captured for reporting to the Board. • RAG rating system to be adopted and whether recommendation was implemented and within timeframe • Trajectory showing whether improvements are being made year on year	November 2018	28.10.19 Closed audits are asked to report evidence of change 5.11.19 MM indicated it was not possible to provide full assurance that the actions were fully robust in terms of outcomes. JAQS decided to leave action open until it can be evidenced as completed. 02.03.20: Lack of capacity in the team has delayed the production of a quarterly progress report. A progress report is planned for April CAESG 28.10.19 Reports as planned will include highlights and outlier status / standards for improvement. For Tier 1 this will be national and local. 5.11.19 Noted would be done going forward, however, JAQS decided to leave action open until it can be evidenced as completed. 02.03.20: Action needs to remain open until the reporting framework is established – potentially following next JAQS meeting provided the annual report received is acceptable. 28.10.19 Quarterly reporting template will document if the audit is on track or delayed- and any remedial action 5.11.19 Noted would be done going forward, however, JAQS decided to leave action open until it can be evidenced as completed.	

	• Indicators to show whether all leads within a particular area are working to the same level • Consideration to be given to whether commissioned services should be included within future Audit Plans • Emphasis to be placed on reflective learning and examining the results of audits in conjunction with performance data in order to provide effective triangulation;		02.03.20: See above 28.10.19 Needs further discussion to understand a level of reporting that is meaningful 5.11.19 Discussion around what exactly the JAQS needed. Agreed that the action related to annual audits where there were improvements to be made and needed to be reported going forwards to demonstrate learning from audits as part of the audit cycle. 02.03.20 Actions reported nationally to WG (part B) will be tracked and reported through the quarterly reports and annual plan. 28.10.19 Reporting full, partial and no compliance with audit activity by area 5.11.19 The Committee requested that the action more appropriately related to whether audit leads were working to the same audit standards as opposed to compliance against the plan. Action to remain open until there is evidence that it has been addressed. 28.10.19 This needs to be within the contracting arrangements; all UK hospitals take part on the NACOR audits 02.03.20Through the quality standards within the contracting process, commissioned services in the UK are expected to complete the same nationally mandated audits as in Wales (UK policy) and so work to the same standards. This action has been considered and is recommended to close. 5.11.19 The Committee requested that partners and commissioned services should be referred to within the policy in recognition of their role in the provision of	

			services. Action to remain open until there is evidence that it has been addressed.	
			28.10.19 Emphasis is being placed on improvement activity and reporting/sharing work.	
			5.11.19 The Committee decided that this action needs to remain open as the Clinical Audit Report was focussed on activity rather than outcomes and learning.	
			02.03.20 The Clinical Audit Policy agreed January 2020 includes the following passage:	
			5.0 Scope.	
			This policy relates to all BCUHB staff (including students and volunteers) and partner organisations participating in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to a specific pathway / care group. This policy is also applicable when BCUHB is working in partnership with other health and social care partners. Where BCUHB commissions activity externally, quality assurance including participation in audit, is included within the contractual arrangements. Suggest close action	
Gill Harris/Adrian Thomas	JAQS 17/5 Clinical Audit Report – GH &AT to discuss highest risk factors outside the meeting.	December 2017	Superseded by discussion and agreement of corporate clinical audit plan at QSG. Revised interim plan includes risk assessment - this will be strengthened going forward (Sept 2019) 28.10.19 Approved plan has risk stratification within it 5.11.19 LR suggested that a Committee action could not be superseded by discussion at an operational group. The Clinical Audit Report in its current form does not	

			identify any risk factors or prioritisation and so the action is to remain open. 10.03.20 This relates to the clinical audit report identifying risk factors with non-compliance and prioritising actions to ensure risk is being addressed appropriately. For Tier 1 audits the Welsh Government returns highlight any areas of significant concern and the action plan addresses these and other priority areas identified by the audit lead. These would then be raised within the audit report currently actions are not reported back in a timely way; this will be addressed in the reporting framework in 2020/21. For example, there has been a recent communication about YGC being an outlier on the 30 day risk adjusted mortality within the national stroke audit and a response with action plan being followed up through the stroke governance group. For Tier 2 audits, when there is significant concern this has been escalated through the governance structure – for example, the consent audit in 2019 was reported to Secondary Care Quality Group with a request from Dr Clark to all Site MDs to produce an action plan for improvement; these have not been forthcoming and the issue has been escalated to QSG. Going forward these will be raised through the new reporting framework. Remains open until there is confidence in the reporting system.	

Adrian Thomas – Dawn Sharp	JAQS 17/5 Clinical Audit Report – Future Audit Committee to give consideration to how recommendations from Clinical Audits are followed up.	November 2018	Being addressed as part of the update report prepared for March 2019 Audit Committee. This will be included within the new clinical audit policy and process 28.10.19 This is within the draft policy and procedure	Close
Gill Harris	JAQS 17/5 Clinical Audit Report – Areas of concern noted around stroke. GH agreed to liaise with MD Radiology re forthcoming report on Stroke.	December 2017	Action superseded. Subsequent reports presented to QSE Committee. 28.10.19 There is an action plan to support the SSNAP audit documented in the report on the agenda for 5.11.19 5.11.19 The Clinical Audit Report includes some actions arising from the SSNAP audit but this is not in the form of an action plan and there is no link back to the previous areas of concern discussed in 2017. 02.03.20 This will need to be actioned in the forthcoming report. Remain open	
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Dementia Strategy to be cross checked against clinical audit plan	November 2018	This will be considered as part of the revised annual plan (Sept 2019) 28.10.19 This is within the annual plan	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – good news stories to be included in future reports	November 2018	Addressed as part of the update report prepared for March 2019 Audit Committee. This will form part of the reporting system to be developed (QSE reports) 28.10.19 This is within the templates	~~Close~~

			5.11.19 The Tier 1 report template includes a section on examples of good practice related to this project but this needs to be reflected within the report. The Clinical Audit Report for Quarter 2 does not include elements of good practice identified. Suggest that this remains open until it has been clearly incorporated within the report. 02.03.20 Needs to remain open until reporting framework agreed. Report expected to include good performance	
Adrian Thomas	JAQS 17/6 Clinical Audit Plan – AT to give further consideration to the process around inclusion of individual clinical audits within the plan and review the arrangements for the tracking of clinical audit recs with a view to adopting a similar system to that in place for internal and external audit recs.	November 2018	Further consideration given to the process and outlined as part of the update report prepared for March 2019 Audit Committee. This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. 28.10.19 This will be part of the business case – outstanding action 02.03.20 Remains outstanding action until digital system in place to support tracking	
Dawn Sharp	JAQS17/7 – Quality Assurance Frameworks and Governance Arrangements – report to be presented to the December 2017 QSE	December 2017	Actioned. This will be reviewed as part of the development of the clinical audit policy and process. 28.10.19 Will be picked up as part of the ongoing governance review	

			5.11.19 The action will remain open until it has been implemented.	
Actions from JAQS meeting 6.11.18				
Adrian Thomas	JAQS18/9&10 – Clinical Audit and Outcome Review Plan and update reports – ET re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	March 2019	Progress report update on agenda for Audit Committee March 2019 This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources. 28.10.19 This will be part of the business case – outstanding action. Need to agree templates; manual collection of information in the interim to populate the reports. 02.03.20 Clinical Audit policy and Procedure now approved; requires additional resources.	
Actions from JAQS meeting 5.11.19				
Lucy Reid Medwyn Hughes	JAQS19/4.2 Review action log outside of the meeting and confirm their acceptance or otherwise of the status of each action, and recirculate.	December 2019	Review undertaken by joint Chairs. Most of the actions remain open - partly because officers present on 5.11.19 were not party to the previous discussions and so some of them have been interpreted in a different way than was originally intended. Given this the Chairs have agreed that actions remain open until they are satisfied that they have been addressed. Proposal that the QSE Committee reviews the JAQS action log in conjunction with the production of the next Clinical Audit Report as most of them relate to this. QSE would then make a recommendation to the Audit Committee for closure or otherwise.	March 2020

			10.03.20 Clarified the action – QSE should receive regular updates on audit alongside the annual plan and report. The reporting framework within the audit policy is quarterly reports to CAEsG with a copy for information to QSG. QSE should receive a Chair's Report from CAEsG and therefore clinical audit progress can be assessed. However, this will need to be reviewed once the revised governance structure is in place.	
Lucy Reid Medwyn Hughes	JAQS19/5.4 Escalate lack of progress around implementation of clinical audit actions including the development of the policy within Chairs' report to Board	January 2020	02.03.20 Clinical Audit Policy now approved.	Close
Melanie Maxwell	JAQS19/5.7 Follow up comments and concerns raised on draft Clinical Audit Policy & Procedure and submit to next Audit Workshop	December 2019	02.03.20 Clinical Audit Policy now approved.	Close
Melanie Maxwell	JAQS19/7.2 Follow up and respond to comments made on the Clinical Audit Report to provide an amended version.	December 2019	02.03.20 Further loss of staff has hampered ability of team to progress the reporting. However, draft document is in production to be finalised for CAESG in April 2020.	
David Fearnley	JAQS19/7.3 Determine whether a priority could be given to undertaking a local respiratory audit in order to provide some level of assurance in absence of	January 2020	02.03.20 No local audit been undertaken due to lack of capacity within the teams. DF in discussion with potential audit lead. Work is needed to provide data collection support in this and other areas.	

Lucy Reid Medwyn Hughes	JAQS19/7.5 Prepare a joint note encouraging clinicians' participation in audit	December 2019	10.3.20 This is in draft format	
Kate Dunn	JAQS19/10 Arrange date of next meeting	December 2019	Meeting proposed in new calendar for 2020-21	

Patient Stories Transcript Form

**Betsi Cadwaladr University Health Board
Patient's Stories Transcript Form**

Who took the patient's story:	**Name:** Lisa Rowland, PALS Officer
Contact details:	Patient Advice & Liaison Support Officer (PALS), Wrexham, Maelor Hospital, Wrexham Lisa.Rowland@wales.nhs.uk
Reason for taking the story and areas covered:	The patient wanted to share her journey to raise awareness and the importance of following the Health Care Professional's advice during cancer treatment.
Brief summary of the story:	Patient: Susan –"My Journey" In 2017, after several weeks of coughing, sore throat and 2 lots of antibiotics, I was referred to the hospital. The referral came through very quickly, and I was anxious to see the consultant. I was hoping it was nothing sinister and just a bout of tonsillitis. I had not had any real preparation discussion with my GP to give me an indication of what might be, or the best or worst case scenario options were. The consultant appointment day arrived and I was not prepared for the events that took place: questions, answers and the consultant did an immediate endoscopy procedure in the room. Minutes later he was referring to my 'sore throat' as 'CANCER'. I felt sick to the stomach, and was sure I had heard him wrong. But no, he kept saying the same word ('cancer') in a few sentences. My world collapsed around me. No time to think. The next step would be a referral for an operation, with the mention of a possible tracheotomy. I couldn't take it in. What started out as hopefully tonsillitis was suddenly so sinister. Yes, the worst thing possible 'cancer.' Walking through the corridor to my pre-op assessment I was numb. It had to be a dream - I had heard him wrong. How could he have diagnosed that with just a tube in my throat? With the pre-op over, it was finally time for home after what felt like the longest day of my life.

Five weeks later and my husband was escorting me to my admission to hospital. I was petrified. Both the doctor and anaesthetist tried to reassure me, and both said they would try to avoid the need for a tracheotomy. But I still couldn't take it in. I woke up after the operation in the recovery are but to me, I was in a nightmare. I couldn't speak; I was scared, panicky, and completely overwhelmed. I was told about the procedure, and how I now had a tracheotomy - my greatest fear was now reality: I had a tube in my neck. I had to adjust. I was determined to learn to clean the tube myself. I couldn't speak; I had to use a white board to write on, to communicate with friend's family and doctors. I felt lonely, and that's when the panic attacks started.

Seven days later and what felt like the longest time ever in hospital, the biopsy results were back and the diagnosis was throat cancer. Determined not to let this get the better of me, my fight was on. Time for a talking tube to be fitted, and for me to hear my own voice again. But I had no voice; it was a bit of whistle at best. But with practise and patience, I produced the letters of words and eventually the words came through.

My treatment plan was finalised; 6 weeks of radiotherapy and 2 weeks of chemo. The chemotherapy began in August at Glan-Clwyd hospital, and I felt good, with a positive attitude and my husband with me, I could do this. All went well. I had no side effects. I had a busy weekend ahead, and I just got on with it. But the side effects eventually gripped me; a sky high temperature and feeling so hot, lethargic and nauseous. I was rushed into hospital - and was guaranteed I had overdone it. I didn't heed the warnings to do nothing but rest. I thought I was invincible.
After the first session of chemo I noticed my hair was beginning to come out. It broke my heart - I cried and locked myself in the bathroom - couldn't face anyone. I kept telling myself I had to get a grip of myself - I will get through this! After 7 days of boredom; needles, bloods, and drips I was ready for home. Finally released and told to 'listen' and rest.

An appointment was made for a hairpiece – my own hair was now so thin and fine. So, back to the hospital I went with my husband and friend for the wig fitting. In my head, I wanted a short wig with a similar hairstyle to my 'normal' hair. The first one came out of the box and I knew it was the one. When they placed it on my head the colour, style and shape was just perfect. It was a good moment. I smiled - I had got hair, and I felt normal. I looked in the mirror – just at my hair; I avoided looking at my neck. I was ignoring the trach. I felt a million dollars. My husband was smiling, my friend was smiling. I felt normal. Even though the wig was a bit itchy, I still had hair and

it needed to go so I came home and the deed was done; "off with my hair". My husband shaved off the wisps which were remaining of my natural hair so that the wig would now sit better on my head. I probably only wore the wig 6 or seven times; a friend ordered me a couple of head scarfs, which were more comfortable. I felt good in the scarves/hat.

The first 2 chemo sessions were ok. I took it in my stride; smiling, cheery and got on with it. I had to have a dental appointment, to check my teeth in preparation of all the therapy. I had a pick line and a feeding peg inserted and the 6 weeks of radiotherapy soon came round:

Week 1	Chemotherapy and radiotherapy - not too bad.
Weeks 2,3 and 4	Radiotherapy – I was advised to get cream to apply to my neck but I didn't listen. I regret that now!
Week 5	Chemotherapy and radiotherapy
Week 6	Radiotherapy. My neck started to burn.

By weeks 3-4 I was exhausted. The 70 miles round trip travelling for each session was taking its toll. I was experiencing side effects of nausea, no appetite, diarrhoea and I felt so tired. It felt nonstop. Get up, go for treatment, home, sleep, and then up again – like a constant loop.

The 17th November came and the last radiotherapy session. It was all over - I got to ring the bell at week 5. That signified nearing the end of my treatment. I felt good at this point, knowing I had done it and was coming out of the other end. Plus, I had had just 1 stay in hospital - I had learnt my lesson, and had slowed down.

A week later when I thought everything was finally going right, the swelling in my throat stopped me from being able to eat. Luckily, I had the feeding tube. I began taking liquid ensures 5 times a day through the tube, accompanied by all my medication. I had learnt how to do this, as had my husband; we had to as this was the only way to get nutrients and to continue. My temperature went high again and once more I was admitted to hospital, although I didn't want to go, but my husband overrode my decision.   I was quarantined again for 7 more days of bloods, needles, drips and my mouth was blistered, my lips were so dry. I was beginning to sink. I was going down instead of up.

It was a hard lesson to learn. I was prescribed cream for my neck to be applied every 20 minutes and mouth washes and lip balm to be applied as often as I needed. I was finally allowed

home, and the next leg of my journey was about to begin. Helen, a Speech Therapist, joined my care package. I was told to do the exercises (daft faces, facial stretches and singing) she provided to help my swallowing, and to assist my eating. Helen asked what my goal would be - my reply; "I want to eat before my husband's special 60th birthday on March 4th.

Again, I thought I knew it all, and I was running before I could walk. I began to eat soup when I was told not to. Helen had told me to have yoghurts and some soup, and to see how I got on. I was coughing and spluttering, with liquids going the wrong way into my lungs. I should have stopped at this point but I continued, determined to do this.

With the trach still in I had to have a swallow x ray, and it was found that anything I swallowed was going down the wrong way, and was going in to my lungs. It felt like one step forward and 10 steps back. Every time I went to see Helen, it was exercises, stretches and swallowing. I felt like I wasn't getting anywhere - 8 months later, and I'm still doing the same routine.

Finally, June 2018 arrived and it was time for the trach to removal. An overnight stay with local anaesthetic, and basically the trach was just pulled out. A dressing was applied and I was heading home the next day. Picked up by a friend, I was surprised when spoke and could hear myself speak normal. No more having to put my finger over the tube – it may be daft, but after all those months of the "finger over the tube to speak" routine, I reached to do the same thing but there was no need to now the trach had gone - this was going to take some getting used to.

Helen decided on an eating plan. I was the first to try this plan - everything back to basics, food wise. Baby food consistency; slow and steady. The first time I did this was horrible. I didn't want mush I wanted normal food (fish and chips or steak and chips) and just to sit and eat a meal.

The second Christmas was approaching with no Christmas dinner again for me. Again, I wanted to run before I could walk. I followed the eating plan (this is when I told Helen I wanted to eat in the March, but she didn't have the heart to tell me this wasn't going to happen I later found out) and the second swallowing x- ray showed a little improvement, and the muscles were getting stronger but I am now informed I have scaring on my throat due to the radiotherapy and I need to have my throat stretched. At this point I'm really scared, as the doctor informs me I may have to have the trach put back in. An overnight stay was planned, and I really didn't know what to expect, but I didn't want to wake up with the trach back in.

The operation was over, and I woke with my throat feeling as sore as though someone had been scratching it with a cheese grater. I couldn't swallow, and my speech sounded raspy. The Doctor told me not to panic (easier said than done) and assured me it would ease off in a few days. He advised me to take take tiny, little sips of water and not to overdo it.

I returned home and 3 days later my throat was beginning to feel a bit better, and my speech was improving again. Drinking water was getting easier, and I wasn't coughing as much - which had been a big problem before the throat stretching. Eating yoghurts and drinking was now easier, and everything was going the right way down when I ate.

During my next appointment with Helen, I had to take yoghurt and a banana with me. I had to eat the yoghurt, and then she asked me for the banana – no!! Last time eating a banana, a tiny bit on a spoon took me 30 minutes. So I purposely didn't take the damn banana, but Helen magically produced one (she knows me so well). Mushing a bit up, some with yoghurt some without, I had to eat it. It was ok I could do that, no coughing. Then I had to bite a piece of banana, chew and swallow. I was panicking and sweating but Helen kept reassuring me; "we can get through this, you can do it". I ate the banana, all of it. I felt as though I'd won the lottery, I had done it!!!

Helen turned the notch up to level 5 of the eating plan with mash potatoes, boiled egg and scrambled egg - a step up from mush. I was at the panic stage again with the different consistency and I thought I would choke. Little by little I followed Helen's instructions correctly for the first time and I had yoghurts, banana, and the other listed foods. Potatoes for the first time in nearly 2 years were amazing. It was like liquid gold. I had missed the taste. I needed to remind myself to walk and not run. I had problems with the eggs. They would stick to the back of my throat, and I started panicking. I hated eating eggs, but with a bit of mayo the problem was resolved. A new taste and texture again – yippee!

During the next visit to Helen I took a cheese spread sandwich. I took a bite, chewed it, and I had big trouble trying but unable to swallow it. I knew though that I was ok, I wasn't going to choke. I was determined to swallow it however long it took (it's amazing how hard and tiring it is just to eat a small amount - it's exhausting).

I've since had further appointments to see other members of the team, and it's all positive. The main focus now is on the eating part of the process. This last month I've had sweet potatoes,

| | carrots, cheese, macaroni and cheese, trifles, stewed apples with custard and bananas. Every day is getting easier. I get the odd blip, but I've learnt not to panic, put the spoon down, sit there a few moments, rest and try again.

In my last appointment with Helen I broke down. Someone asking me how I felt about what had happened to me was the straw that broke the camel's back. I became emotional, cried and I finally let it out; how I started with a sore throat to the process I'd then been through which had been a nightmare. I told her every time I ate I was afraid I would I would choke - I had refused to eat alone at home. Looking back now, I know it was in my head, but it was hard to overcome.

I wanted to share my story and give some advice to anyone going through treatment for cancer; they say you 'may' get side effects or not - always expect to get some.
Listen to the experts, follow instructions. You are not superwoman/superman. We are human beings.
I thought I was invincible, I didn't listen and I thought I knew myself. But I wasn't myself; I was going through something new. I'm getting there slowly. I still have bad days, but they are getting fewer. I'm positive about my outcome. I will come through this. |
|---|---|

Key themes emerging:	A possible element of learning from the opening comments where the patient states she was not "prepared" for the news she received and did not receive any discussions regarding the referral to ENT or the possible best case / worse case scenarios she may have faced.
Lessons learnt:	
Proposed action / shared with:	Helen Paterson (Speech & Language Therapist) – Helen.Patterson@wales.nhs.uk Pat Evans – Cancer Services, East Cancer Patient Forum – Pat.Evans@wales.nhs.uk Katie Procter – Primary Care Clinical Governance Manager – Katie.Procter@wales.nhs.uk QSE
Sensitive issues to be aware of:	

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Plan Progress Monitoring Report (APPMR)
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Dr Jill Newman, Director of Performance
Craffu blaenorol: Prior Scrutiny:	The paper has been scrutinised and approved by the Executive Team and the Executive Director of Planning and Performance.
Atodiadau Appendices:	Appendix 1 – January 2020 report

Argymhelliad / Recommendation:

The Quality, Safety & Experience Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval *		Ar gyfer Trafodaeth For Discussion*		Ar gyfer sicrwydd For Assurance*		☞ Er gwybodaeth For Information*	

Sefyllfa / Situation:

This report provides a self-assessment by the executive leads of the progress being made in delivering the key actions contained in the 2019/20 Operational plan.

Cefndir / Background:

The operational plan has a number of key actions required to be delivered during 2019/20. The Executive lead reviews on a monthly basis progress against their areas for action and RAG-rates progress. Where an action is complete this is RAG rated purple, where on course to deliver the year end position the rating is green. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery is no longer likely to be achieved. For Amber and Red rated actions a short narrative is provided.

Asesiad / Assessment

Strategy Implications
Delivery of the operational plan actions is key to implementation of the Boards strategy

Financial Implications
Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources.

Risk Analysis
The RAG-rating reflects the risk to delivery of key actions

Impact Assessment
The operational plan has been Equality Impact Assessed.

January 2020

Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

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

January 2020

Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

This report presents performance as at the end of January 2020 against the 2019/20 Annual Plan actions, and is presented in the same order as the plan i.e. health improvement and health inequalities, care closer to home, planned care, unscheduled care, workforce, digital, estates and finance.

The ratings have been self assessed by the relevant lead executive director. All the ratings have been reviewed and approved by the lead executive.

Where a red or amber rating is applied in any month, a short narrative is provided to explain the reasons for this and actions being taken to address.

To interpret this report, it is necessary to note the basis of the rating which provides a succinct forecast of delivery, combined with an assessment of relative risk. Future milestone markers are included as M in the matrix to indicate when elements of actions contained in the report were due for completion. Many of the actions have multiple milestones to support delivery of the year end position. Only when all milestones are complete can the action be achieved.

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

RAG	Every month end	By year end	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points expaining why and what is being done to get back on track
Amber	Some risks being managed	N/A	Where RAG is Amber: Please provide some short bullet points expaining why and what is being done to get back on track
Green	On track, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

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Programme

Health Improvement & Health Inequalities Matrix

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

Three Year Outlook and 2019/20 Annual Plan
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January 2020

Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

AP002 – Improve access to Children's weight management specialist services – The tier 3 Business case originally due by Qtr.1 2020/21 is delayed due to review of delivery models elsewhere to better inform the business case development.

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AP009	Put in place agreed model for integrated leadership of clusters in at least three clusters, evaluate and develop plan for scaling up	Executive Director Primary & Community Care	Quality, Safety & Experience	G	G	A	A	A	M	G	G	G	G		M
AP010	Put in place Community Resource Team maturity matrix and support to progress each CRT	Executive Director Primary & Community Care	Quality, Safety & Experience	G	G	G	G	G	G	G	G	M	G		M
AP011	Work through the RPB to deliver Transformational Fund bid	Executive Director of Primary and Community Care	Strategic Partnership & Population Health	G	G	G	G	G	G	G	G	G	G		M
AP012	Define and put in place Model for integrated Primary and Community Care Academy (PACCA) to support GP practices under greatest pressure	Executive Director of Primary and Community Care	Quality, Safety & Experience	A	A	G	G	G	M	G	G	G	G		M
AP013	Develop and implement plans to support Primary care sustainability	Executive Director of Primary and Community Care	Strategic Partnership & Population Health		G	G	G	G	G	A	G	M	A		M
AP014	Model for health & well-being centres created with partners, based around a 'home first' ethos	Executive Director of Primary and Community Care	Strategic Partnership & Population Health	A	A	A	A	A	M	A	A	A	A		M
AP015	Implementation of RPB Learning Disability strategy	Executive Director of MH & LD	Strategic Partnership & Population Health		G	G	G	G	G	G	G	G	G		M
AP016	Plan and deliver digitally enabled transformation of community care	Executive Director of Primary & Community Care	Digital & Information Governance	G	G	A	A	A	A	A	A	G	A		M
AP017	Develop and Implement a Social prescribing model for North Wales	Executive Director of Primary & Community Care	Strategic Partnership & Population Health	G	G	G	G	G	G	G	G	G	G		M
AP018	Establish framework for assessment for CHC and individual packages of care for people with mental health needs or learning disabilities	Executive Director of MH & LD	Quality, Safety & Experience	G	G	P									M
AP019	Establish a local Gender Identity Team	Executive Director of Primary & Community Care	Quality, Safety & Experience	A	A	A	A	A	A	G	G	M	P		

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AP013 Develop & Implement plans to support Primary Care sustainability

A Business Case has been drafted, and is currently being completed, to further develop the Primary & Community Care Academy (PACCA). This will be presented in line with the health board planning considerations for 2020/21. The Business Case for the PACCA includes workforce plans.

A plan and business case has been developed for Clinical Triage by phone. Initial local work on this has been completed, and a business case paused due to the need to align with similar work underway nationally, and greater BCU coordination of managed practices. Clinical triage of calls in primary care is being tested in some managed and independent practices to inform further planning.

AP014 Model for Health & Wellbeing Centres

This work is progressing but is not as far progressed as was originally intended. Work is ongoing to make up lost time, linking to the development of future operational plans in the Areas.

AP016 Plan and deliver digitally enabled transformation of community care

This work is being progressed with partners as part of the Community Transformation plans, including the development of Welsh Community Care Information System (WCCIS). The Malinko Scheduling System has been commissioned as a pilot with 2 CRTs in Central Area, to trial a system to support workload allocation and optimise management of caseloads in a more effective and efficient use of staffing resource (nursing, therapists and social services)..

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AP020	Centralisation of complex vascular surgery services supported by a new hybrid theatre on YGC site	Executive Director of Nursing & Midwifery	Finance & Performance	P											
AP021	Implement preferred service model for acute urology services	Executive Director of Nursing & Midwifery	Finance & Performance	G	G	A	R	R	M	R	R	R	A		M
AP022	Business case, implementation plan and commencement of enabling works for Orthopaedics (refer to estates section/ plan)	Executive Director of Nursing & Midwifery	Finance & Performance	G	G	A	A	A	M	A	A	A	R		
AP023	Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists	Executive Director of Nursing & Midwifery	Finance & Performance	A	A	A	R	R	M	R	A	A	A		
AP024	Rheumatology service review	Executive Director of Primary & Community Care	Finance & Performance	G	G	A	A	A	A	A	A	M	G		
AP025	Systematic review and plans developed to address service sustainability for all planned care specialties (RTT).	Executive Director of Nursing and Midwifery	Finance & Performance	G	G	A	A	A	M	A	A	A	A		
AP025	Implement year one plans for Endoscopy	Executive Director of Therapies & Health Sciences	Finance & Performance	G	G	A	R	R	R	R	A	A	A		
AP025	Systematic review and plans developed to address diagnostic service sustainability	Executive Director of Therapies & Health Sciences	Finance & Performance	G	G	A	R	R	A	A	A	A	R		M
AP025	Systematic review and plans developed to address service sustainability	Executive Director Nursing & Midwifery	Strategic Partnership & Population Health	G	G	A	A	A	A	A	G	A	A		M
AP026	Fully realise the benefits of the newly established SURNICC service	Executive Director Primary and Community Care	Finance & Performance		G	A	G	G	G	G	G	M	P		
AP027	Implement the new Single cancer pathway across North Wales	Executive Director of Therapies & Health Sciences	Finance & Performance	A	R	A	G	G	G	G	G	G	G		
AP028	Develop Rehabilitation model for people with Mental Health or Learning Disability	Executive Director of Mental Health & Learning Disabilities	Quality, Safety & Experience		G	G	G	A	A	G	G	G	P		M

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AP021 - **Implement preferred service model for acute urology services** - Work is on-going to finalise the business case. It is expected this will be presented during March 2020.

AP022 - **Business case, implementation plan and commencement of enabling works for Orthopaedics (refer to estates section/ plan)** - work is continuing on the orthopaedic plan. The outline Business Case was submitted to Board in January 2020. The appointment of the orthopaedic network manager completed and appointee is now in post.

AP023 –Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists - Draft business case is complete and has been submitted to the business case scrutiny group. 6 optometry practices have been appointed to develop share care glaucoma pathway.

AP025 – Systematic review and plans developed to address service sustainability for planned care specialties (RTT) – Systematic review and plans developed to address service sustainability for planned care specialties (RTT)– Now shared with finance to be costed.

AP025 – Implement one year plans for endoscopy - We are progressing with our work in Endoscopy linking in with the National Endoscopy Group and each DGH site had a pre JAG assessment visit at the end of November arranged by them. The Health Board has also prepared an Endoscopy Action Plan for the National Endoscopy Group with three phases - Immediate, Stabilisation and Sustainability. We are working closely with the NHS Collaborative and are in the process of appointing an individual who will be an interim network manager dedicated to supporting Endoscopy.

AP025 – Systematic review and plans developed to address diagnostic service sustainability - Radiology are procuring additional capacity needed for the year end. They are working on their sustainability plan with the findings from the Kendall Bluck report.

AP025 - Systematic Review and plans developed to address sustainability - A number of streams are being worked upon for 2020/21 within the planned care improvement group; these include work on referral management and contracting for insourcing and outsourcing. Work is also continuing to improve OPD utilisation. The anticipated impact is to increase efficiency and utilisation.

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AP029	**Demand** Improved Urgent care out of hours / 111 service	Executive Director Nursing and Midwifery	Finance & Performance	G	G	G	G	G	G	G	G	M	G		
AP030	**Demand** Enhanced care closer to home / pathways	Executive Director Primary and Community Care	Finance & Performance	G	G	G	A	A	M	A	A	M	A		M
AP031	**Demand** Workforce shift to improve care closer to home	Executive Director Nursing and Midwifery	Finance & Performance	G	G	G	A	R	M	R	R	A	A		
AP032	**Demand** Improved Mental Health crisis response	Executive Director of MH & LD	Finance & Performance	G	A	A	A	A	M	G	G	G	G		M
AP033	**Demand** Improved Crisis intervention services for children	Executive Director Primary and Community Care	Finance & Performance	A	A	G	A	A	A	A	A	A	G		M
AP034	**Flow** Emergency Medical Model	Executive Director Nursing and Midwifery	Finance & Performance	G	G	A	G	A	M	A	A	A	A		
AP034	**Flow** Management of Outliers	Executive Director Nursing and Midwifery	Finance & Performance	Grey	Grey	Grey	G	A	M	A	A	A	A		
AP035	**Flow** SAFER implementation	Executive Director Nursing and Midwifery	Finance & Performance	G	A	A	A	A	M	A	G	M	P		
AP036	**Flow** PICU for Mental Health	Executive Director of MH & LD	Finance & Performance	G	A	A	A	A	G	G	G	G	A		M
AP037	**Flow** Early Pregnancy Service (emergency Gynaecology)	Executive Director of Public Health	Finance & Performance	G	G	G	G	G	M	G	G	M	G		
AP038	**Discharge** Integrated health and social care	Executive Director Nursing and Midwifery	Finance & Performance	A	A	A	A	A	M	A	A	A	A		M
AP039	Stroke Services	Executive Medical Director	Finance & Performance	A	A	R	A	R	R	R	R	R	R		

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AP030 Demand: Enhanced Care Closer to Home Pathways - Improvements are being made in Emergency Departments (EDs) to provide timely care although progress is slower than planned. New ED escalation triggers and action cards implemented across all sites. Targeted gold level command and control work has commenced across all three EDs to improve patients access to timely ED care. Individuals in post are progressing well on training programmes. Rated as amber as should not be described as 'embedded' yet, although it is progressing well.

AP031 Demand: Workforce shift to improve Care Closer to Home - 31a Kendall Bluck workforce review was completed at the end of December with recommendations for ED workforce changes – including at ANP level. A task and finish group has been established to work through the staffing recommendations and associated recruitment

AP034 Flow: Emergency Medical Model - Milestone hit at Ysbyty Glan Clwyd (YGC) and Ysbyty Wrecsam Maelor (YMH). Ysbyty Gwynedd (YG) has opened the new ED unit but models of care are still being finalised to fully operationalise the space. Plans for these were implemented in December 2019.

AP034 Flow: Management of Outliers - Work to reduce outliers in Wrexham has been successful through achievement of new acute floor. Part of the gold level command and control has been focused on ensuring the patient is in the right bed, first time and supporting teams through making bed allocation decisions. Strategic plans in place to look at how we can use the Christmas period to re-balance patients in the Hospital as we are likely to be the lowest occupied on Christmas Eve.

AP036 – PICU for Mental Health - Psychiatric Intensive Care Unit (PICU) Programme work is under consultation and implementation will be dependent on the outcome. Working with corporate engagement team to undertake further engagement on PICU in line with community health council request. To be completed end of June 2020.

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AP038a Discharge Integrated Health & Social Care – Winter pressures money is being used to support our Home First model which includes intermediate care to address shortage in provision of packages of care

AP038b Discharge Integrated Health & Social Care –AP038c Discharge Integrated Health & Social Care - Winter pressures money is being used to further support the Home First models. Work commenced in West in November and in the East and Central in January. Impact in the West has been 808 bed days saved with 126 directly from YG, 627 from community hospitals and 55 from admission avoidance. Impact from East and Central will be available for next month.

AP038d Discharge Integrated Health & Social Care – "What Matters" conversations are happening but not consistently within 24 hours and further work is needed on discharge planning.

AP039 Stroke Services – This action remains red rated as it has not been possible to find a route to resource the business case in 2019/20. However, progress has been made in implementing aspects of year 1 of the business case. The thrombectomy service (clot retrieval) has been expanded to provide a seven day per week service from November 2019. The health board has been successful in its bid for rehabilitation assistants and is moving forward to recruit 2 whole time equivalent assistants for each acute site, to increase the acute therapeutic time patients receive and support optimal recovery and early discharge. The consultants' home-based technology has been improved to support prompt decision-making in relation to opportunities for thrombolysis. Work is continuing to include the implementation of the early supportive discharge and rehabilitation model within the health community plans for 2020/2021. In addition, the stroke pathway is a priority for the 20/21 plan, and will include adopting a value based health care approach to redesign the pathway. This will form part of the clinical strategy's integrated pathway programme, and also will be informed by the national clinical framework which is likely to prioritise stroke pathways. Details of the Health Board methodology will be developed during the next couple of months for the clinical strategy programme, with a document prepared by July aligning the work. The anticipated outcomes from the implementation of the pathway include timely access and diagnostics, reduced admissions, improved discharge and reduction in bed days. National evidence shows improvement in survival and reduced disability post-stroke from full implementation of the pathway.

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AP041	Establish an integrated workforce improvement infrastructure to ensure all our work is aligned	Executive Director Workforce & Organisational Development	Finance & Performance	G	G	G	G	G	M	G	G	G	G		
AP042	Build on QI work to develop the BCU improvement system and delivery plan for efficient value based healthcare	Executive Director Workforce & Organisational Development	Quality, Safety & Experience	G	G	G	G	G	M	G	G	G	G		M
AP043	Deliver Year One Workforce Optimisation Objectives - reducing waste and avoidable variable/premium rate pay expenditure. Demonstrating value for money and responsible use of public funds	Executive Director Workforce & Organisational Development	Finance & Performance	A	A	A	A	A	M	A	A	A	A		M
AP044	Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture	Executive Director Workforce & Organisational Development	Quality, Safety & Experience	G	A	A	A	A	M	A	A	M	A		M
AP045	Develop an integrated multi professional education and learning Improvement Programme in liaison with HEIW	Executive Director Workforce & Organisational Development	Strategic Partnership & Population Health	A	G	G	G	G	M	G	G	M	G		
AP046	Develop a Strategic Equality Plan for 2020-2024	Executive Director Workforce & Organisational Development	Strategic Partnership & Population Health	G	G	A	G	G	M	G	G	G	G		
AP047	Deliver Year One Leadership Development programme to priority triumvirates	Executive Director Workforce & Organisational Development	Finance & Performance	G	A	A	A	A	M	G	G	M	G		M
AP048	Develop an integrated workforce development model for key staff groups with health and social care partners	Executive Director Workforce & Organisational Development	Strategic Partnership & Population Health	G	G	G	A	A	G	G	G	M	G		M
AP049	Provide 'one stop shop' enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services	Executive Director Workforce & Organisational Development	Strategic Partnership & Population Health	A	A	A	A	A	M	A	A	A	A		M
AP050	Develop and Deliver Year one Communications Strategy to improve Communications and enhance BCUHB reputation	Executive Director Workforce & Organisational Development	Strategic Partnership & Population Health	A	G	G	G	G	M	G	G	M	G		M
AP081	Staff (Clinical Rostering)	Executive Director Workforce & Organisational Development	Finance & Perfomance	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	A		

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AP043 Deliver Year One Workforce Optimisation Objectives - reducing waste and avoidable variable/premium rate pay expenditure. Demonstrating value for money and responsible use of public funds - Progress has been achieved in areas such as; the Retention Improvement Plan, which is in place and actions are progressing, Nurse and Midwife bank capacity increased through revised rates and auto-enrolment, Establishment Control (EC) system via electronic portal enabling effective establishment control. Workforce Optimisation Programmes and associated Project Initiation Documents (PID) are in place and overseen by the Workforce Improvement Group (WIG). However this objective remains Amber as whilst work programmes are all being vigorously pursued and some schemes are green there are still programmes in early stages of development. Next Steps: Continued oversight and delivery of all Workforce Optimisation programmes including: Medical Productivity & Efficiency, Nursing; Midwifery and AHP Productivity & Efficiency, Non Clinical Productivity & Efficiency and Overarching / T&Cs Application.

AP044 - Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture - The Qtr. 3 2019 / 20 report updated on work underway to address the gaps in compliance in Health & Safety legislation, the risk remains amber, however a comprehensive set of action plans is being implemented and monitored to address the shortfalls in key areas of concern. The most significant risks are now on tier 1 risk register which include asbestos, legionella, contractor management and control, fire safety and electrical safety. There are a number of groups now established to focus on the risks identified above and these will be monitored by the Strategic Occupational Health & Safety Group. The Occupational Health Service are developing the Safe Effective Occupational Health Standards (SEQOSH), this will be implemented in July 2020. A comprehensive set of policies will form the basis of the next 12 months work that are realistic and clear on roles and responsibilities. Action plans are being completed as scheduled and Q3 report has been provided to QSE in January 2020 to track progress.

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AP049 - Provide 'one stop shop' enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services - A number of aspects of this objective have been achieved e.g. further developing guidance to assist managers to take ownership of actions, increasing organisational capacity in regards to Equality Impact Assessment knowledge and understanding. However, this objective remains amber as whilst teams across W&OD have deployed a multi-team intervention model in support reconfiguration/ workforce redesign in areas such as sickness management and in support of various workforce PIDS this model has not been formalised and publicised. Next Steps: W&OD will continue multi-team support to Workforce Optimisation programmes and will document this approach in order to develop this into an 'offer' which can be publicised to areas planning significant change.

AP081 – Staff (Clinical Rostering). The roster alignment project aspect of this milestone is outstanding as the shift consultation remains ongoing and consequently the staff bandings haven't been built into the roster templates. The consultation within MH & LD has also been paused. In terms of the support and challenge meetings these have been established across secondary care with YGC and YG holding weekly meetings and WMH holding monthly meetings, all of which are supported by the rostering team, WOD and finance colleagues. Within the other divisions if the meetings are being held they have not requested rostering support / attendance at these.

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AP051	Phase three of Welsh Patient Administration Project (PAS) starts. It will replace the Commercial PAS system in the West and standardise processes relating to this system in other sites	Executive Medical Director	Digital & Information Governance	G	G	G	G	G	M	G	G	G	G		M
AP052	Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	Executive Medical Director	Digital & Information Governance	A	A	R	R	R	M	R	R	Moved to 2021/22			
AP053	Reconstitute the Welsh Emergency Department System upgrading the Emergency Department System in the East (phase 1) and extending instances to Central and West (phase 2 and 3)	Executive Medical Director	Digital & Information Governance	G	G	G	G	G	M	G	G	G	G		M
AP054	Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	Executive Medical Director	Digital & Information Governance	G	G	G	G	G	M	G	G	G	G		
AP055	Support the identification of storage solution for Central Library	Executive Medical Director	Digital & Information Governance	A	A	A	A	A	M	G	G	G	G		
AP056	Transition program to review the management arrangements for ensuring good record keeping across all patient record types	Executive Medical Director	Digital & Information Governance	G	G	A	A	A	A	A	A	A	A		M
AP057	Delivery of information content to support flow/efficiency	Executive Medical Director	Digital & Information Governance	A	A	G	G	G	M	G	G	G	G		M
AP058	Rolling programmes of work to maintain / improve the digital infrastructure e.g. migration of telephone infrastructure from an end of life solution to one which is fully supported and capable of underpinning service change e.g. single call centre	Executive Medical Director	Digital & Information Governance	G	G	A	A	A	A	A	A	A	A		M
AP059	Provision of infrastructure and access to support care closer to home	Executive Medical Director	Digital & Information Governance	A	A	A	A	A	A	A	A	A	A		M
AP060	Support Eye Care Transformation	Executive Medical Director	Digital & Information Governance	G	G	G	G	G	G	G	G	G	P		M
AP061	Implement Tracker 7 cancer module in Central and East.	Executive Medical Director	Digital & Information Governance	A	A	G	G	A	M	A	A	A	A		

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AP056 Transition program to review the management arrangements for ensuring good record keeping across all patient record types - Funding has been secured via the HASCAS and Ockenden Board for the recruitment of a Project Manager. The delay lies currently with the translation of the recruitment papers. The project will start a 12 month plan from the date of recruitment.

AP058 Rolling programmes of work to maintain / improve the digital infrastructure - The discretionary Capital programme allocation for 2019/20 has been reduced from £3 million to £2.7million following formal change control. Circa £957k of the allocation was spent at the end of Period 9. The majority of outstanding purchases will be made in January 2020 with the exception of Computer Hardware, which will be made as scheduled in February 2020. Going forward some slippage against schemes is likely as a result of pressures born through the allocation of Digital Priorities funding in November 2019. Full outturn will be prioritised.

AP059 Provision of infrastructure and access to support care closer to home - Project Brief presented to Regional Integrated Services Digital Transformation Board 9/1/20 and scope approved. Outline Business Case now in development to bid for capital and revenue funding identified

AP061 Implement Tracker 7 cancer module in Central and East - WPAS Upgrade v19.2 has been completed as scheduled but it does not support service needs. The Service have identified issues with functionality, which increases workload and lengthens processes. A SharePoint site fulfils current requirements. When identified developments are delivered it will be implemented to the Service for User Acceptance Testing and Implementation.

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AP062	Statutory Compliance / Estate Maintenance	Executive Director Planning and Performance	Finance & Performance	G	G	G	G	G	G	G	G	G	G		M
AP063	Primary Care Project Pipeline	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	G	G	G	G	G			M
AP064	Well-being Hubs	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	A	A	A	A	A	A	A	A		M
AP066	Ruthin Hospital	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	P							M
AP067	Vale of Clwyd	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	G	G	R	Removed				
AP068	Orthopaedic Services	Executive Director Planning and Performance	Finance & Performance	G	G	G	G	G	G	G	G	G	G		M
AP069	Ablett Mental Health Unit	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	A	R	R	G	G	Moved to 2021/22		
AP070	Wrexham Maelor Infrastructure	Executive Director Planning and Performance	Strategic Partnership & Population Health	R	R	R	R	P	M						
AP071	Hospital Redevelopments	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	A	A	A	A	A	G		M
AP072	Central Medical Records	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	A	A	R	G	G	R		M
AP073	Residencies	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	G	G	A	A	R	R		M
AP074	Integrated Care Fund (ICF) Schemes	Executive Director Planning and Performance	Strategic Partnership & Population Health	G	G	G	G	A	G	G	G	G	G		

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AP064 Wellbeing Hubs - A wellbeing hub will not be complete in 2019/20 despite some progress being made, hence the change in score to red. The developing understanding of the needs of the emerging integrated health and social care localities has instigated a review of the primary care pipelines and the future configuration of health and well-being hubs. Problems have been encountered in identifying a suitable, cost effective site for Pen y Groes, and the complexity of delivering through a third party has impacted on the programme for Bangor.

AP072 Central Medical Records - This scheme to reprovide medical records storage was originally prioritised as a result of the proposed redevelopment of the Ablett Unit at YGC - medical records are currently partly stored in Tawel Fan. The change to the likely preferred option for Ablett business case to a new build elsewhere on the YGC site has reduced some of the urgency. Current progress with a digital health record means the need for physical storage may be lessened - albeit over the long term.

AP073 Residencies - A draft business case has been shared with potential housing partners. Discussions are needed with Welsh Government on the potential availability of public sector capital. Further meetings are scheduled for March.

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				Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP075	Governance	EDN&M & Deputy CEO	Finance & Perfromance	Grey	Grey	M	A	A	M	A	A	A	A		
AP076	Grip and Control	Executive Director of Finance	Finance & Perfromance	Grey	Grey	M	A	G	M	A	A	A	A		
AP077	Planning	Executive Director of Finance	Finance & Perfromance	Grey	Grey	M	A	A	M	A	A	A	A		
AP078	Procurement	Executive Director of Finance	Finance & Perfromance	Grey	Grey	M	A	G	M	A	A	A	A		
AP079	Risk Management	Deputy CEO	Audit Committee	Grey	Grey	Grey	Grey	Grey	M	G	G	G	G		

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

January 2020

AP075 Governance - Work is continuing on developing the Governance framework of the Health Board. The revised draft Clinical Risk Strategy is on target for implementation in April 2020. The work to date has highlighted a number of issues to be addressed and posed 6 emergent risk management themes, which need to be considered in order to align with the work on the overall governance framework.

AP076 Grip and control - Progress is being made against the Financial Recovery Action Plan, but this has not delivered a reduction in the expenditure run rate to allow progress towards the control total of £25m deficit. The Health Board has identified further areas to scrutinise discretionary expenditure for the last quarter of the year, and to increase the levels of financial governance and control within the organisation.

AP077 Planning - Performance against in-year financial plan (including savings programme) is being tracked. Accurate forecasting and delivery of financial recovery actions are critical in driving the required reduction in expenditure by divisions over the last quarter of the year. Planning cycle for future years is underway. We are learning lessons from current year planning, in-year performance to date, and from the Financial Recovery programme to better inform future planning.

AP078 Procurement - Efficiency framework and other opportunities are being scoped and accessed. Conformance with procurement requirements is being monitored and any deviations reported. Lessons from this year show that utilising national frameworks and All-Wales approaches via NWSSP is not sufficient to guarantee meeting the Health Board's financial targets. Engagement with NWSSP on All-Wales approaches has begun between the Director of Finance and new Director of Procurement, to identify any potential opportunities which can deliver at scale.

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

January 2020

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

The link to these papers is shown below:

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

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

January 2020

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Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Integrated Quality & Performance Report (IQPR)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Dr. Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Director of Performance
Atodiadau **Appendices:**	1) IQPR

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to scrutinise the report and to escalate any areas of issue to the Board.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval *		Ar gyfer Trafodaeth For Discussion*		Ar gyfer sicrwydd For Assurance*	☞	Er gwybodaeth For Information*	

Sefyllfa / Situation:

This report provides an update on the Health Boards position against National Performance Indicators and Local Performance Indicators deemed priority areas by the Committee Members. The report includes exception reports for indicators no performing in accordance with the operational plan. Where delivery of the operational plan is below the national target the exception reports have been retained within the report. For some indicators such as the research indicators performance is cumulative and therefore progress is monitored with exception reporting provided at year end. Additional information is provided in this reported this month in relation to the reasons for cancellation of procedures for non-clinical reasons.

Cefndir / Background:

This report forms part of the Health Board's assurance framework to ensure the organization is sighted on its performance. Areas of poor performance will be supported by an exception report providing background on the position, and actions and timelines for recovery.

Asesiad / Assessment

Strategy Implications

The performance measures within the IQPR are aligned with the Annual Plan and identified as the key performance indicators in monitoring and managing the Health Board's strategy. The measures arise from the National NHS Wales Annual Delivery Plan. The report demonstrates the health boards latest reported position against these measures, the progress in-year in relation to the planned performance and national targets and the comparative period in 2018-19 to enable a longer-term view of performance to be identified.

Financial Implications

The financial benefits arising from high quality safe care are recognised and the cost of poor performance both to the individual patient, staff morale, organisational reputation and financial cost is integral to improving the performance of the Health Board
Risk Analysis

The RAG-rating reflects the performance against the Plan. Where there aren't Plan Profiles, the performance is measured against the national target. Failure to deliver performance in line with the plan presents risks for the population, patients and the health board.

Impact Assessment

The operational plan has been Equality Impact Assessed. The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

March 2020

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

March 2020

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

The measure code relates to the code applied within the NHS Wales Annual Delivery Framework, which Welsh Government hold the Board accountable for delivering. A key difference in the structure of the IQPR for 2019/20, in comparison to 2018/19 is that it is that the report reflects the organisational priorities as set out in the Operational Plan approved by the Board . The report maps each the measures included against the corresponding work programme within the Annual Plan for 2019/20. This is done via a reference number in the 5th box of the Measure Component Bar.

The format of the Measure Component Bars and the Chapter Summaries have been improved in this report. The Measure Component Bars have been simplified and data for the full 2019/20 Year to Date is presented. Furthermore, the Chapter Summaries have also been simplified. All Measures are now RAG rated against the Annual Plan except where no Plan Profile is available. In this case, performance will be RAG rated against the National Target.

⬆ Performance has improved since last reported

⬇ Performance as got worse since last reported

➡ Performance remains the same as last reported

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Profiles

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

Escalated Exception Reports

When performance on a measure is worse than expected, the Lead for that measure is asked to provide an exception report to assure the relevant Committee that they have a plan and set of actions in place to improve performance, that there are measurable outcomes aligned to those actions and that they have a defined timeline/ deadline for when performance will be 'back on track', preferably demonstrable through a recovery trajectory. Although these are normally scrutinised by the Quality, Safety and Experience Committee (QSE) of the Board, there may be instances where they need to be 'escalated' to the Board. The timings of the Board and its committees does mean on occasions the Board will have received timely information on the performance compliance ahead of the QSE committee scrutinising the performance.

Performance Trends

Where appropriate run charts or SPC charts are used to present performance data. The report contains data for 2019-20 and for the same period in 2018-19 .This will assist with tracking performance over time, identifying unwarranted trends and outliers and fostering objective discussions rather than reacting to 'point-in-time' data.
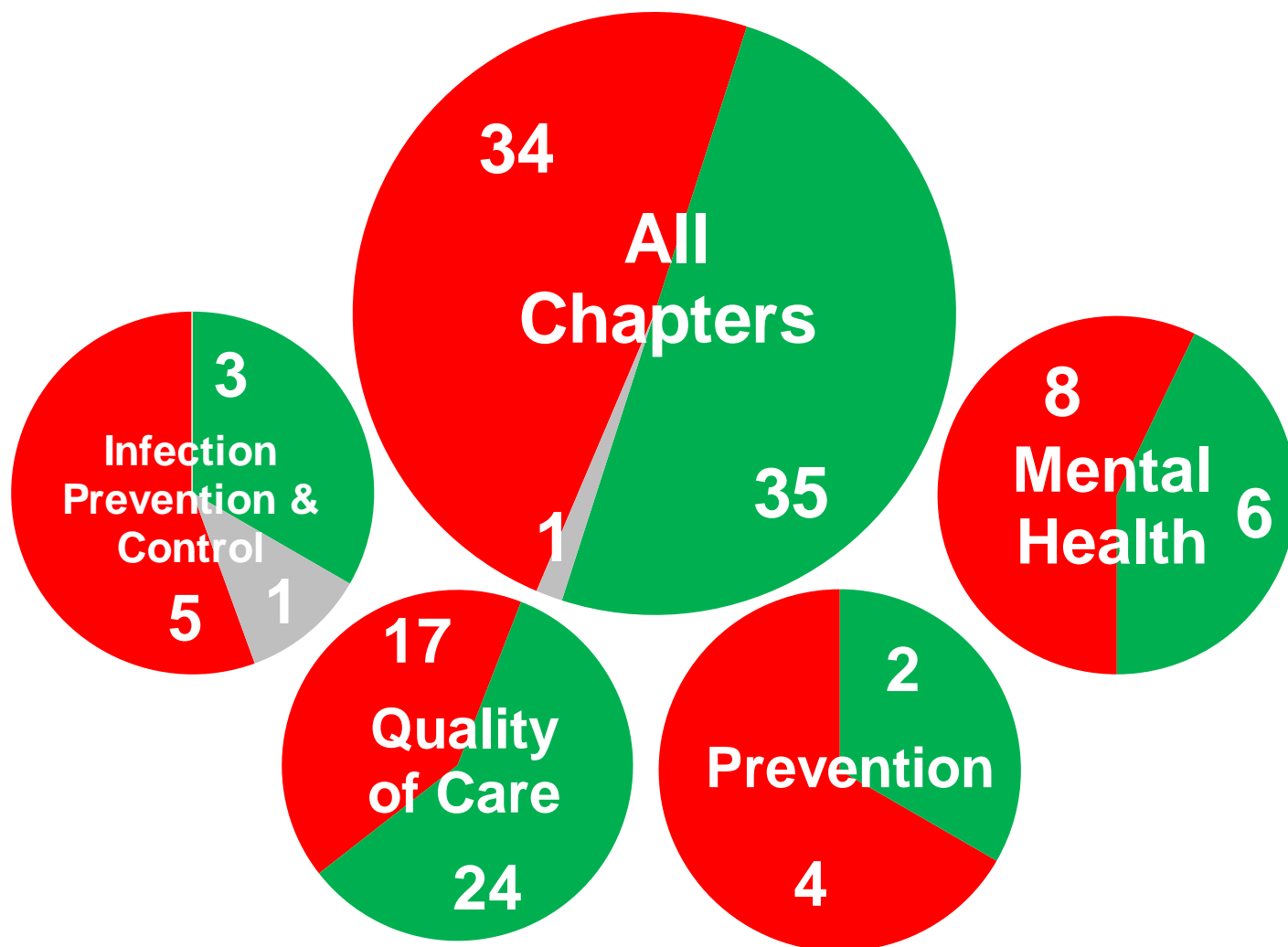
Cycle of business

This report demonstrates performance against profile for January 2020 where the measure and profile is reportable monthly. This is because the majority February 2020 data is currently being validated, with submission date for this report being earlier in the month than the February submissions to Welsh Government. Where February data is available this has been included to give the committee the latest validated position.

This report also includes the local indicator ; Healthcare Acquired Pressure Ulcers and provides disaggregation of the Health Care Acquired Infection data.

An additional slide is provided this month on the procedures cancelled at short notice which is an action requested at the last meeting of the QSE Committee.

In addition to this report all committees are provided with a RAGP self-assessment of progress against the actions within the Annual Plan.

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Improved

Code	Measure	Status		Annual Plan Profile	National Target
DFM027	Universal Mortality Reviews within 28 Days	96.80%	↑	>= 95%	>= 95%
DFM005d	Flu Vaccination: Health Care Workers	54.60%	↑	>= 40%	>= 60%
DFM023	Serious Incidents Assured within timescales	65.00%	↑	>=47%	>= 90%

Of Most Concern

Code	Measure	Status		Annual Plan Profile	National Target
DFM058	26 Week Wait: Adult Specialist Mental Health Psychological Therapy	21.47%	↓	AP	>= 80%
LM023c	Total Number of Healthcare Acquired Pressure Ulcers	590	↓	AP	AP
DFM021b	Cumulative Rate: S.Aureus	29.89	↓	<= 20	<= 20
DFM028	Crude Mortality Rate (Under 75 years of age)	0.80%	↓	<= 0.70%	Reduce

Grey = No Data available at the time of reporting
AP = Awaiting profile

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

The committee are asked to note the progress in the following areas:

Prevention – the health board has delivered a performance better than its plan against the three influenza immunisation measures reflecting the good work of the team and the change in approach to vaccine administration. Vaccination will continue until the end of March with a view to achieving further improvement. It is noticeable that not only is the benchmarked performance the best in Wales for patients over 65 years and at risk under 65 year olds, but the volume of vaccines administered is significantly higher than in other areas. Work is underway in line with national plans to address COVID19. This is being led by the Medical Director.

It is noted that the timely reporting of serious incidents to Welsh Government continues to improve and has been ahead of the local profile set for the last 4 consecutive reporting periods. This gives increased confidence that investigations are being undertaken promptly to facilitate learning to be shared and applied so as to reduce risk of recurrence. However as this measure is yet to deliver the national target , the committee will continue to receive exception reports.

The health board has achieved the target for universal mortality reviews to be completed with 28 days for the first time this month, continuing our good process in introducing this process as part of normal practice. This is reflected in our benchmarked position compared to other health boards. It is also recognised that improvement in awareness of sepsis within our ED departments is resulting in improved mortality rates arising from Sepsis.

The committee are asked to note the following key indicators where performance is of concern:
Ward staffing – the staff fill rate for nursing staff deteriorated further in January 2020, being the lowest level this year. This has the potential to impact on the quality of care delivered to patients and reflects both the volume of vacancies, time to recruitment, effective rostering and level of staff absences.

Data for the end of January 2020 demonstrates the health board has exceeded the level of infections set as national targets for the year for all infections reported. It is noted that 71% of infections reported are classified as unavoidable and therefore focus is on prevention of the avoidable healthcare infections. Of the reported infections 70% arise in the community. The report highlights that for a number of infections the January number of infections is lower than has been achieved for a number of months.

Access to psychological therapies, especially in the East continues to be a concern being addressed through the actions arising from recommendations of the independent review.

Recruitment is progressing to address the long waits for neuro-development, however the time lag before staff are in post will not provide a quick resolution. The committee are asked to note the other actions being taken to complement recruitment.
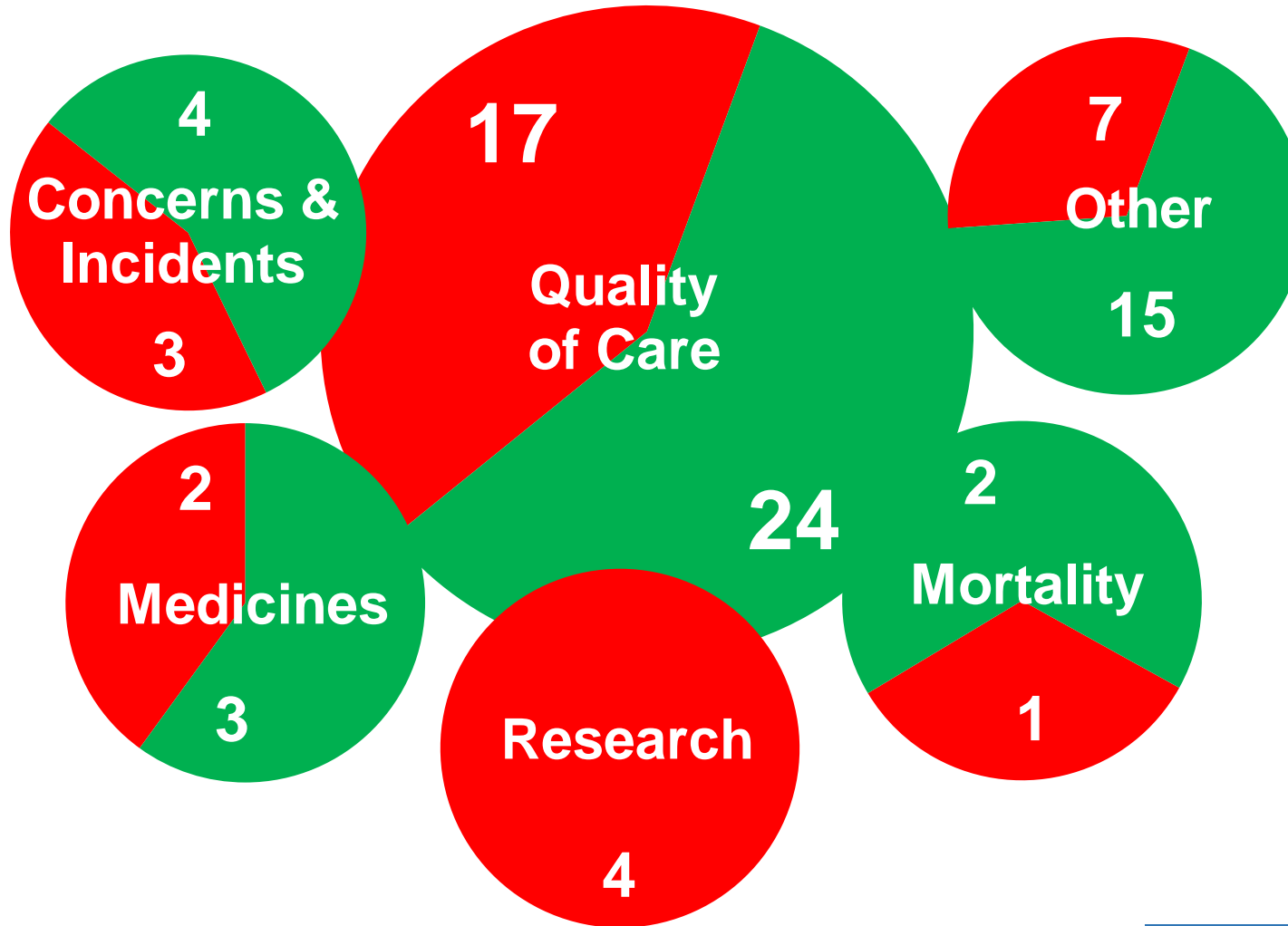
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Code	Measure	Status		Annual Plan Profile	National Target
DFM008	Alcohol Attributed Admissions	444.10	↑	N/A A	Reduce
DFM009	Learning Disabilities Annual Health Check (Annually Reported Figure)	36.50%	↑	AP	>= 75%
DFM010	Disclosure and Barring Checks: Children	75%	↑	AP	Improve
DFM011	Disclosure and Barring Checks: Adults	81%	↑	AP	Improve
DFM012	Hospital Admissions mention Self Harm in Children & Young	4.53	↑	Reduce	Reduce
DFM013	Amenable Mortality Rate	127.2	↑	AP	Reduce
DFM014	Sepsis Six Bundle: Inpatients	100%	→	100%	Improve
DFM015	Sepsis Six Bundle: Emergency Department	51.50%	↑	>= 81%	Improve
DFM016	Preventable Hosptial Acquired Thrombsis	0	→	NIP	Reduce
DFM017	Opiod Average daily quantities per 1,000 patients	4,815	↑	<=4,961	Reduce
DFM018	Antipsychotic Prescriptions for Over 65s	2,260	↓	AP	Reduce

Code	Measure	Status		Annual Plan Profile	National Target
DFM019	Antibacterial Items per 1,000 STARPUS	259.8	↑	<= 275.6	Reduce
DFM020	Combined 4 Antibacterial items prescribed	12.68	↑	<= 14.33	Reduce
DFM022	Patient Safety Solutions Wales Alerts and Notices	1	↑	<= 5	0
DFM023	Serious Incidents Assured within timescales	65.00%	↑	>=47%	>= 90%
LM023a	Serious Incidents: Patient Falls	12	→	<= 11	<= 11
LM023b	Serious Incidents: Pressure Ulcers	2	↑	0	0
LM023c	Total Number of Healthcare Acquired Pressure Ulcers	590	↓	AP	AP
DFM024	Total Number of New Never Events	0	→	0	0
DFM027	Universal Mortality Reviews within 28 Days	96.80%	↑	>= 95%	>= 95%
DFM028	Crude Mortality Rate (Under 75 years of age)	0.80%	↓	<= 0.70%	Reduce
DFM032	NICE Approved New Medicines made available Within 3 Months	99.50%	↓	100%	100%

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Code	Measure	Status	Annual Plan Profile	National Target
DFM033	Number of Clinical Research Studies *	64 ⬆	+7.5%	Increase
DFM034	Number of Commercial Research Studies *	5 ⬆	+3.75%	Increase
DFM035	Number recruited to clinical studies *	1278 ⬆	+7.5%	Increase
DFM036	Number recruited to commercial studies *	36 ⬆	+3.75%	Increase
DFM037	Survey Results: Satisfaction with Health Services	6.17 ⬇	Improve	Improve
DFM038	Number of Postponed Procedures (Non-clinical)	2,292 ⬇	Reduce	Reduce
DFM040	Concerns Replies within 30 Days	55.20% ⬇	>= 48%	>= 75%
DFM041	Over 65's with Dementia registered with GP	52.20% ⬆	Improve	Improve
DFM042	Survey Results: Dignity and Respect	96.60% ⬆	Improve	Improve
DFM043	Survey Results: Satisfaction with GP care	92.50% ⬆	Improve	Improve

| Code	Measure	Status	Annual Plan Profile	National Target
DFM044	Survey Results: Satisfaction with Hosptal Care	94.60% ⬆	Improve	Improve
DFM045	NHS Staff Dementia Training	93.70% ⬆	Improve	>= 85%
DFM046	GP Practice Dementia Training (Reported annually in arrears)	18.90% ⬇	Improve	Improve
DFM075	Qualitative Report: Advancing Equality	Yes ➡	Yes	Submit QR
DFM076	Qualitative Report: Health & Wellbeing	Yes ➡	Yes	Submit QR
DFM077	Qualitative Report: Accessible Communication	Yes ➡	Yes	Submit QR
DFM078	Qualitative Report: Welsh Language	Yes ➡	Yes	Submit QR
WGM001	Ward Staff Fill Rate (Nursing)	82.00% ⬇	>= 95%	>= 95%
WGM002	Ward Staff Skill Mix (Nursing)	56.00% ➡	>= 60%	>= 60%

* Clinical and commercial study KPIs have an annual % increase target. Data is recorded cumulatively in year and any exception to the annual target will be reported QSE Committee in May 2020.

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Code	Measure Description	Responsible Executive Officer	National Target	Plan Ref	Plan Target	Current Period	Actual	Status	Wales Benchmark	Same Period Last Year	Apr-19	May-19	Jun-19	Qtr 1 19/20	Jul-19	Aug-19	Sep-19	Qtr 2 19/20	Oct-19	Nov-19	Dec-19	Qtr 3 19/20	Jan-20	Feb-20	Mar-20	Qtr 4 19/20
DFM014	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	David Fearnley	Improve	AP039	100%	Jan-20	100%	→	1st	100%	100%	100%	100%	-	100%	100%	100%	-	100%	100%	100%	-	100%			
DFM015	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	David Fearnley	Improve	AP039	>= 81%	Jan-20	51.50%	↑	4th	54.31%	66.21%	51.55%	44.78%	-	44.27%	53.13%	58.50%	-	52.36%	46.60%	48.15%	-	51.50%			

Sepsis Six Bundle within 1 Hour for Inpatients
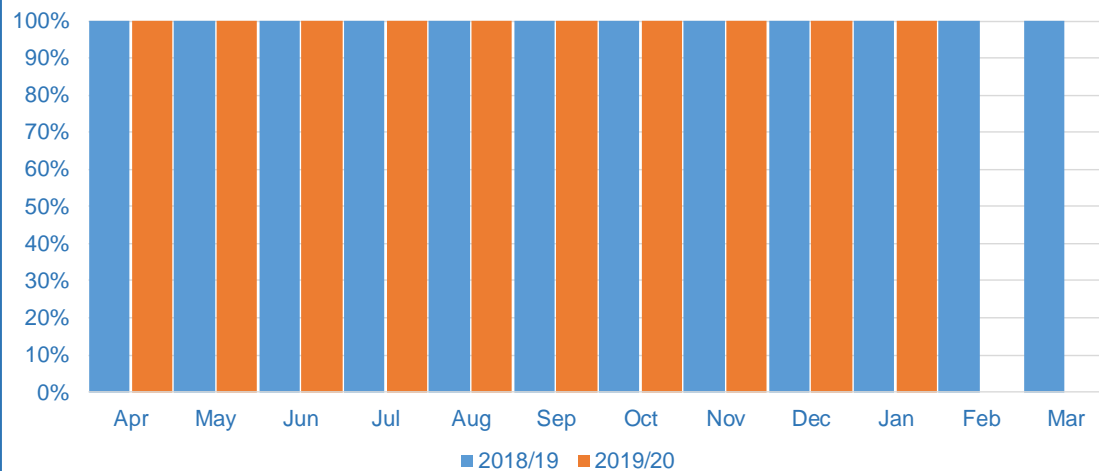
Sepsis Six Bundle within 1 Hour at Emergency Departments
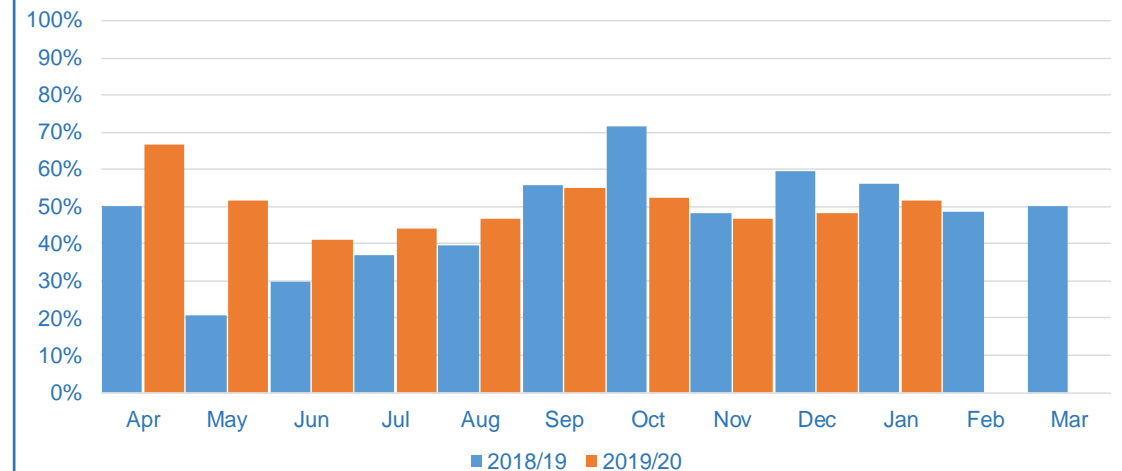
Why we are where we are: The current issues in Emergency department performance are due to a number of factors. These are as follows:
1. Departmental pressures 2. Access to sepsis bundle books, trial taking place in YGC to use sticker instead. 3. Poorly completed paperwork
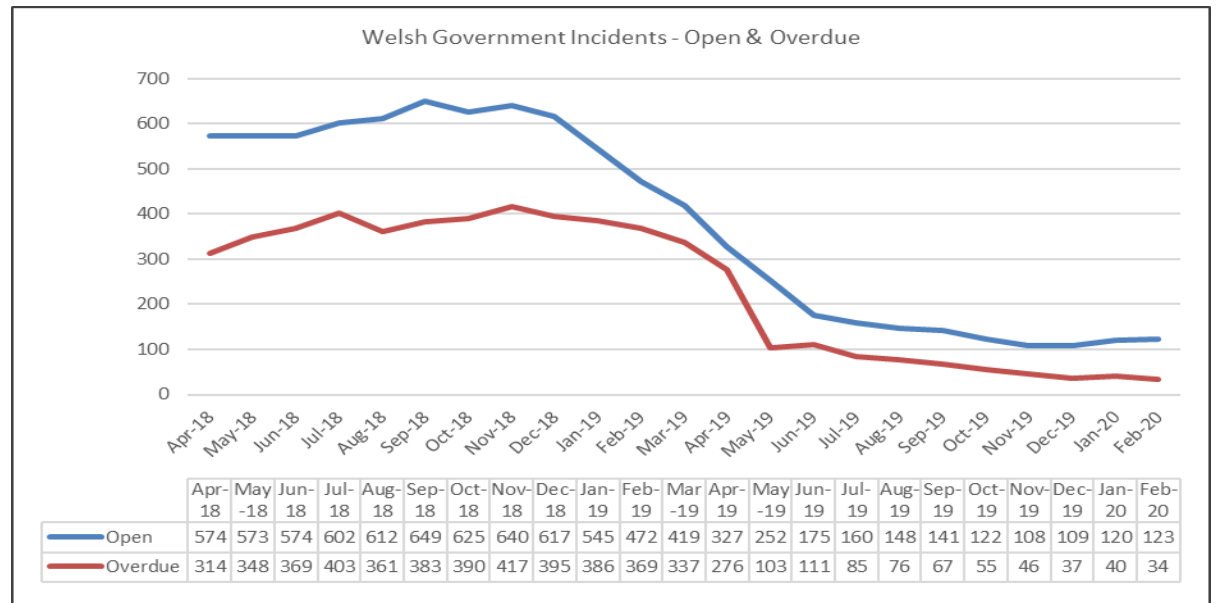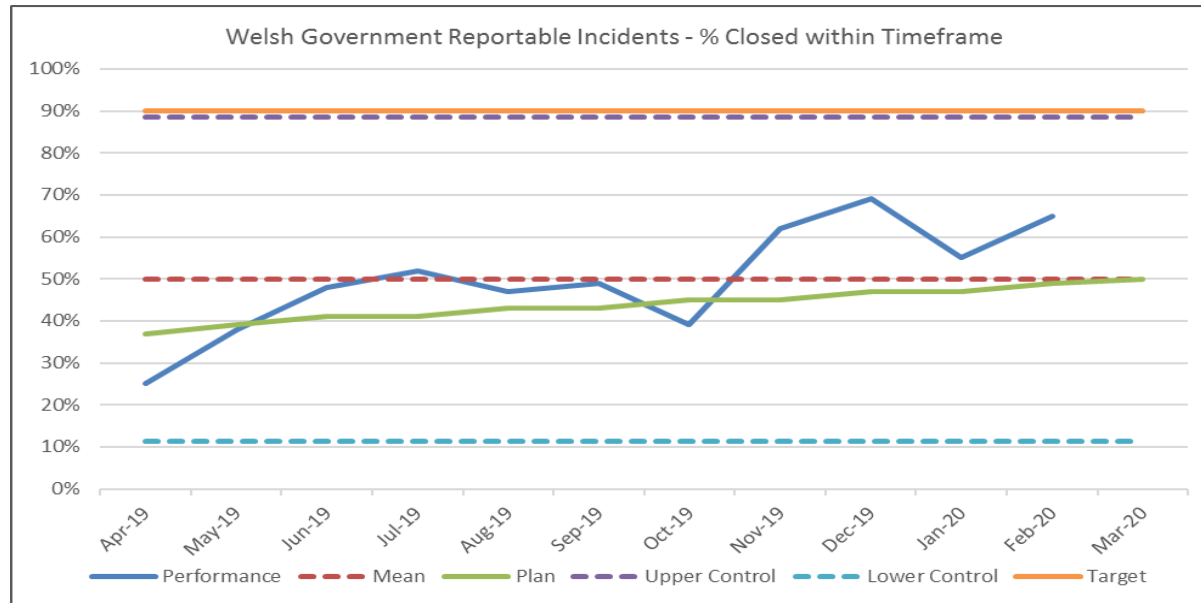
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Actions	Outcomes	Timeline
1. Sepsis collaborative (Emergency Departments) • The Sepsis collaborative enables and supports teams in the emergency departments to work together locally and across the health board, to make improvements in sepsis management and share success with others to improve patient outcomes for sepsis in line with best practice. • Day 5 of the sepsis collaborative took place on 12th Feb 2020. A further session is being arranged for June 2020. • Trial of sepsis stickers commenced in February 2020 to support improvements in identification and response to suspected sepsis cases.	• Improve understanding of issues and develop action plans to rectify problems as identified • Improved ownership around sepsis and helps staff to aspire to be the best they can. • A reduction in suspected sepsis mortality is being now being reported on some acute sites as a result of the improvement work (3% reduction for Ysbyty Glan Clwyd and Wrexham Maelor).	Ongoing during 2020
2. Sepsis dashboard • Development work on the dashboard is now complete. • Sepsis dashboard is active and in use within Emergency Departments (ED) across the sites. It is now being used to inform progress during ED DRIPS (data, review, improve, plot the dots and share) meetings.	Provision of live data to inform staff of progress and help identify areas of weakness that need improvement.	Action now complete
3. Introduction of DRIPS* meetings • **DRIPS stands for data, review, improve, plot the dots and share -** All acute site EDs are now running DRIPS meeting to review progress and make improvements to early sepsis treatment.	• Improve understanding of issues and develop action plans to rectify problems as identified. • Improved ownership around sepsis and helps staff to aspire to be best they can.	Predicted April 2020

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

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DFM018	Number of patients aged 65 or over prescribed antipsychotic, as a percentage of all patients aged 65 or over	David Fearnley	Reduce	AP039	AP	Qtr 2 19/20	2,260	⬇	N/A	New 19/20	-	-	-	2,215	-	-	-	2,260	-	-	-		-	-	-	

Why we are where we are: People started on antipsychotics for behavioural symptoms of dementia or delirium may be discharged to primary care and the medication continued even if no longer clinically indicated.

Actions	Outcomes	Timeline
1. **GP Quality Assurance and Improvement Framework** Review all patients > 65 with dementia on antipsychotic	Reduce and stop if no longer indicated	All patients reviewed by March 2021
2. **Implement guidance** Ensure clear timescale for antipsychotic when started and on transfer of care. Audit showed that antipsychotics started appropriately but not reviewed in a timely way. Guidelines MM52 and MM17 (DELIRIUM) provides clear guidance on review.	Clear instruction to GP to review and stop antipsychotic	Ongoing
3. **Education and awareness** Increase opportunities for training and education on antipsychotics in dementia in training programs for care home staff, medical staff, GP practice staff. Work with dementia practice development nurses via the care homes subgroup	Staff awareness and skills to manage patients without long term antipsychotics	Ongoing
4. **Increase capacity for medication review in Practices** A MDT bid includes need for pharmacy staff to lead on medication review in people with dementia has been submitted as part of the HASCAS recommendation 2.	Medication has timely review and outcomes optimised, reduced harm	Sent to HASCAS group Jan 2020, to be presented on 13th March

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DFM023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Deborah Carter	>= 90%	AP039	>=47%	Feb-20	65.00%	⬆	1st	36.84%	25.00%	38.24%	48.28%	-	51.52%	46.51%	51.60%	-	39.50%	62.16%	69.44%	-	55.00%	65.00%		-

Welsh Government Reportable Incidents - % Closed within Timeframe

Welsh Government Incidents - Open & Overdue

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Open	574	573	574	602	612	649	625	640	617	545	472	419	327	252	175	160	148	141	122	108	109	120	123
Overdue	314	348	369	403	361	383	390	417	395	386	369	337	276	103	111	85	76	67	55	46	37	40	34

Why we are where we are: There is a continued effort to reduce the number of Welsh Government reportable incidents open. This has seen a decrease in the number of overdue cases month on month, with the number open as of the 26th February 2020 being 123, of which 34 are overdue. There is a focus on the management of incidents and this is increasing the timeliness of managing of incidents more effectively. The weekly incident review meetings continue to scrutinize progress as well as detail of incidents. Closure is dependant upon appropriate investigation. Changes in service governance arrangements is expected to impact positively on performance of WG reportable incidents going forward.

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Actions	Outcomes	Timeline
1. The new Assistant Director of Patient Safety and Experience has continued the scrutiny of open and overdue incidents, and divisions have continued their focus on timely completion. This focus will continue.	Continued focus and scrutiny has seen a sustained reduction in overdue closure forms and an improvement in timely completion.	Ongoing
2. A review of the procedures and processes for incidents is planned with a view to streamlining and simplifying. This will be done in co-production with divisions. The review will explore new processes, training and documentation.	A simpler process for staff to follow reducing delays.	Review to start by March 2020
3. Implementation of the new All-Wales Concern System (replacement Datix system).	A simpler, improved and more accessible recording of investigations and learning and easier reporting to Welsh Government (WG).	National rollout during 2020-2021 WG

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LM023a	Number of Patient Falls reported as Serious Incidents	Deborah Carter	<= 11	NIP	<= 11	Jan-20	12	→	N/A	6	6	12	19	0	19	12	10	-	6	9	12	-	12			

Number of Patient Falls reported as Serious Incidents

Legend: 2018/19 — 2019/20 — Target
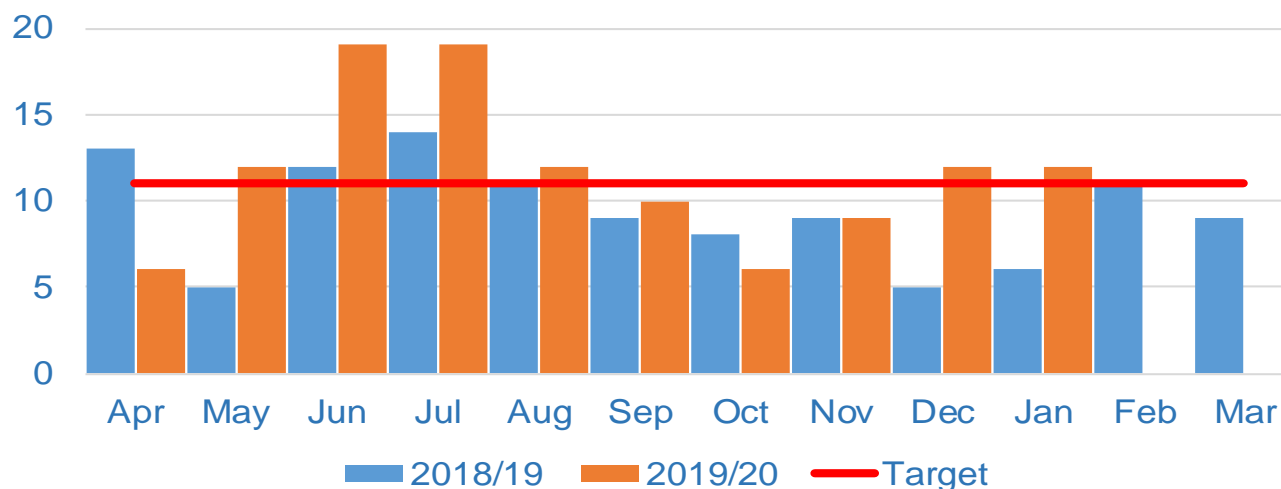
- **Harms resulting from patient falls in January 2020**:

- Total of **12** Falls reported with as serious incident with harm

- 6 patients in Secondary care -3 fractured neck of femurs, 1 fracture to Lumbar vertebrae, 1 fractured fibula, 1 fractured elbow

- 3 patients in community inpatients -3 fractured neck of femurs (Hips)

- 3 Mental Health & Learning Disabilities - 2 fractured neck of femurs (OPMH), 1 dislocated shoulder

Why we are where we are: Total number of falls with harm remain unchanged from the previous month December 2019

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Actions	Outcomes	Timeline
1. Falls collaborative continues –Wards are continuing to test individual interventions and other collaborative ward interventions to determine Health Board (HB) standard	To reduce inpatient falls by 30% in collaborative wards	30th April 2020
2. Falls collaborative faculty projects include development of education resources, update HB falls prevention web page	To implement a clear pathway/metrics of education resources for all levels of clinical staff	30th April 2020
3. Implementation of all Wales documentation (in line with all Wales implementation plan) to replace HB Falls Pathway	Seamless transition to all Wales documentation	1st May 2020
4. Falls strategic group (inpatients only) re established	To review and monitor progress against HB improvement plan	On going

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LM023b	Number of Healthcare Acquired Pressure Ulcers reported as Serious Incidents	Deborah Carter	0	NIP	0	Jan-20	2	↑	N/A	2	3	4	2	-	2	6	2	-	10	10	4	-	2			-
LM023c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	Deborah Carter	AP	NIP	AP	Jan-20	590	↓	N/A	ND	508	452	543	-	550	502	482	-	539	536	516	-	590			-

Number of Healthcare Aquired Pressure Ulcers reported as Serious Incidents

2018/19 · 2019/20 · Target
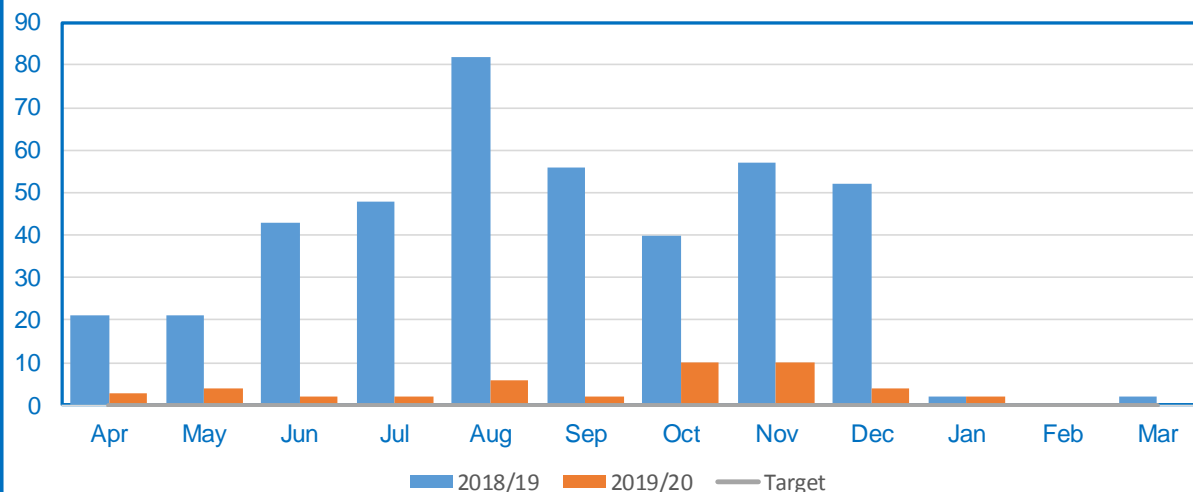
Total Number of Hospital Aquired Pressure Ulcers (All Grades)

2019/20
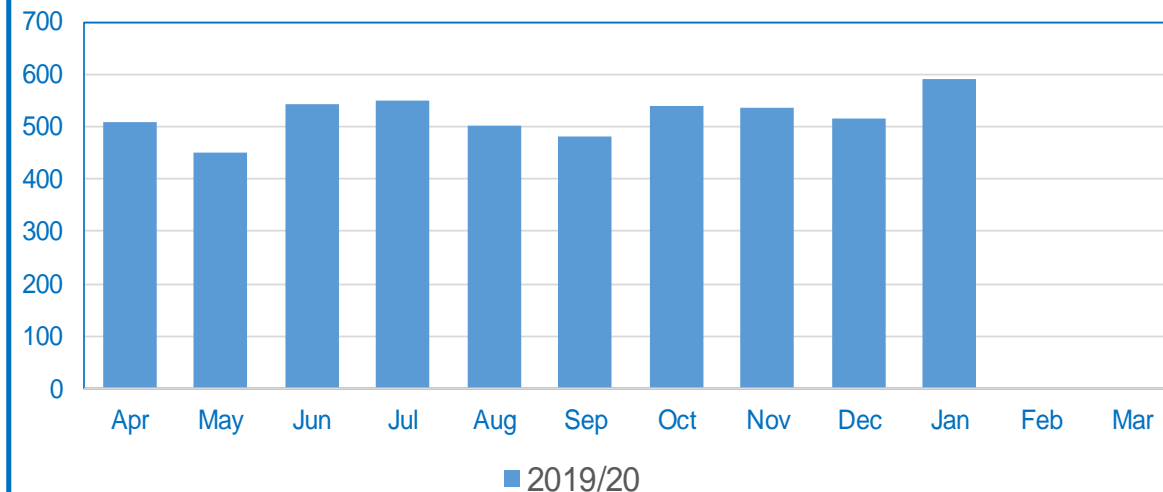
Why we are where we are: Total of **2 HAPU** reported as serious incidents in January 2020:
1 reported in Secondary care Wrexham
1 reported in Secondary care Ysbyty Gwynedd

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Actions	Outcomes	Timeline
1. All Wales Risk Assessments with corresponding care plan to be implemented as part of the introduction of revised Health Board Risk Assessment booklet by 30th April 2020 in line with All wales implementation plan	Combined Risk Assessment and SSKIN* bundle will support identification and preventative intervention will reduce incidence of HAPU	30th April 2020
2. Communication and implementation plan for risk assessment booklet will include corporate nursing team for e.g. Tissue Viability team, QI team supporting the wards during implementation and signposting to developed resources	For staff to be aware and knowledgeable of the risk assessment tool, care plan and SSKIN bundle	30th April 2020

***SSKIN** = **S**urface, **S**kin inspection, **K**eep moving, **I**ncontinence/moisture, **N**utrition

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DFM024	Number of new never events	Deborah Carter	0	AP039	0	Feb-20	0	➡	1st	0	0	0	0	-	0	0	1	-	1	1	1	-	0	0		-

Details on never events:

There were no new Never Events reported for the month of January & February.

Currently the Health Board have 3 Never Events open and under investigation:

1) A Retained foreign object post – operation. Reported 23/10/2019 – A serious incident review has been undertaken, chaired by the Hospital Medical Director and supported by the Head of Patient Safety. Report has been completed and a closure form for Welsh Government is being drafted.

2) Retained foreign object post – operation. Reported 21/11/2019 – A rapid review has been undertaken. An investigating officer has been appointed and the investigation commenced.

3) Wrong site surgery – Reported 17/12/2019 – A review has been undertaken and the report is currently being drafted.

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DFM027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	David Fearnley	>= 95%	AP039	>= 95%	Jan-20	96.80%	⬆	2nd	82.70%	92.10%	95.80%	96.70%	-	90.50%	91.70%	90.50%	-	89.60%	91.20%	92.80%	-	96.80%			
DFM028	Crude hospital mortality rate (74 years of age or less)	David Fearnley	Reduce	AP039	<= 0.70%	Dec-19	0.80%	⬇	4th	0.77%	0.73%	0.83%	0.76%	-	0.74%	0.71%	0.75%	-	0.80%	0.79%	0.80%	-				-

Universal Mortality Reviews carried out within 28 Days of Death
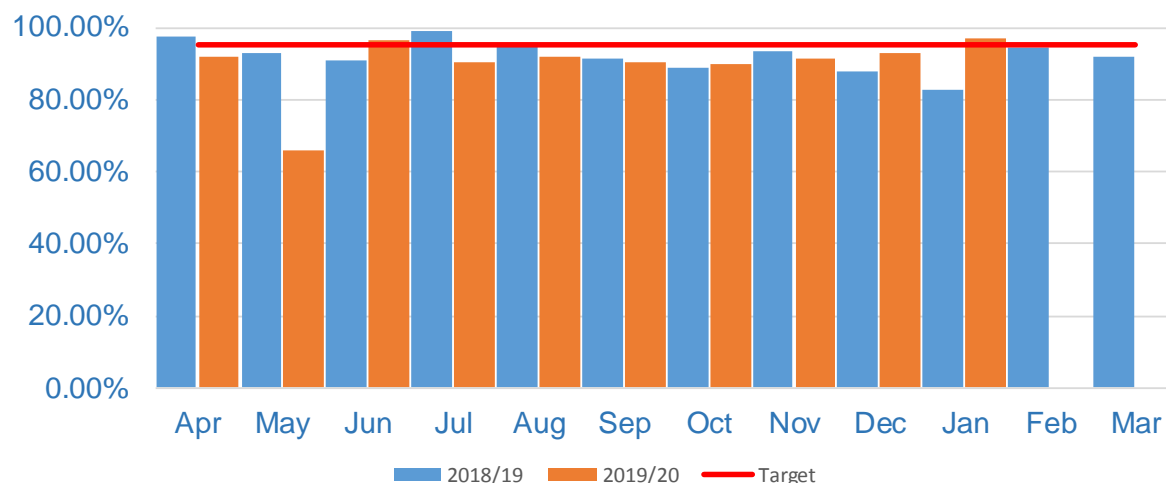
Crude Mortality Rates: 74 years of age and under
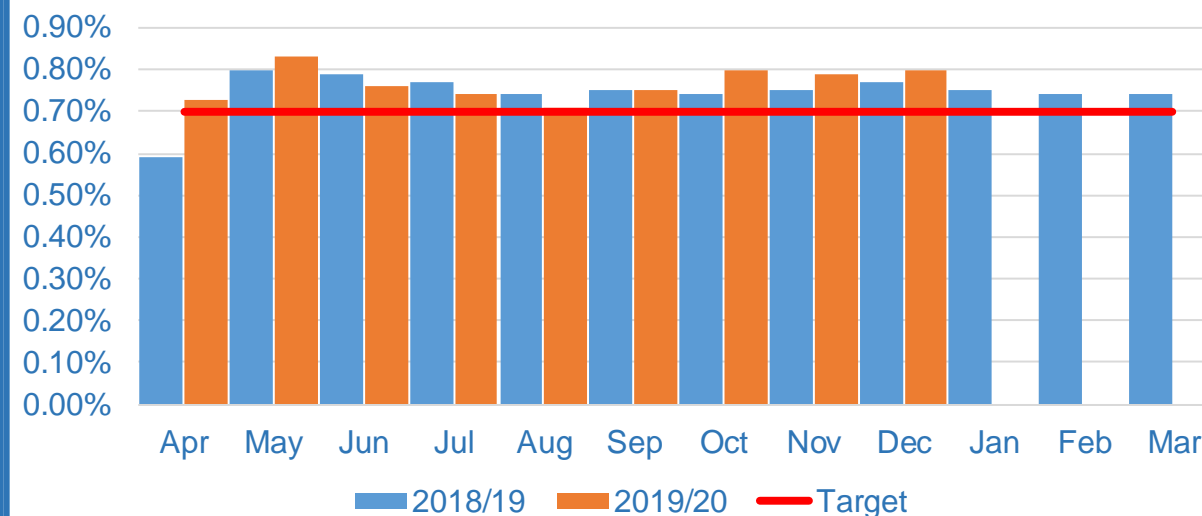
Why we are where we are: Unchanged from last months report, Crude mortality rate is a stable process with no special cause variation to suggest concern. Universal Mortality review (UMR) performance has improved and is now above target. Actions previously reported, are in progress.

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Actions	Outcomes	Timeline
1. Reduction in mortality through focussed improvement collaborative for Sepsis identified at the acute site Emergency Departments.	• Improved compliance with sepsis six bundle. • Downward shift in sepsis associated mortality.	31st Oct 2020
2. Reduction in mortality through focussed improvement collaborative on Acute Kidney Injury (AKI) arising in primary care.	• All GPs complete Quality Improvement Training to at least "Bronze" level - 1 year. • Relevant Metrics established 6 - 12 months. • Engagement framework developed 6 months. • At risk population identified and testing commenced on first step interventions 6 months. • Impact on AKI associated admissions and mortality expected to reduce over a 2 year period.	31st October 2021
3. Mortality systems review with secondary care, to ensure alignment of process with strategic intent.	• SBAR completed and meeting arranged with secondary care. • Agree, Design and Implement over 6 - 12 months. • DATIX system implemented across all areas. • Achieve 95% target for UMR (universal mortality reviews). • Achieve review of all deaths within 6 weeks. • Readiness of systems to receive referrals from Medical Examiners.	31st Oct 2020
4. Develop Learning From Deaths (LFD) policy and take through consultation and approval process.	• Support consistent process through policy, to improve outcomes.	30th Sep 2020
5. Extend systematic mortality review, in readiness for Medical Examiners.	• All apply processes consistent with LFD policy. • DATIX mortality review system established for all.	31st Oct 2021

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

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DFM038	Number of procedures postponed either on the day or the day before for specified non-clinical reasons (Rolling 12 Months)	David Fearnley	Reduce	AP025	Reduce	Dec-19	2,292	⬇	3rd	2,796	2,242	ND	ND	-	2,236	2,227	2,239	-	ND	2,277	2,292					-

Number of procedures postponed either on the day or the day before for specified non-clinical reasons (rolling 12 months)

Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
2570	2508	2281	2242			2236	2227	2239		2277	2292

■ Rolling 12 month

Number of procedures postponed either on the day or the day before for specified non-clinical reasons (month breakdown)

■ 2017/18 ■ 2018/19 ■ 2019/20

Why we are where we are: The organisation is still reporting a significant number of postponed procedures, this leads to poor patient satisfaction, increased waiting times and loss of activity within theatres. The operating theatre is one of the most expensive organisational assets to run both in pay and non-pay, its effectiveness is critical to good patient outcomes and financial viability.

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Background

Postponed procedures reported relate to procedures cancelled on the day of or day prior to surgery for non-clinical reasons. This is a sub-set of all postponed procedures which are made up of both patient and hospital cancellations, with hospital cancellations split into non-clinical and clinical reasons.

Analysis

Cancellations at short notice for non-clinical reasons account for c38% of all cancellations:

Short Notice Cancellations as a % of Total	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
WEST	37.26%	36.11%	35.06%	36.66%	38.42%	33.22%	37.13%
CENTRAL	33.33%	32.45%	35.26%	37.85%	35.04%	36.29%	41.30%
EAST	40.87%	38.21%	42.20%	40.48%	41.66%	40.70%	37.38%

The reasons for these cancellations are classified as:
 Administrative Error, Clinical Staff Unavailable, Emergency Admission, Equipment Unavailable, ITU/HDU bed unavailable, Ward bed unavailable, and Other-non clinical.
Some cancellations are unavoidable, however wherever possible cancellations should be avoided as they represent a poor patient experience and an inefficient use of resource especially where cancellation happens at short notice.
The highest volume of cancellations at short notice arise from clinical staff unavailability.
There is a seasonal pattern to cancellations due to bed availability with slightly higher level of cancellations in the winter months. Cancellations due to emergency surgery is rising, with the highest volume of these recorded in the East. While the overall pattern over time is relatively static the picture demonstrates opportunity for improvement, with this work being under the remit of the Planned Care Improvement Group.

Total non clinical cancellations by reason 1.4.18-31.12.19.

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Actions	Outcomes	Timeline
1. Planned care capacity planning is on-going, within this work will be establishing how to improve theatre efficiency beyond the work to date.	By identifying the areas of service improvement, a focus at speciality level will be identified for each site. A programme of work will then be established to improve at specialty and theatre level.	Qtr. 1 2020
2. Further analytical support is being requested.	A business analyst for planned care is being requested to help understand the data and provide improved information for each site.	Qtr.1 2020

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WGM001	Ward Staff Fill Rate Percentage	Deborah Carter	>= 95%	NIP	AP	Jan-20	82.00%	↓	N/A	88.00%	85.00%	86.00%	86.00%	-	85.00%	84.00%	86.00%	-	87.00%	86.00%	86.00%	-	82.00%			-
WGM002	Ward Staff Skill Mix Ratio of Registered v Non-Registered Percentage	Deborah Carter	>= 60%	NIP	AP	Jan-20	56.00%	→	N/A	55.00%	55.00%	55.00%	55.00%	-	55.00%	55.00%	55.00%	-	56.00%	56.00%	56.00%	-	56.00%			-

Ward Staffing Levels Fill Rate (Medical & Surgical Acute)
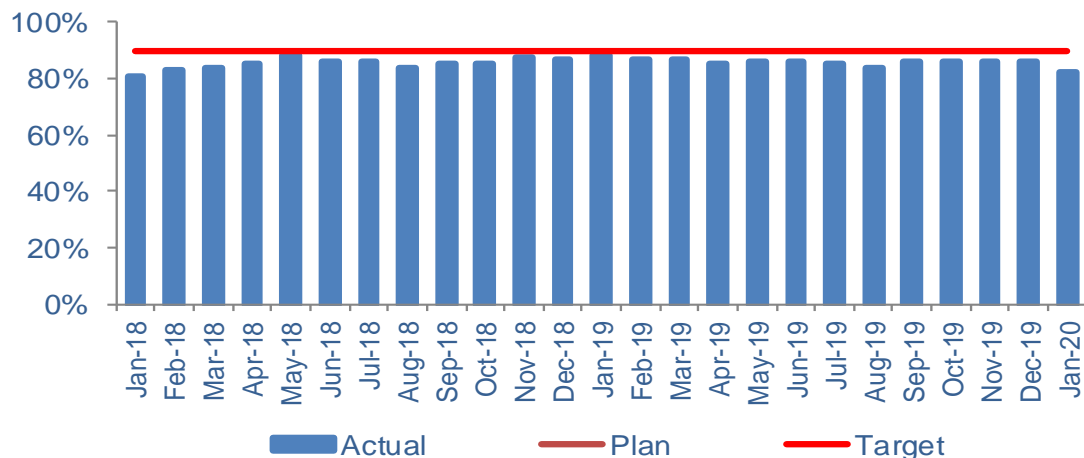
Ward Staffing Skill Mix Ratio Registered : Unregistered (Medical & Surgical Acute)
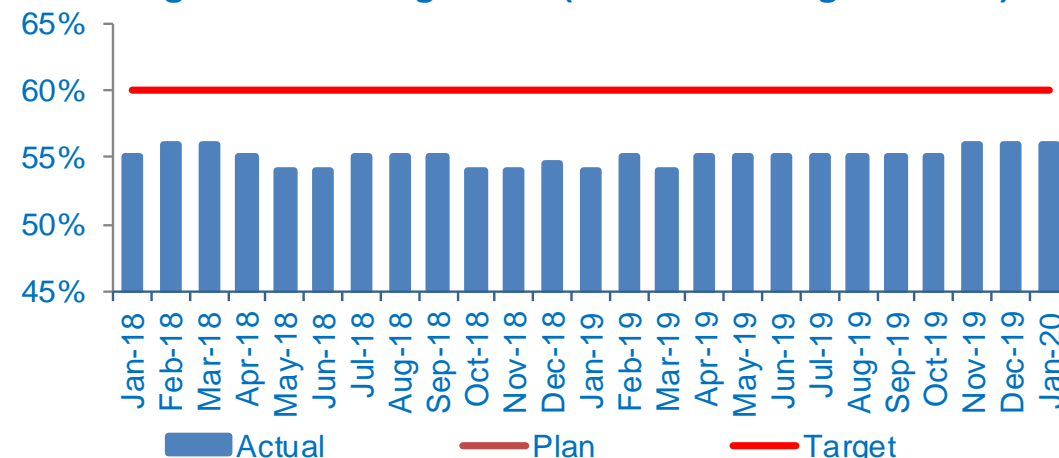
Why we are where we are: Current levels due to significant vacancies across the Health Board. Vacancy pressures are not unique to BCUHB and other Health Boards in Wales as well as comparative organisations in England are reporting these pressures as cited in a number of forums: Buchan, J. Charlesworth, A. Gershlick, B. Seccombe, I. (2019). A critical moment: NHS Staffing trends, retention and attrition. The Health Foundation.

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Actions	Outcomes	Timeline
1. Triangulated establishment reviews following recent national Acuity audit.	1. Ensure establishments are in line with demand, acuity and professional judgement. 2. Accurate reporting to the Health Board.	May 2020
2. Revision of Terms of Reference for the Secondary Care overarching Recruitment and Retention Group.	1. Work plans to be reviewed in line with Health Board Recruitment and Retention strategy. 2. Review and action planning regards lessons learned. 3. Identify targeted recruitment/retention issues. 4. Initiation of workforce clinics.	April 2020
3. Review of rostering effectiveness to ensure optimal staff deployment.	1. Roster review meetings monthly supported by Insight data analysis. 2. Targeted roster support as identified. 3. Sharing of lessons learned and best practice findings.	February 2020

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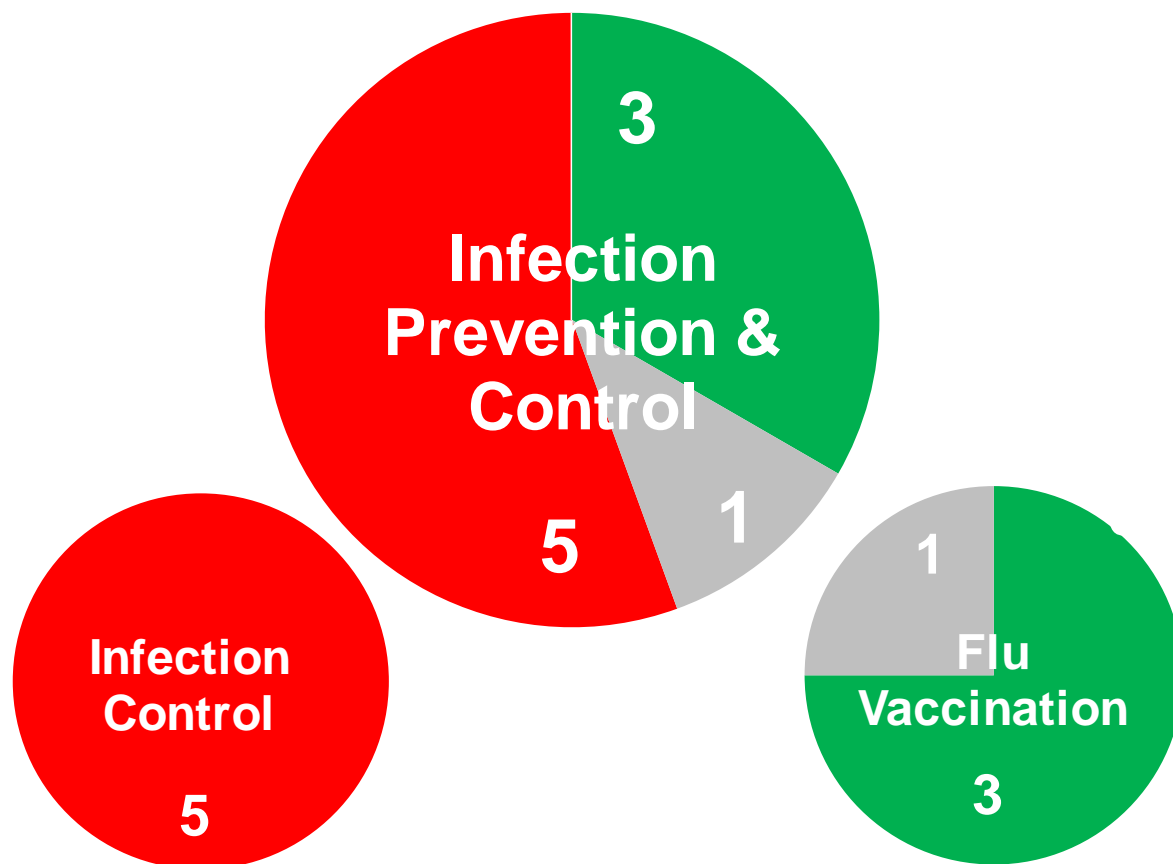
Code	Measure	Status		Annual Plan Profile	National Target
DFM021a	Cumulative Rate: E.Coli	83.86	⬆	<= 67	<= 67
DFM021b	Cumulative Rate: S.Aureus	29.89	⬇	<= 20	<= 20
DFM021c	Cumulative Rate: C.Difficile	26.82	⬆	<= 22	<= 22.13
DFM021d	Cummulative Number: Klebsiella sp	123	⬇	<= 88	<= 106
DFM021e	Cumulative Number: P.aeruginosa	35	⬇	<= 21	<= 27
DFM005a	Flu Vaccination: 65's and Over	70.50%	⬆	>= 65%	>= 75%
DFM005b	Flu Vaccination: Under 65's at Risk	45.00%	⬆	>= 40%	>= 55%
DFM005c	Flu Vaccination: Pregnant Women				
DFM005d	Flu Vaccination: Health Care Workers	54.60%	⬆	>= 40%	>= 60%

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DFM021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	Deborah Carter	<= 67	AP039	<= 67	Jan-20	83.86	⬆	3rd	82.91	97.85	83.59	88.38	-	83.77	85.63	83.39		83.04	83.11	85.52		83.86			
DFM021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	Deborah Carter	<= 20	AP039	<= 20	Jan-20	29.89	⬇	4th	23.47	26.21	27.57	29.29	-	28.35	27.75	29.13		29.31	29.13	29.46		29.89			
LM021b1	Cumulative Number of laboratory confirmed MRSA cases	Deborah Carter	0	AP039	0	Jan-20	7	➡	N/A	13	1	2	4		6	6	6		6	6	7		7			
LM021b2	Cumulative Number of laboratory confirmed MSSA cases	Deborah Carter	<= 139	AP039	<= 114	Jan-20	168	⬇	N/A	122	14	31	49		63	75	96		114	130	148		168			
DFM021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	Deborah Carter	<= 22.13	AP039	<= 22	Jan-20	26.82	⬆	3rd	25.53	19.22	21.54	25.42	-	24.06	25.69	27.99		29.31	28.49	28.51		26.82			
LM021c	Cumulative Number of laboratory confirmed C.difficile cases	Deborah Carter	<= 153	AP039	<= 126	Jan-20	157	⬇	N/A	0	11	25	44		56	74	98		120	133	150		157			
DFM021d	Cumulative Number of laboratory confirmed Klebsiela cases per 100,000 population	Deborah Carter	<= 106	AP039	<= 88	Jan-20	123	⬇	5th	New 19/20	13	18	29		43	59	74		89	99	113		123			
DFM021e	Cumulative Number of laboratory confirmed Aeruginosa cases per 100,000 population	Deborah Carter	<= 27	AP039	<= 21	Jan-20	35	⬇	5th	New 19/20	1	3	6		11	13	19		24	27	31		35			

Why we are where we are: The infection numbers for January 2020 continued to fluctuate in relation to the previous 10 months. This is expected variation. January 2020 saw a rise in MSSA infections but all the others remained stable or decreased as seen in further narrative. As with the majority of other Health Boards, BCU will not achieve the trajectories for 2019/20, however it should be noted that all infections, Unavoidable, Contaminant and Avoidable are included in the numbers.

Infection numbers in Central Health Community continue to be the highest at 41% compared to East 37% and West 23%. The additional Infection Prevention and Antimicrobial Stewardship resource continues to support preventative measures. The work to drive down avoidable infections continues. It must be noted that East are under trajectory for all but 1 of the organisms, with Central and West over on all. It is important to note the majority of the 79 infections for January were deemed as unavoidable, 71%, and 70% were community onset with a reduction to 7.5% from care homes, this is an improvement.

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Clostridium difficile per 100,000 population

MSSA per 100,000 population

Klebsiella sp. per 100,000 population

MRSA per 100,000 population

Escherichia coli per 100,000 population

Pseudomonas aeruginosa per 100,000 population

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Actions	Outcomes	Timeline
1. Continue with the weekly analysis and trends which includes every infection within the 6 trajectory organisms.	Post Infection Reviews and completion of the deep dive analysis continues to give us the detail in which we can implement the necessary changes to continue to decrease any avoidable infections. For Q4 and beyond we need to concentrate our efforts on an uninterrupted HPV programme and a "Catheter Amnesty" to reduce unnecessary urinary catheters, a common theme for Blood Stream Infections. Work needs to be considered with the Continence Service and Quality Improvement to implement a Trail Without Catheter (TWOC) initiative and review of all devices to remove where possible, including urinary catheters.	Review end of March 2020
2. Antimicrobial stewardship is discussed with antimicrobial pharmacy colleagues and relevant clinicians were this is thought to be the root cause of infection. The report from Welsh Government shows significant resistance to key antibiotics in BCUHB.	Antimicrobial stewardship in the community setting is crucial in reducing the incidence of multi resistant organisms, particularly e Coli/gram negative infections which are on the increase. This is crucial in the Central Health Economy which continues to have the most numbers of infections which are Community Onset and the most overall. This is reliant on appropriate resource and thorough analysis or resistance patterns across the Health Board. Considering that 71% of infections overall are UNAVOIDABLE, and 70% are Community Onset the Quality Improvement work needs to concentrate on where a difference can be made as above.	Review end of March 2020
3. Increase the visibility of the IP team and senior clinicians in terms of quality support visits, and introduction of the Link Practitioner programme.	Educational event took place on 6th December 2019. Timely support and actions to respond to any IPC gaps in practice, cleaning and the environment via Link communications and meetings. We experienced a high amount of activity in Q3 overlapping with activity for Preparedness for COVID 19 throughout January 2020. January continued to see positive Flu, RSV and Norovirus in addition to the other infections.	Review end of March 2020

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Chart1. Betsi Cadwaladr UHB monthly numbers of C. difficile by location type, Apr 10 to Oct 19

Number of non-inpatient specimens ■ Number of inpatient specimens ■ Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Oct 19

■ Rate/1,000 admissions ■ 12 month rolling rate/1,000 admissions

Chart1. Betsi Cadwaladr UHB monthly numbers of E. coli bacteraemia by location type, Apr 10 to Oct 19

Number of non-inpatient specimens ■ Number of inpatient specimens ■ Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of E. coli bacteraemia per 1,000 hospital admissions, A... 10 to Oct 19

■ Rate/1,000 admissions ■ 12 month rolling rate/1,000 admissions

Clostridium difficile (CDI)

The Health Board will not achieve the 2019/20 trajectory for Clostridium Difficile infection (CDI) with 157 infections to end of January 2020 and a trajectory of 153. This is 12% less (19) than the target last year due to good reduction in 2018/19. In addition new molecular testing increases findings by 1-2%.

The IP team continue to follow up all CDI cases for a minimum of 4 weeks. There is also a significant amount of work ongoing with genotyping and the cluster of patients receiving chemotherapy that develop CDI.

It should be noted that in January 2020 saw the lowest numbers of CDI since February 2019 with a reported position of 8.
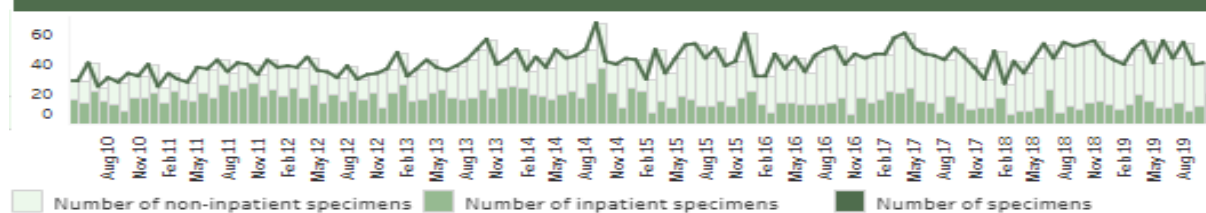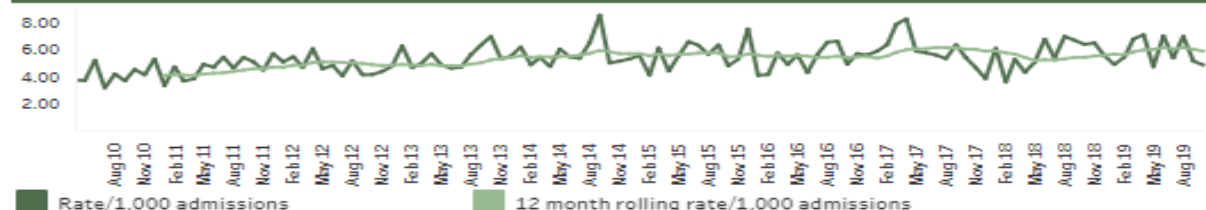
Escherichia coli

The Health Board will not achieve the 2019/20 trajectory for E. coli Blood Stream Infections (BSIs) with 491 infections to end of January and a trajectory of 467.

The majority of these are related to UTIs and many resistant to oral antimicrobials. These do not appear to be Catheter Device related. However the majority are Community onset as can be seen from the graph above.

For January 2020 numbers decreased and were at the lowest level seen since May 2019.

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Chart1. Betsi Cadwaladr UHB monthly numbers of MRSA bacteraemia by location type, Apr 10 to Oct 19

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart1. Betsi Cadwaladr UHB monthly numbers of MSSA bacteraemia by location type, Apr 10 to Oct 19

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of MRSA bacteraemia per 1,000 hospital admissions, A ... 10 to Oct 19

Rate/1,000 admissions   12 month rolling rate/1,000 admissions

Chart 2. Betsi Cadwaladr UHB monthly rates of MSSA bacteraemia per 1,000 hospital admissions, A ... 10 to Oct 19

Rate/1,000 admissions   12 month rolling rate/1,000 admissions

MRSA bacteraemia

Numbers continue to decrease, however the trajectory is zero and to date the health Board has had 7. All have been in males over 65 years of age, 50% were from care homes and all had been in hospital or had heath care intervention from a urology/device perspective.

Q4 needs us to concentrate on a "catheter amnesty" for removal, including access to swift TURP were surgery is a recommendation, TWOC services, consideration of Intermittent catheterisation, continence assessment for other products, supra pubic catheters for long term male catheterisation and a further in-patient and community snap shot. This is likely to be undertaken from now until the end of Qtr. 1 2020/21.
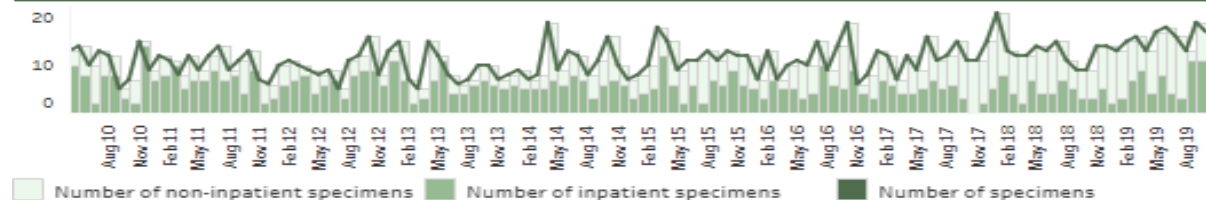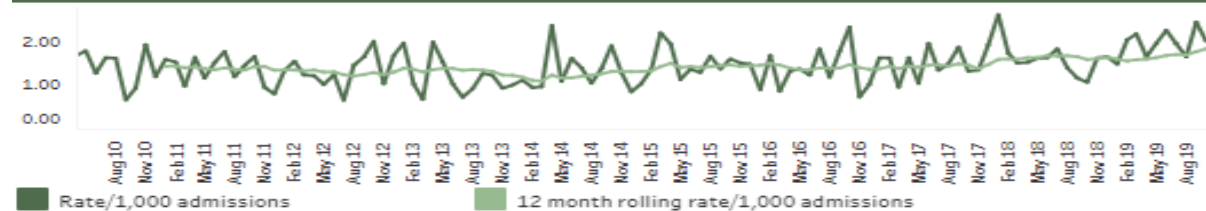
MSSA bacteraemia

MSSA infections are a concern and the Health Board will not achieve the trajectory of 139 with 168 infections to date.

The majority are community onset and again highest in Central. However the majority are unavoidable.

In terms of trends there appears to be a relation to skin breaches, wounds and lines, wound care and tissue viability antimicrobial stewardship are being considered by IP.

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Chart1. Betsi Cadwaladr UHB monthly numbers of Klebsiella sp bacteraemia by location type, Apr 10 to Oct 19

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart1. Betsi Cadwaladr UHB monthly numbers of P. aeruginosa bacteraemia by location type, Apr 10 to Oct 19

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to Oct 19

Rate/1,000 admissions   12 month rolling rate/1,000 admissions

Chart 2. Betsi Cadwaladr UHB monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to Oct 19

Rate/1,000 admissions   12 month rolling rate/1,000 admissions

Klebsiella sp. bacteraemia

The Health Board will not achieve the trajectory of 106 with 123 to date. The majority of these are in the East. East also have the highest numbers of devices which is being considered and reviewed along with the work around urinary catheters.

Overall Klebsiella infections have decreased since August 2019. In January 2020 less than 10% of infections were hospital onset, and again this is related to community onset cases were there may be NO healthcare intervention. All Klebsiella infections in East now have a full post Infection review.
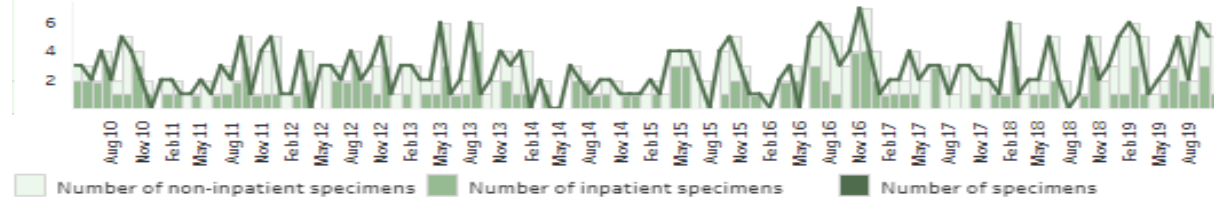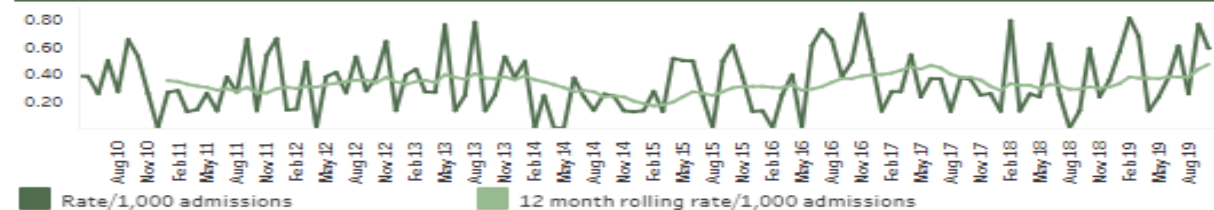
Pseudomonas aeruginosa bacteraemia

None of these infections are related to water but will not achieve trajectory of 27 with 35 to date. West has the highest numbers and resistance patterns and all infections now have a full Post Infection review carried out.

Pseudomonas infections have decreased since the peak seen in September 2019.

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DFM005a	Uptake of the influenza vaccination among: a. 65 year olds and over	Teresa Owen	>= 75%	AP007	>= 65%	Jan-20	70.50%	⬆	1st	68.00%	-	-	-		-	-	N/D		53.90%	65.90%	69.10%		70.50%			
DFM005b	Uptake of the influenza vaccination among: b. Under 65s in risk groups	Teresa Owen	>= 55%	AP007	>= 40%	Jan-20	45.00%	⬆	1st	43.80%	-	-	-		-	-	N/D		19.80%	36.00%	42.40%		45.00%			
DFM005c	Uptake of the influenza vaccination among: c. Pregnant women	Teresa Owen	>= 75%	AP007	N/A	Mar-20				88.20%	-	-	-		-	-	-		-	-	-		-			
DFM005d	Uptake of the influenza vaccination among: d. Health care workers	Teresa Owen	>= 60%	AP007	>= 40%	Jan-20	54.60%	⬆	5th	41.05%	-	-	-		-	-	N/D		41.06%	51.40%	54.54%		54.60%			-

Influenza Vaccination Uptake for Over 65's and Under 65's at Risk - 31st December 2019

Health Board	Patients aged 65 Years and Older				Patients Aged 6m to 64y at Risk			
	Inmmunised	Population	Uptake %	Rank	Immunised	Population	Uptake %	Rank
Aneurin Bevan	85,872	125,304	68.50%	3rd	35,120	84,900	41.40%	3rd
Betsi Cadwaladr	113,910	164,748	69.10%	1st	38,499	90,777	42.40%	1st
Cardiff & Vale	57,260	83,374	68.70%	2nd	25,413	63,989	39.70%	4th
Cwm Taf Morgannwg	6,226	93,933	66.20%	4th	24,191	67,408	35.90%	7th
Hywel Dda	61,052	97,636	62.50%	6th	18,444	50,333	36.60%	6th
Powys	24,807	37,881	65.50%	5th	6,895	16,581	41.60%	2nd
Swansea Bay	53,777	81,256	66.20%	4th	20,771	52,926	39.20%	5th
Wales	**458,904**	**684,132**	**67.10%**	**-**	**169,333**	**426,914**	**39.70%**	**-**

Source: Public Health Wales - National Influenza Immunisation Summary Update 12 ((02 01 2020)

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Why we are where we are:

- We are coming to the end of the active vaccination period which will conclude on 31st March 2020. Currently, BCUHB has achieved the same uptake as last year for those people aged 65 years and over at 71%. However we have vaccinated more people than ever before as the numbers of elderly people are increasing by 2-3% annually.
- 65 years and over - since last year an additional 4,551 people have become eligible and an additional 3,304 people have been vaccinated.
- 6 months to 64 years with an at risk condition - an additional 1,969 people have become eligible and an additional 3,002 have been vaccinated
- The Point of Delivery Audit for pregnant women was conducted in the three main maternity units in early January 2020 – uptake data awaited

Actions	Outcomes	Timeline
1. Circulate vaccine uptake data to the Areas, Clusters and GP practices.	Maximise uptake in all the eligible groups to reduce variation in uptake.	To continue until 31st March 2020
2. Contact lower uptake GP practices to raises awareness of lower uptake.	Identify any technical issue in data submission.	To continue until 31st March 2020
3. Summarise the feedback from the Flu debrief held on 24th February 2020.	To aid early planning to take forward new ideas and innovative working for the 200-21 campaign.	31st March 2020
4. Encourage GP practices to hold a flu debrief to evaluate their campaign.	Early planning for 2020-21 campaign.	30th June 2020
5. Remind pharmacies and district nurses and nursing homes to ensure all immunisation data is submitted to the patient's GP practice.	Ensure data accuracy.	31st March 2020

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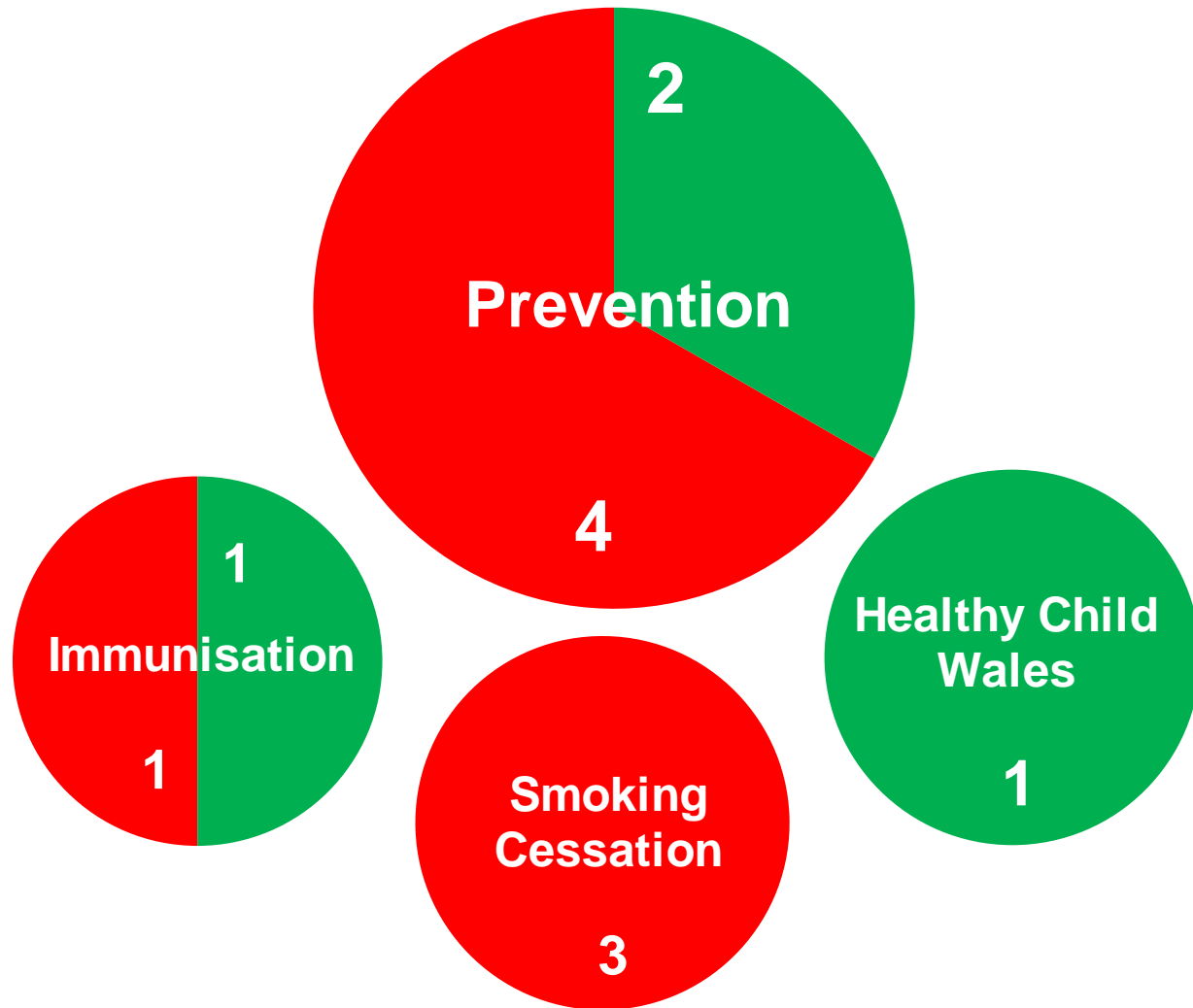
Code	Measure	Status	Annual Plan Profile	National Target
DFM001	Smoking Cessation: Pregnant Women	10.70% ↑	Improve	Improve
DFM002	Immunisation: 3 doses of 6 in 1	95.30% ↓	>= 95%	>= 95%
DFM003	Immunisation: 2 doses of MMR	93.60% ↓	>= 95%	>= 95%
DFM004	Healthy Child Wales Programme	94.40% ↑	Improve	Improve
DFM006	Smoking Cessation: % Service Use	2.13% ↑	>= 4.1%	>= 5%
DFM007	Smoking Cessation: Validated as Quit	34.70% ↓	>= 38.7%	>= 40%

Due to capacity being diverted to the management of COVID 19, there is a delay with some Public Health Wales data. At the time of the report Q3 data is unavailable for DFM002 and DFM003

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DFM006	The percentage of adult smokers who make a quit attempt via smoking cessation services	Teresa Owen	>= 5%	AP001	>= 4.1%	Qtr 2 19/20	2.13%	↑	N/A	0.97%				1.26%				2.13%								
DFM007	The percentage of those smokers who are CO-validated as quit at 4 weeks	Teresa Owen	>= 40%	AP001	>= 38.7%	Qtr 2 19/20	34.52%	↓	N/A	41.00%				35.00%				34.70%								

Why we are where we are: The service integration paper has been written and requires a business case to support the implementation. Efficiencies and leadership identified through the integration of services will show an improvement in outcomes.

Actions	Outcomes	Timeline
1. Business case to be written with a proposed change to service delivery and leadership of the various teams.	Provides an opportunity to identify economies of scale between the various teams to increase the referrals and quit rates.	Business case for submission in Qtr. 1 2020
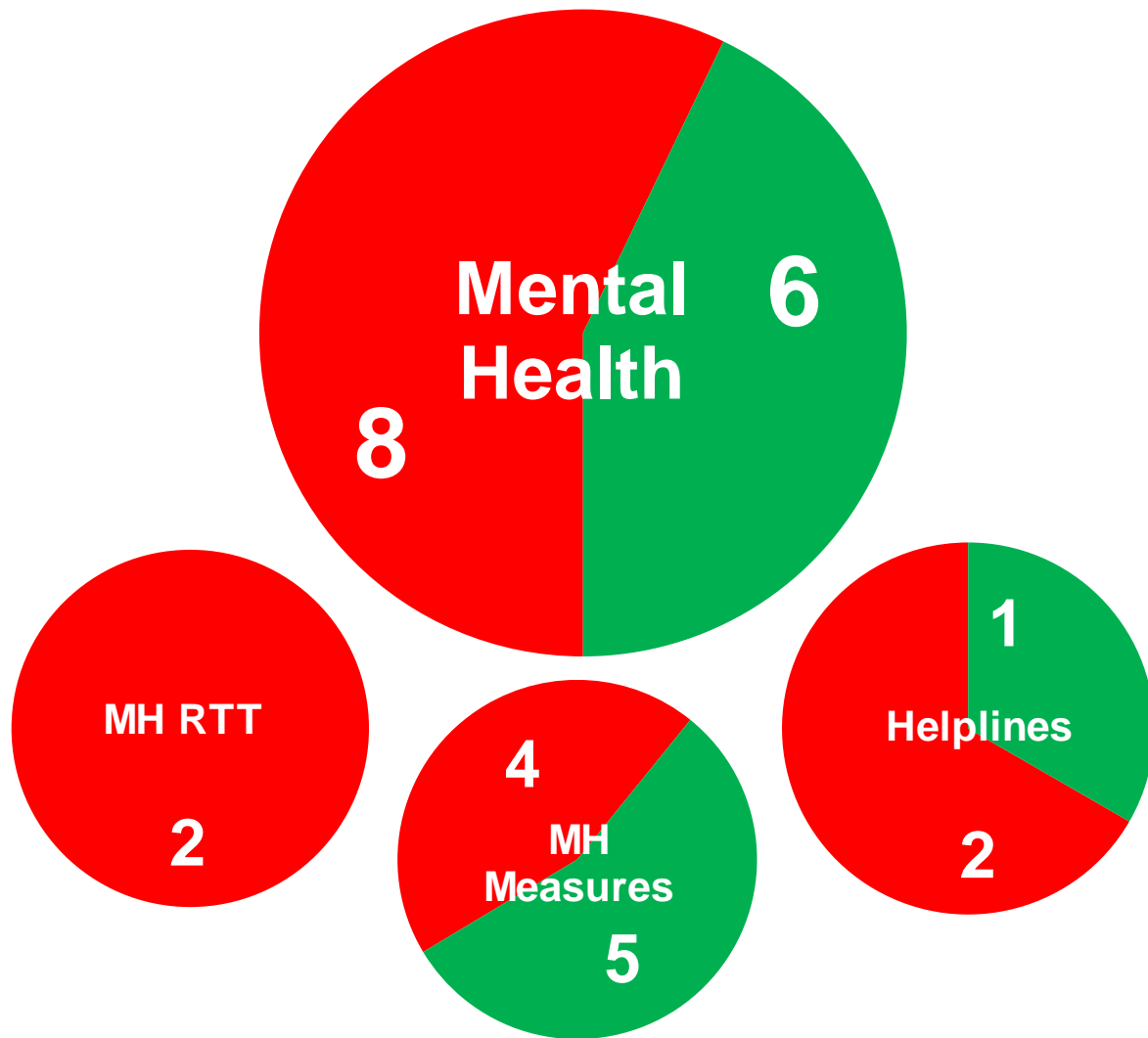
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Mental Health

Code	Measure	Status		Annual Plan Profile	National Target
DFM058	26 Week Wait: Adult Specialist Mental Health Psychological Therapy	21.47%	⬇	AP	>= 80%
DFM059	26 week Wait: Children and Young People Neurodevelopment Assessment	26.03%	⬆	AP	>= 80%
DFM060	MHM1a - Assessments within 28 Days (Combined)	66.9%	⬇	N/A	>= 80%
DFM061	MHM1b - Therapy within 28 Days (Combined)	61.1%	⬇	N/A	>= 80%
DFM060a	MHM1a - Assessments within 28 Days (Adult)	65.70%	⬇	>= 74%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (Adult)	59.70%	⬇	>= 70%	>= 80%
DFM060b	MHM1a - Assessments within 28 Days (CAMHS)	77.40%	⬇	>= 80%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (CAMHS)	69.40%	⬇	>= 80%	>= 80%
DFM062	MH Independent Mental Health Advocacy (IMHA)	100%	➡	100%	100%
DFM082	MHM2 - Care Treatment Plans (CTP)	92.40%	➡	>= 90%	>= 90%
DFM083	MHM3 - Copy of Agreed plan within 10 Days	100%	➡	100%	100%
DFM079	Helplines: CALL	215.1	⬆	>= 212	Improve
DFM080	Helplines: Dementia	7.7	⬇	>= 9	Improve
DFM081	Helplines: DAN	41.8	⬇	>= 50	Improve

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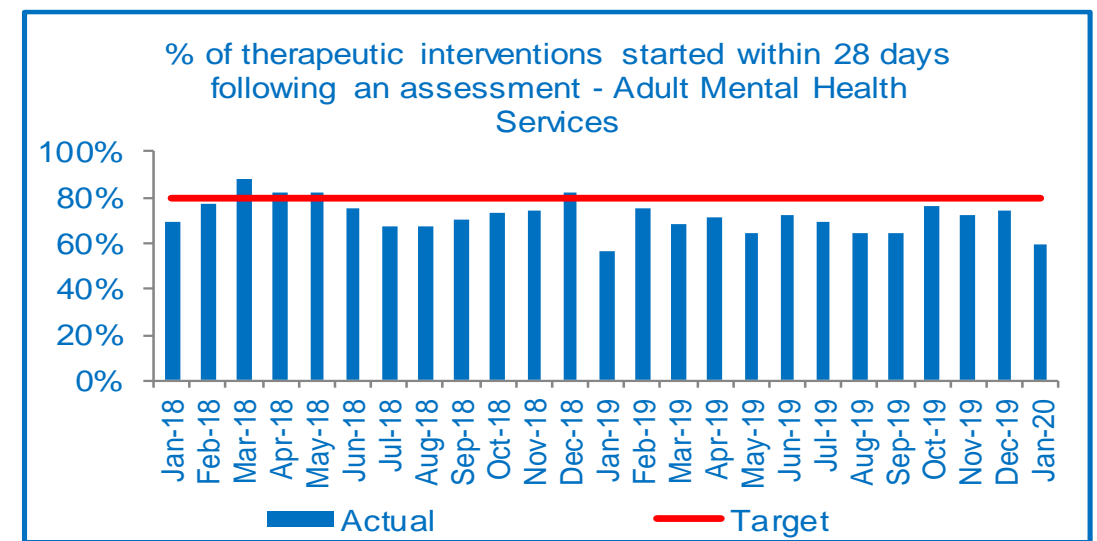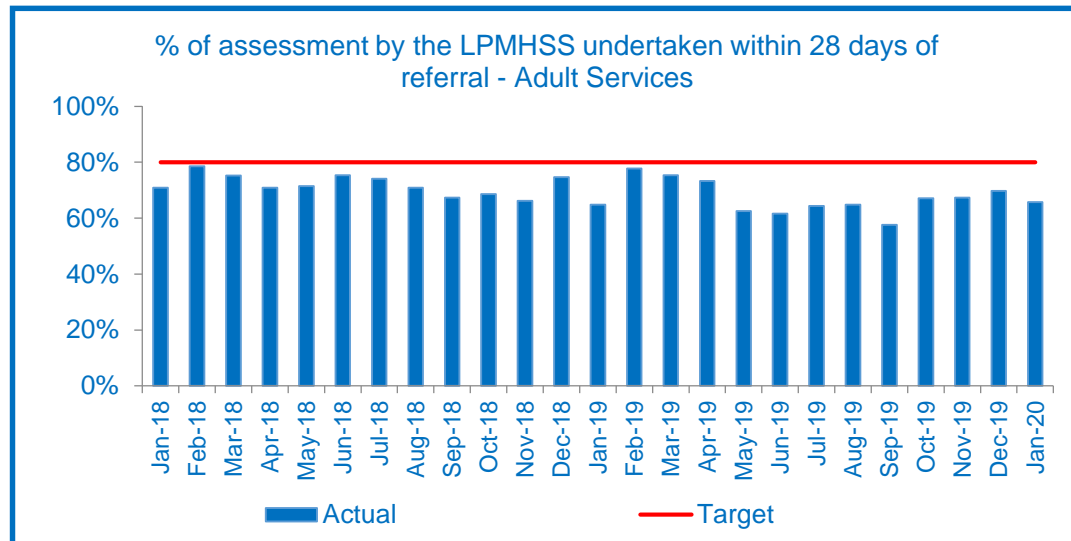**Quality, Safety & Experience Committee Version**

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DFM058	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Andy Roach	>= 80%	NIP	AP	Jan-20	21.47%	⬇	7th	New 19/20	23.56%	22.37%	19.96%	-	19.85%	19.00%	20.21%	-	16.70%	21.27%	25.18%	-	21.47%			

% of patients waiting less than 26 weeks for Psychological Therapy - BCU - January 2020

% of patients waiting less than 26 weeks for Psychological Therapy West January 2020

% of patients waiting less than 26 weeks for Psychological Therapy Centre January 2020

% of patients waiting less than 26 weeks for Psychological Therapy East January 2020
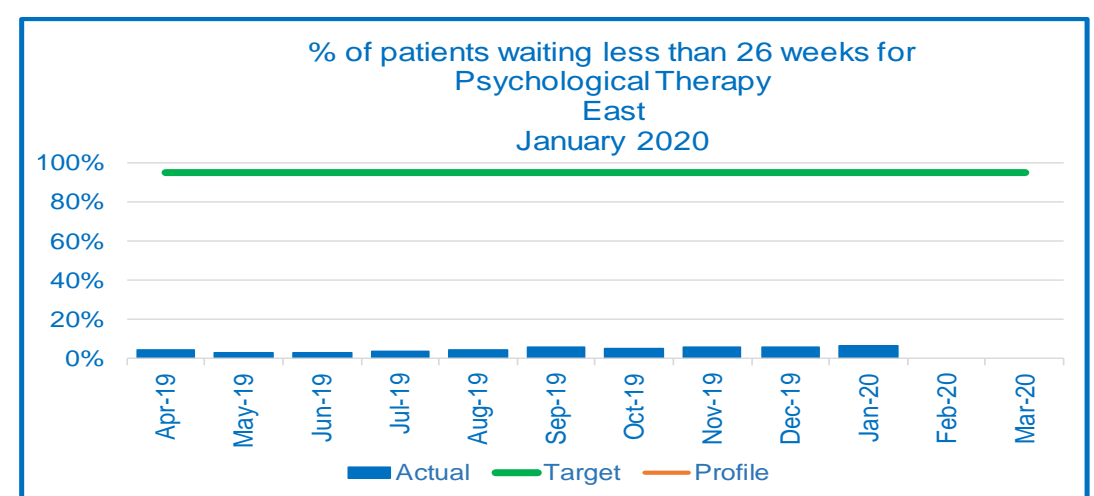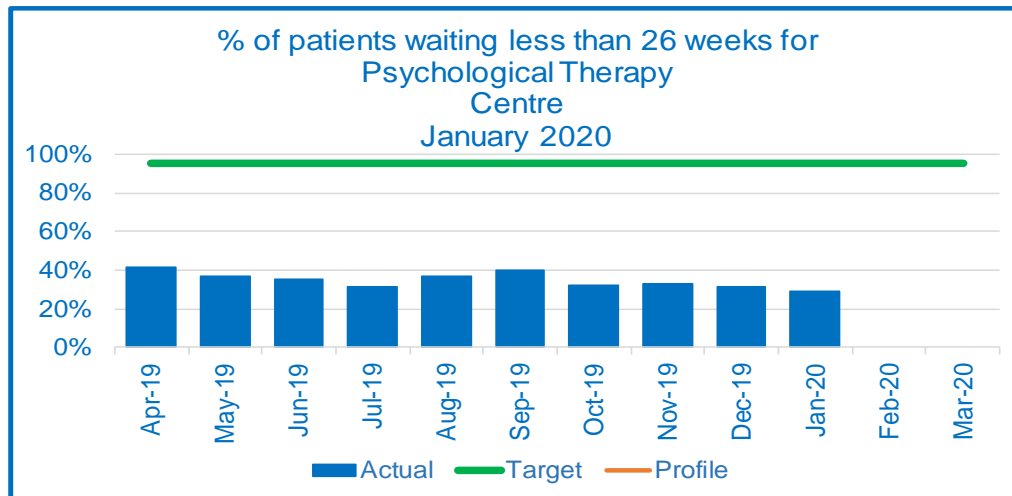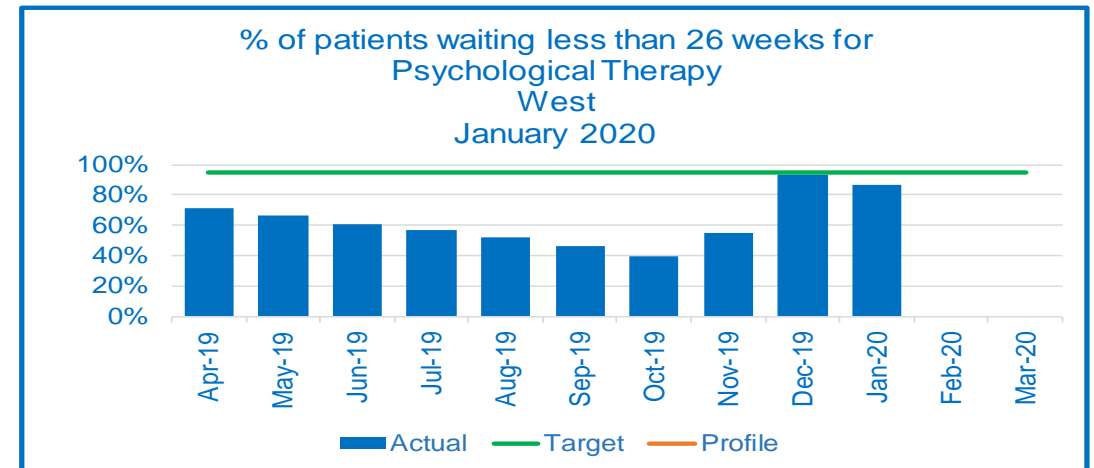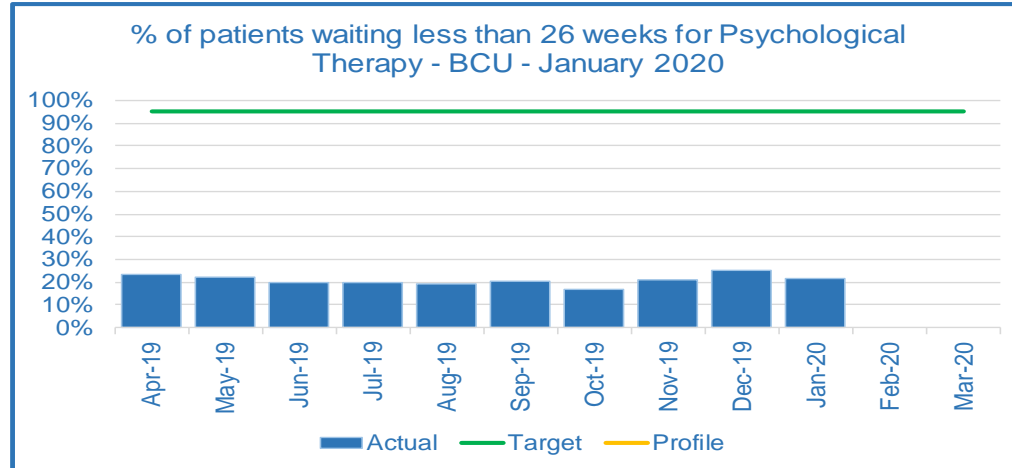
Why we are where we are: Timely access to psychological therapies and interventions is an issue across Wales. The last decade has seen significant increases in demand and public awareness of effectiveness of such interventions. To encourage improvements in access, WG introduced reportable targets in April 2019 for one step in the pathway – 26 week secondary care specialist CMHT level. Despite improvement work, low levels of specialist resource at CMHT level and a lack of NHS infrastructure to support workable multiple stepped care pathways across primary and secondary care means people are waiting too long at the specialist end of the pathway. In February 2020 there are North Wales CMHT areas which are compliant with target but Wrexham and the East remain concerning.

Actions	Outcomes	Timeline
1. Improvement work including review of waiting lists and clinical review of people waiting; prioritisation of people at risk. Flexible utilisation of low resource staff across MDTs, targeting of hotspots.	Analysis of data over the last 2 years indicates the number of people waiting has reduced, with a steady reduction and a marked decline to date. Variances outside of Wrexham due to vacancies.	Ongoing
2. Psychological therapies teaching, supervision, advice and consultation to MDT staff, to ensure wider provision for service users from MDT primary and secondary services so reducing need to step up to specialist.	Multiple CBT & DBT training programmes delivered in the last 2 years. Set up of Psychological Therapies Training Team for systematic provision – fully recruited to Jan 2020. Supported by North Wales PTMC, and national curriculum work.	Review and full programme plan for 2020 - deliver April 2020
3. Recruitment of Stepped Care Psychologist, CBT Therapist and 6 Assistant Psychologists.	Mapping of individual and group interventions across Tier 0, Tier 1, Tier 2, Tier 3, engage staff - developing roadmap, tools, and groups for equity provision across the 6 counties.	Recruited January 2020 Mapping//first phase engagement on ground completed March 2020
4. BCUHB MHLD commissioned external review of psychological therapies 2019.	Six key recommendations given to support improvement work. Recommends WG national stepped care model Matrics Cymru (2018).	BCUHB Report released 24.12.19 BCUHB Workshop 4.2.20 BCUHB Programme Board 24.2.20
5. Five Programme Board work streams.	TOR, working groups, and leads agreed.	30/5/20 first phase, 12 months delivery plan

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GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
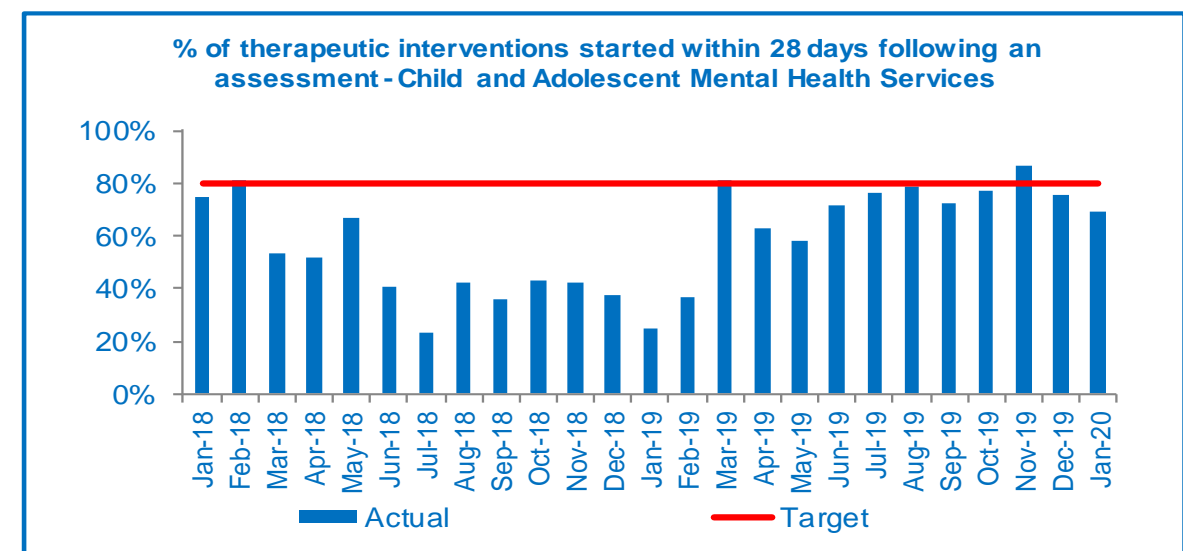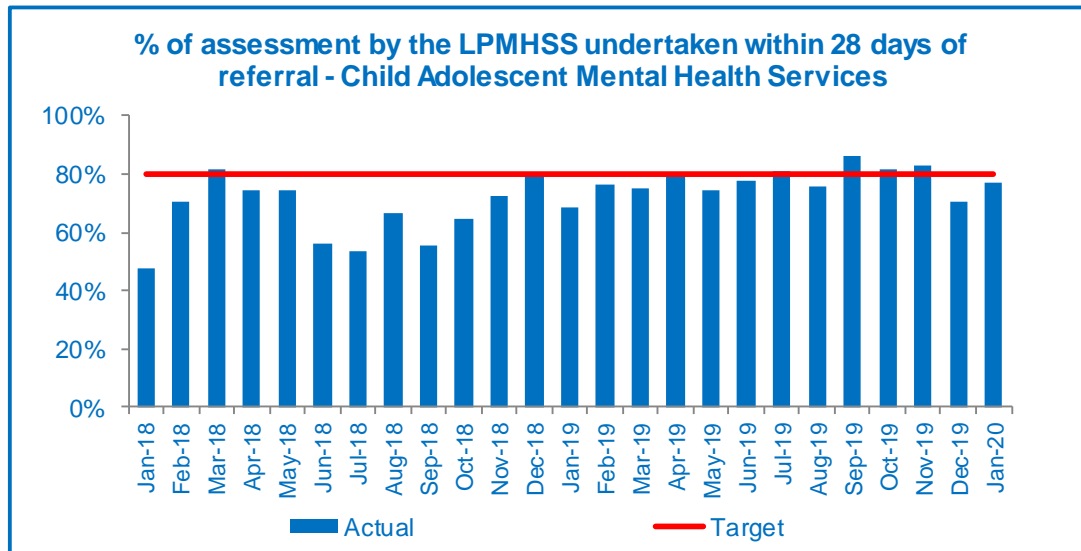
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DFM059	Percentage of children and young people waiting less than 26 weeks to start a neurodevelopment assessment	Chris Stockport	>= 80%	AP005	AP	Jan-20	26.03%	↑	6th	New 19/20	39.34%	39.53%	39.76%	-	40.62%	37.21%	35.55%	-	29.90%	26.84%	25.76%	-	26.03%			-

% of patients waiting less than 26 weeks for Neurodevelopment Assessment December 2019
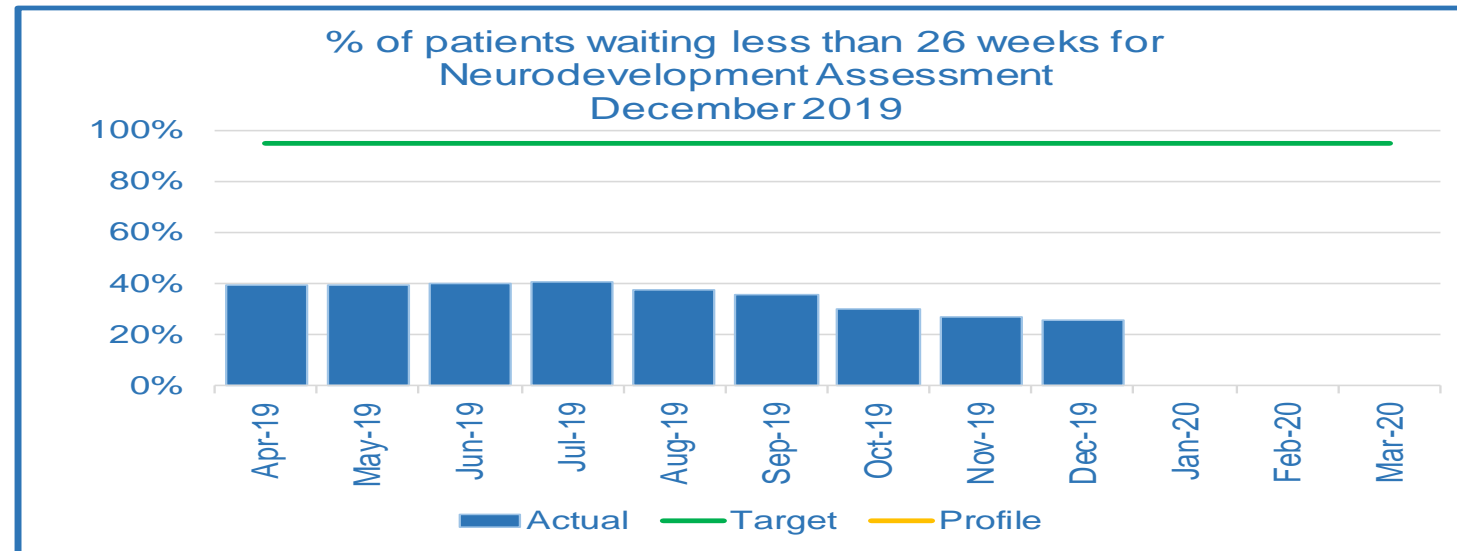
Why we are where we are: Year to date there has been a 30% gap between demand and capacity in the Neurodevelopment (ND) service. The overall waiting list (WL) has grown by 4% whilst the over 26 weeks WL has grown by 15%. This is in part due to teams having to prioritise urgent assessments ahead of those that have waited the longest. Recruitment to full establishment and the recent expansion of capacity is going well with the majority of recruitment occurring in the first round. New starters are likely to be in post from mid March to September, so there will be some delay on impacting the reduction of growth in the WL. Other actions are covered in the summary.

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Actions	Outcomes	Timeline
1. Regional Approach: The three areas have agreed and commissioned a regional approach to delivery and outcomes of the Welsh Government (WG) Funding Granted in Aug 2019	Plan has been reviewed and remains in place Monthly meeting to continue and be reviewed in April 2020.	April 2020
2. Workforce: Recruitment, retention and development	The majority of posts have been filled during the first round of recruitment. Those that weren't have been advertised again. Successful candidates start dates vary from March to September 2020.	Ongoing
3. Waiting List Recovery: Action to reduce current WL	The Tender process for additional ND assessment capacity was completed in February, with the contract to be exchanged in March.	Tender process completed by March. WL reduction from Apr 2020, the providers estimated time to deliver is up to 18 months
4. Model of Working: assurance of universal service offering	Joint training and education completed giving reassurance re model and standard of it application. WG have commissioned the Delivery Unit to provide universal demand and capacity training to all ND services in Wales. BCUHB has been scheduled for this in April 2020.	Reviewed Quarterly from April 2020
5. Working with Partners: Addressing demand expectation and increasing joint working.	Area led engagement with Local Authorities Heads of Service	Quarterly feedback meeting

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LM060a	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Adult)	Andy Roach	>= 80%	AP027	>= 74%	Jan-20	65.70%	⬇	N/A	64.87%	73.26%	62.55%	61.61%	-	64.40%	64.80%	57.61%	-	67.13%	67.33%	69.70%	-	65.70%			-
LM061a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	Andy Roach	>= 80%	AP027	>= 70%	Jan-20	59.70%	⬇	N/A	58.50%	71.22%	64.18%	72.21%	-	69.41%	64.00%	64.51%	-	76.45%	72.21%	74.30%	-	59.70%			-

% of assessment by the LPMHSS undertaken within 28 days of referral - Adult Services

% of therapeutic interventions started within 28 days following an assessment - Adult Mental Health Services

Why we are where we are: Mental Health Recovery Plans for Part 1a and b are in place across all areas with a trajectory for compliance by April 2020. In order to achieve this, out of hour clinics have been established, additional resource secured from Welsh Government monies as part of the waiting list initiative, additional staff employed at Band 6 and Band 3. Service transformation will be supported by a Quality Improvement initiative to commence March 2020 and led by a project team for standardised approach to primary care delivery. While recovery is being delivered the performance is expected to decline as patients in the backlog over 28days are being seen.

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Actions	Outcomes	Timeline
1. Regional Services People in Regional Services are consistently above target for treatment supported by robust monitoring and review processes in place via Operational Delivery meetings.	Monitoring to continue through usual operational process.	Backlog and waiting list trajectory to clear March 2020 – this is already meeting target.
2. West / East / Centre • Recruitment of additional Band 6 staff start mid March 2020 in primary care for Gwynedd and 2 Band 3 staff will be in place Mid March 2020. • Additional clinic capacity in place at weekends for Mon services and 2 Band 3 staff now in place. • Flintshire have become compliant with both Parts of the MHM and this is being monitored through the weekly meeting. • Wrexham's compliance has improved slightly during March and additional evening sessions are being facilitated throughout the month in an effort to clear the waiting list. • Conwy remains non compliant with the MHM and this is monitored through operational meetings.	• Additional capacity for Gwynedd and Mon will address people waiting over 28 days • There are additional assessment and intervention sessions • Reduce by 40 of the 51 people waiting for Part 1b • Monitoring to continue through usual operational process • Monitoring to continue through usual operational process • Monitoring to continue through usual operational process	• Positive impact on Part 1b for Gwynedd - Backlog and waiting list trajectory to clear April 2020 • Positive impact on Part 1b for Mon - Backlog and waiting list trajectory to clear April 2020 • Backlog and waiting list trajectory to clear March 2020 – this is already meeting target • Backlog and waiting list trajectory to clear April 2020 • Backlog and waiting list trajectory to clear March 2020
3. Division-wide Mental Health Measure Leads are now in each of the Area Teams placing greater support to ensuring correct and validated data.	Correct and validated information ensuring Teams are timely informed and engaged and also can implement any remedial actions quickly.	Current and ongoing action - Backlog and waiting list trajectory to clear end of March 2020
4. Division-wide Sustainable delivery of Mental Health Measure performance through greater operational grip and control alongside service transformation.	Routine delivery of target performance across all counties and all areas of the Mental Health Measure.	The solution to target achievement is a complete service transformation through the planned Quality Improvement approach. The training to embed the approach scheduled for March 2020.

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LM060b	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (CAMHS)	Chris Stockport	>= 80%	AP027	>= 80%	Jan-20	77.40%	↑	N/A	50.43%	80.15%	74.74%	78.00%	-	81.20%	75.80%	85.56%	-	81.70%	82.73%	70.70%	-	77.40%			
LM061b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	Chris Stockport	>= 80%	AP027	>= 80%	Jan-20	69.40%	↓	N/A	24.32%	63.24%	58.14%	71.64%	-	76.00%	79.00%	72.92%	-	76.92%	86.80%	75.70%	-	69.40%			-

% of assessment by the LPMHSS undertaken within 28 days of referral - Child Adolescent Mental Health Services

% of therapeutic interventions started within 28 days following an assessment - Child and Adolescent Mental Health Services

Why we are where we are: Assessment and intervention target not achieved for January due to further serious illness and bereavement within the central area team, and an increase in demand in the East. Recruitment to the additional posts is progressing. Central Area has received additional slippage from WG to commission an independent provider to undertake assessments and intervention packages.

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Actions	Outcomes	Timeline
1. Recruitment of staff across teams following successful bid for Mental Health Service Improvement funding including the Cluster posts. All teams are currently going through the recruitment process, some posts have had to be re-advertised.	Development of Early Intervention teams and enhancement of core service to deliver Part 1 targets.	Staff in post February 2020 – April 2020.
2. Bid submitted to WG for additional slippage funding to cover agency costs and to commission independent provider.	Successful, funding awarded. Independent provider commissioned.	End of March 2020
3. Progress the Parliamentary Review Transformation Programmes with our Local Authority partners which is focussed on children and young people who are on the edge of care or looked after and meeting their needs.	Reduction in crisis presentations in ED and admissions to the paediatric wards or attendance at the s136 suites. Reduction in DTOCs on the paediatric wards.	Staff in post March 2020
4. CAMHS Improvement group established with focus on Action plan to be developed for CAMHs services following receipt of final report from Delivery Unit. Report and action plan received by Mental Health Act Committee (MHA) and Board, update on action plan to be provided to MHAC/QSE.	Clarity of Primary/Secondary Care thresholds/improved record keeping/improved communication with GPs/service specification clarity and consistency.	Update to MHAC/QSE by end of March 2020
5. Weekly meetings held across the teams to assess demand and review capacity available in form of core staff availability, additional hours, bank and agency staff. Clinical prioritisation is robust, and alternative provisions to meet the need being established e.g. group interventions.	Understanding of current demands levels and capacity available to meet, identifying any gaps/anticipated breaches.	Ongoing

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

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

Further information on our performance can be found online at:
- Our website   www.pbc.cymru.nhs.uk
       www.bcu.wales.nhs.uk
- Stats Wales   www.statswales.wales.gov.uk

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

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Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Elective Cancellations Briefing Note
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Dr. Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Director of Performance.
Atodiadau **Appendices:**	1) Elective Cancellations update

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to note the additional information provided in the briefing paper.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval *		Ar gyfer Trafodaeth For Discussion*		Ar gyfer sicrwydd For Assurance*		Er gwybodaeth For Information*	⚑

Sefyllfa / Situation:

At the January 2020, Quality, Safety and Experience Committee it was noted that the information in the IQPR did not provide sufficient information to advise the committee of the reasons associated with cancelled procedures. This note aims to expand on the information provided in this month's IQPR report.

Cefndir / Background:

This briefing note addresses QSE Committee action from the January 2020 meeting:
QS20/9.7 Briefing note to be circulated in relation to postponed procedures which focused on the specified non-clinical reasons.

This note sets the non-clinical reasons within the context of all cancelled procedures and drills down into the reasons for the cancellations. The appendix provides detail at hospital site level.
The paper identifies that work is required to improve cancellations, however does not provide detail of improvement plans.

Asesiad / Assessment

Strategy Implications

Delivery of a reduction in cancellations especially those which occur at short notice is important to addressing the efficient running of theatres, reducing the distress caused to patients and their carers and optimising the throughput of clinical resources. Overall efficiency and productivity within theatres contributes to the reduction waiting times for patients.

Financial Implications

The financial benefits arising from reduction in cancellations is both in terms of the cost of re-working in rescheduling patients and in terms of reduction in lost clinical time. Not all cancellations result in loss of clinical time due to the scheduling of other patients onto cancelled appointments, however the shorter the notice of cancellation the more difficult it is to use this capacity for other patients.

Impact Assessment

This briefing note does not require impact assessment.

	Elective Cancellations Briefing Performance Directorate February 2020
GIG **CYMRU** **NHS** **WALES** Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board	

Background.

Elective cancellations represent a poor patient and carer experience at a time when the patient is already anxious. Cancellations may also increase the risk of harm for some patients as they represent a delay to treatment which could be time critical. In addition cancellations are generally inefficient requiring at best re-work by administrative staff, at worst lost opportunity to treat patients and fallow time in theatres, one of our most expensive resources and wasteful of clinical staff resource.

All Elective Cancellations in NHS Wales have the reason for cancellation defined within Data Set Change Notice (DSCN) 2013 / 03.

Cancellations are classified as either patient or hospital initiated. Within these sub-classification breaks down the hospital cancellation reasons into clinical or non-clinical with further sub-classification under these headings.

All cancellations should be avoided where possible and therefore effective systems and processes need to be in place to:
a) Ensure patients are adequately prepared for their procedures through good communication, psychological preparation, consenting and pre-operative assessment
b) Ensure effective scheduling of theatre, equipment and clinical resources to the available time to produce an efficient theatre list.
c) Planning of capacity across unscheduled and scheduled care to minimise impact of unscheduled care on planned care delivery.

Not all cancellations will be avoidable, for example short notice sickness of patient or surgeon. However short notice cancellations are to be avoided where ever possible as it is these cancellations that both cause patients and their carers the most disruption and distress and also are the most difficult to backfill so as to ensure the available resources are utilised.

The NHS annual delivery framework measure reported within the QSE IQPR is the number of short notice i.e. day of or day prior to planned procedure cancellations arising from specific non-clinical reasons.
The specific non-clinical reasons include:
- Administrative Error
- Clinical Staff Unavailable
- Emergency Admission
- Equipment Unavailable
- ITU/HDU bed unavailable
- Ward bed unavailable
- Other-non clinical.

Situation

Data source for this summary is BCUHB Informatics Department and covers all BCUHB sites for the dates 01.04.2018 – 31/12/2018.

Table 1 demonstrates the total number of Elective Cancellations by region (West, Central, East and Other). Table 2 is a subset of table 1 and shows those cancellations made on the day or the day before surgery, this is an important inclusion when reviewing cancellations data as short notice cancellations impact on the organisations ability to reschedule and adversely impacts on theatre efficiency. Table 3 demonstrates the short notice cancellations as a percentage of the total cancellations and in all areas account for more than a third of cancellations.

Please note that "Other" includes unknown / uncoded sites along with the inclusion of some additional commissioned activity at Robert Jones and Agnes Hunt in 2018/19. "Other" cancellations have only been included in Tables 1 & 2, all other tables focus on West, Centre and East specific data.

Total Elective Cancellations
April 2018 - December 2019

	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
WEST	1334	1382	1198	1361	1192	1216	1387
CENTRAL	1623	1741	1503	1593	1661	1703	1840
EAST	1857	1858	2289	1969	1534	1624	1707
OTHER	108	31	1	0	1	0	0
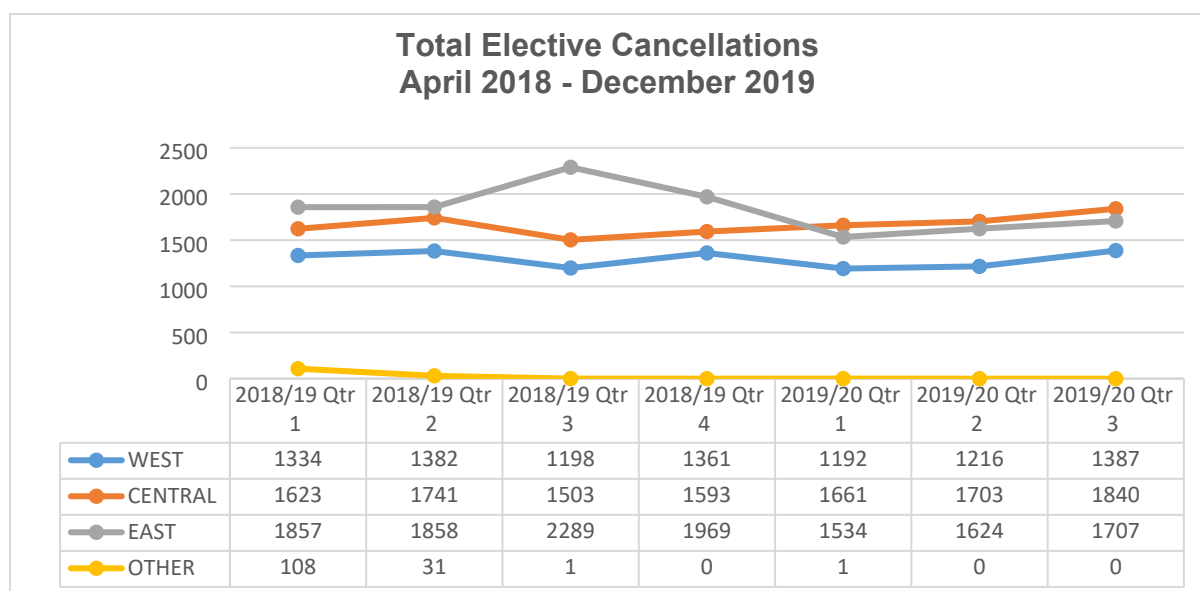
Table 1: Total Cancellations

Total Short Notice Elective Cancellations
April 2018 - December 2019

	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
WEST	497	499	420	499	458	404	515
CENTRAL	541	565	530	603	582	618	760
EAST	759	710	966	797	639	661	638
OTHER	58	16	0	0	1	0	0
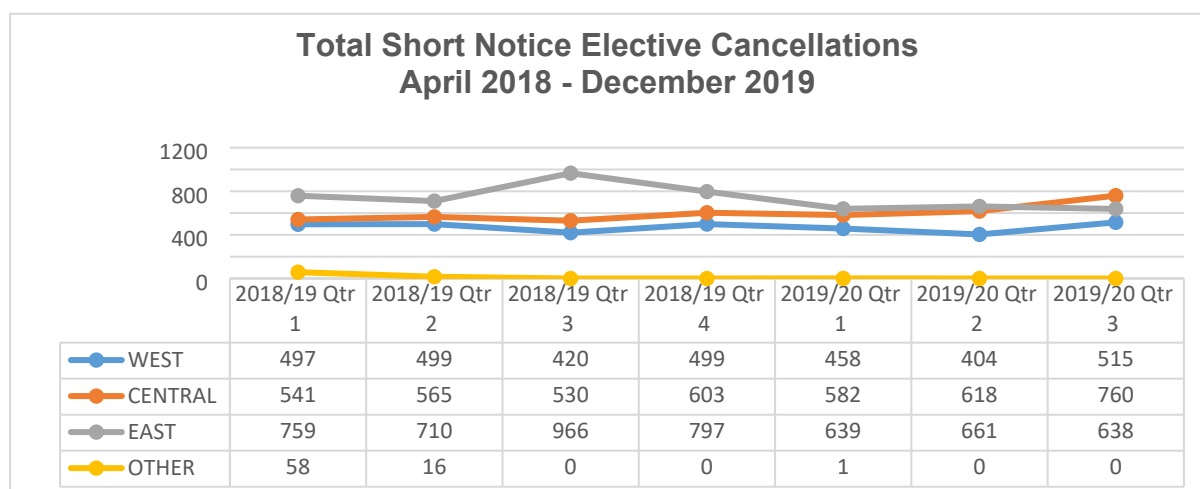
Table 2: Short Notice Cancellations

Short Notice Cancellations as a % of Total	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
WEST	37.26%	36.11%	35.06%	36.66%	38.42%	33.22%	37.13%
CENTRAL	33.33%	32.45%	35.26%	37.85%	35.04%	36.29%	41.30%
EAST	40.87%	38.21%	42.20%	40.48%	41.66%	40.70%	37.38%

Table 3: Short Notice Cancellations as % of Total

Reasons for cancellations vary across the site and the following table demonstrates the top 5 reasons for Elective Cancellations for the period April 2018 – December 2019. Notably Clinical reasons for cancellation do not feature prominently in this list.

West Top 5	Reason	Type	Number
1	Appointment Inconvenient	Patient	1889
2	Clinical Staff Unavailable	Non-clinical	1005
3	Did Not Attend	Patient	859
4	Unfit for procedure	Patient	831
5	Procedure Not Wanted	Patient	773
Central Top 5	Reason	Type	Number
1	Appointment Inconvenient	Patient	2364
2	Procedure Not Wanted	Patient	1530
3	Other – Non Clinical	Non-clinical	1503
4	Other – Clinical	Clinical	1224
5	Clinical Staff Unavailable	Non-clinical	1025
East Top 5	Reason	Type	Number
1	Other Clinical	Clinical	2404
2	Appointment Inconvenient	Patient	2184
3	Emergency Admission	Non-clinical	1209
4	Clinical Staff Unavailable	Non-clinical	1149
5	Procedure Not Wanted	Patient	978

The appendix shows a fuller breakdown of cancellations reasons for West, Central and East. Please note there are a number of entries listed as (blank), these are data quality issues where cancellations have not been coded.

Analysis

The table below shows the overall breakdown of the reasons for cancellation are fairly static overtime. However the numbers of patient cancellations have declined while the number of hospital initiated cancellations for non-clinical reasons have increased. Hospital non-clinical cancellations now equate to 37% of all cancellations and while this is an in-year improve it is an increase compared to the same period in previous years.

	Reason for cancellation	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
West	Patient	703	651	542	620	621	611	683
Centre	Patient	703	651	542	620	621	611	683
East	Patient	777	770	776	701	529	538	557
BCU	Patient	2183	2072	1860	1941	1771	1760	1923
	% of total	45.3	41.6	37.3	39.4	40.4	38.7	39.0
West	Hospital -clinical	231	227	223	246	193	210	180
Centre	Hospital -clinical	297	300	270	334	327	371	393
East	Hospital -clinical	486	538	626	632	420	430	462
BCU	Hospital -clinical	1014	1065	1119	1212	940	1011	1035
	% of total	21.1	21.4	22.4	24.6	21.4	22.3	21.0
West	Hospital -non-clinical	417	422	346	433	576	526	497
Centre	Hospital -non-clinical	550	640	491	535	667	627	647
East	Hospital -non-clinical	594	550	887	636	585	656	688
BCU	Hospital -non-clinical	1561	1612	1724	1604	1828	1809	1832
	% of total	32.4	32.4	34.5	32.6	41.7	39.8	37.1

Analysis of the non-clinical cancellations at short notice demonstrates that the highest volume of cancellations are due to clinical staff unavailability.

The often quoted reason for cancellation i.e. availability of beds is relatively low in the reasons. It is noted that a high volume are recorded as non-clinical other which raises questions of accuracy in data recording as this field should be used by exception to cover reasons not included in the other sub-categories.

Total non clinical cancellations by reason 1.4.18-31.12.19.

Non clinical cancellations at short notice
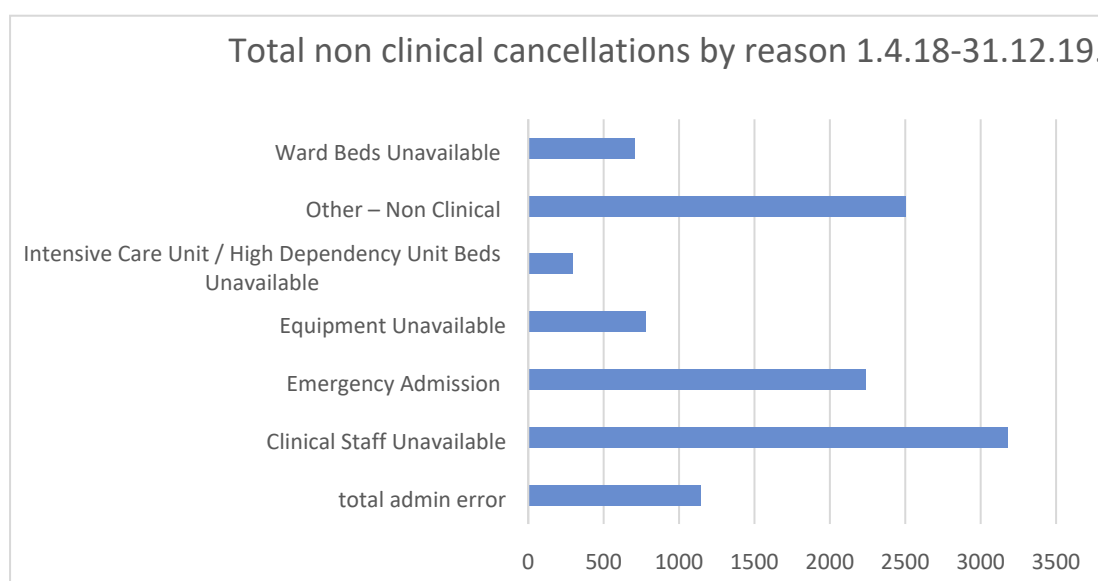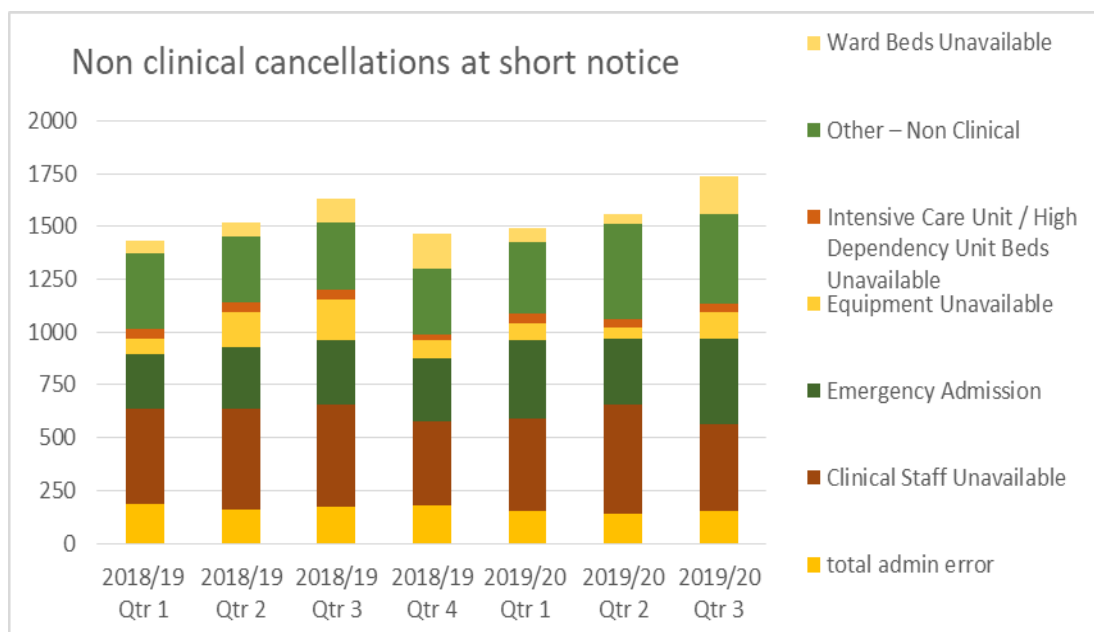
The graph above shows does show a slight seasonable variation in the cancellations due to bed availability which increases slightly in Q3 and 4 compared to Q1 and 2.

Site analysis demonstrates cancellations due to lack of ITU/HDU beds has reduced considerably at YG, which may reflect the investment in capacity on this site, while the volume cancelled at YGC has increased.

Overall emergency admissions as a reason for cancellation i.e. emergency theatre activity reducing capacity for elective patients has increased over time , with the highest proportion of these cancellations being in the East:

Cancellation due to emergency admission activity by site
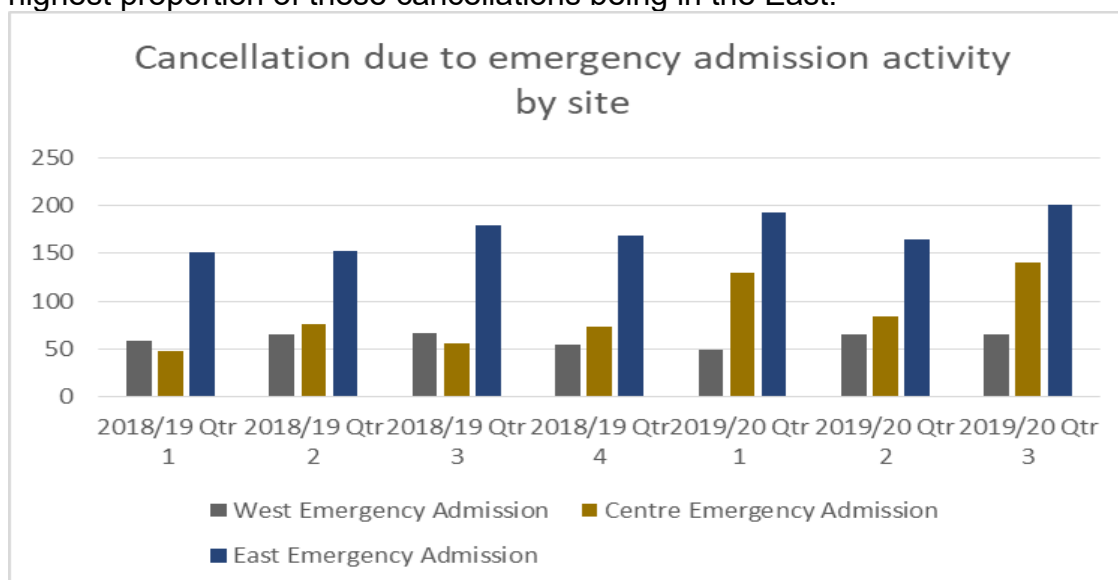
Summary

The level of cancellations for planned procedures is too high. While some level of cancellations are unavoidable the majority can be reduced by improved systems and processes. The overall position has not shown significant change over the past two years and demonstrates opportunity for improvement.

Appendix – Site level reasons for cancellation over time

Total Cancellations	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
WEST	1334	1382	1198	1361	1192	1216	1387
South Gwynedd Mental Health Team	0	0	0	0	1	0	0
3) Patient	0	0	0	0	1	0	0
Appointment Inconvenient	0	0	0	0	1	0	0
Ysbyty Gwynedd	1334	1382	1198	1361	1191	1216	1387
1) Clinical	231	227	223	246	193	210	180
(blank)	7	11	1	4	3	3	6
Other – Clinical	89	83	76	75	71	82	57
Pre-existing Medical condition	50	46	58	59	35	36	37
Procedure No Longer Necessary	22	16	13	21	13	19	16
Unfit with Acute Illness	63	71	75	87	71	70	64
2) Non-clinical	400	504	433	495	377	395	524
(blank)	52	116	128	128	88	81	74
Administrative Error	82	57	30	61	50	53	61
Clinical Staff Unavailable	114	151	131	126	138	154	191
Emergency Admission	58	65	67	55	49	65	65
Equipment Unavailable	15	40	12	70	14	3	2
Intensive Care Unit / High Dependency Unit Beds Unavailable	31	28	20	14	4	7	6
Other – Non Clinical	24	9	12	14	15	16	11
Ward Beds Unavailable	24	38	33	27	19	16	114
3) Patient	703	651	542	620	621	611	683
Appointment Inconvenient	324	292	212	232	267	256	305
Did Not Attend	141	158	111	100	108	120	121
Other – Patient	0	1	0	2	1	0	1
Pre-op Guidance Not Followed	14	13	7	12	15	9	5
Procedure Not Wanted	123	110	103	109	101	130	97
Unfit for procedure	101	77	109	165	129	96	154
Grand Total	1334	1382	1198	1361	1192	1216	1387

Total Cancellations	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
CENTRAL	1623	1741	1503	1593	1661	1703	1840
Abergele Hospital	318	404	297	333	285	258	309
1) Clinical	92	96	72	108	109	79	66
(blank)	1	0	2	0	0	1	0
Other – Clinical	33	37	27	36	45	28	23
Pre-existing Medical condition	22	10	5	11	8	12	11
Procedure No Longer Necessary	4	8	7	14	5	6	3
Unfit with Acute Illness	32	41	31	47	51	32	29
2) Non-clinical	83	185	120	79	71	63	137
(blank)	0	2	0	0	0	0	0
Administrative Error	16	10	6	13	9	13	6
Clinical Staff Unavailable	12	50	20	25	8	15	12
Emergency Admission	8	17	16	9	9	10	57
Equipment Unavailable	11	71	42	1	15	3	18
Other – Non Clinical	36	35	36	31	30	20	44
Ward Beds Unavailable	0	0	0	0	0	2	0
3) Patient	143	123	105	146	105	116	106
Appointment Inconvenient	54	52	49	64	45	68	61
Did Not Attend	11	13	8	8	12	6	3
Pre-op Guidance Not Followed	0	1	0	3	4	4	2
Procedure Not Wanted	51	40	25	40	25	23	20
Unfit for procedure	27	17	23	31	19	15	20
Denbigh Community Hospital	1	0	0	0	0	0	0
2) Non-clinical	1	0	0	0	0	0	0
Other – Non Clinical	1	0	0	0	0	0	0
Llandudno General Hospital	114	95	83	83	96	91	41
1) Clinical	17	24	23	22	29	21	7
(blank)	1	2	0	0	1	0	0
Other – Clinical	8	11	8	6	11	9	0
Pre-existing Medical condition	4	6	8	7	12	7	0
Procedure No Longer Necessary	2	3	1	1	4	4	4
Unfit with Acute Illness	2	2	6	8	1	1	3
2) Non-clinical	50	33	25	23	20	38	13
(blank)	4	3	3	1	2	1	0
Administrative Error	4	4	6	8	5	3	5
Clinical Staff Unavailable	30	17	7	9	9	17	5
Emergency Admission	5	3	1	2	0	3	0
Equipment Unavailable	2	2	2	0	1	1	0
Intensive Care Unit / High Dependency Unit	0	0	1	0	0	0	0
Other – Non Clinical	5	4	4	3	2	12	3
Ward Beds Unavailable	0	0	1	0	1	1	0
3) Patient	47	38	35	38	47	32	21
Appointment Inconvenient	29	18	20	22	26	19	12
Did Not Attend	3	7	7	4	8	6	3
Pre-op Guidance Not Followed	1	0	2	0	1	2	0
Procedure Not Wanted	10	5	3	7	7	4	6
Unfit for procedure	4	8	3	5	5	1	0
Ruthin Community Hospital	0	0	0	2	0	0	0
2) Non-clinical	0	0	0	2	0	0	0
Other – Non Clinical	0	0	0	2	0	0	0
Ysbyty Glan Clwyd	1190	1242	1123	1175	1280	1354	1490
1) Clinical	188	180	175	204	189	271	320
(blank)	1	0	1	2	1	0	1
Other – Clinical	136	114	122	138	127	177	128
Pre-existing Medical condition	8	9	10	7	6	11	5
Procedure No Longer Necessary	9	17	12	12	7	11	18
Unfit with Acute Illness	34	40	30	45	48	72	168
2) Non-clinical	417	422	346	433	576	526	497
(blank)	12	15	2	10	7	9	8
Administrative Error	18	18	34	31	32	31	34
Clinical Staff Unavailable	168	152	86	93	121	111	58
Emergency Admission	34	56	39	62	121	71	83
Equipment Unavailable	10	0	9	8	29	4	63
Intensive Care Unit / High Dependency Unit	6	21	18	6	37	30	21
Other – Non Clinical	147	144	139	172	194	246	193
Ward Beds Unavailable	22	16	19	51	35	24	37
3) Patient	585	640	602	538	515	557	673
Appointment Inconvenient	264	320	262	246	265	236	232
Did Not Attend	102	120	101	92	77	88	104
Other – Patient	0	0	0	0	0	0	0
Pre-op Guidance Not Followed	5	10	8	10	3	10	8
Procedure Not Wanted	185	167	189	146	142	184	251
Unfit for procedure	29	23	42	44	28	39	78
Grand Total	1623	1741	1503	1593	1661	1703	1840

Total Cancellations	2018/19 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2019/20 Qtr 2	2019/20 Qtr 3
EAST	1857	1858	2289	1969	1534	1624	1707
Wrexham Maelor Hospital	1857	1858	2289	1969	1534	1624	1707
1) Clinical	486	538	626	632	420	430	462
(blank)	13	25	17	15	20	10	24
Other – Clinical	339	365	420	456	269	274	281
Pre-existing Medical condition	48	32	42	36	26	29	23
Procedure No Longer Necessary	5	7	8	11	6	9	15
Unfit with Acute Illness	81	109	139	114	99	108	119
2) Non-clinical	594	550	887	636	585	656	688
(blank)	43	42	43	58	39	28	38
Administrative Error	63	73	95	69	58	38	48
Clinical Staff Unavailable	130	106	244	143	163	222	141
Emergency Admission	151	152	179	169	192	165	201
Equipment Unavailable	38	50	128	11	16	42	47
Intensive Care Unit / High Dependency Un	9	1	5	5	10	3	12
Other – Non Clinical	146	116	132	87	96	152	174
Ward Beds Unavailable	14	10	61	94	11	6	27
3) Patient	777	770	776	701	529	538	557
(blank)	0	0	1	0	0	0	0
Appointment Inconvenient	387	346	375	339	223	270	244
Did Not Attend	155	163	124	97	83	57	80
Other – Patient	0	0	0	0	0	0	4
Pre-op Guidance Not Followed	39	56	60	49	33	33	34
Procedure Not Wanted	145	150	145	151	135	128	124
Unfit for procedure	51	55	71	65	55	50	71
Grand Total	1857	1858	2289	1969	1534	1624	1707

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Infection Prevention (IP) Report Q3 2019-20
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris - Deputy Chief Executive / Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Amanda Miskell – Assistant Director of Nursing – Infection Prevention
Craffu blaenorol: Prior Scrutiny:	Infection Prevention Sub Group Quality & Safety Group
Atodiadau Appendices:	N/A

Argymhelliad / Recommendation:

The Quality Safety & Executive Committee meeting is asked to note the Q3 report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	

Sefyllfa / Situation:

The IP quarter 3 (Q3) report provides an update to the Quality, Safety & Experience Committee on the position of IP performance, innovations and any associated risks relating to IP and those areas, which support delivery of the IP work programme / agenda.

This report provides an overview of IP activity, achievements, incidents and performance in relation to IP in Q3. The report should assure the meeting members and relevant others of the innovative and quality work to prevent avoidable infection and incidence within the Health Board.

During Q3 the position of the Health Board in relation to Infection Prevention trajectories across the six Health Boards in Wales was 2nd and 3rd place for all six infections.

Cefndir / Background:

The quarterly reports from the Assistant Director of Nursing for IP reports against the standards found within the Health Standards Framework (2015) published by Welsh Government. IP sits under Theme 2 "Safe Care" and has 12 criteria that should be met. These standards compliment the guidance written within The Code of Practice for the Prevention and Control of Healthcare Associated Infections "The Code" (2014) published by Welsh Government and has 9 standards, which must be adhered to in preventing Health Care Acquired Infections (HCAIs).

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

Asesiad / Assessment & Analysis

Achievements

1. The first "Link Practitioner" educational event took place in December 2019 with over 100 attendees and extremely positive evaluations. A further event in 2020 is already booked. The number of link practitioner has exceeded 180 since the launch in the summer of 2019. IP staff are now Flu vaccinators.
2. Peripheral devices bundles redesigned, approved, printed and distributed.
3. Aseptic Non Touch Technique (ANTT) key trainers updated.
4. To date the Health Board has a reduction of Meticillin Resistant Staphylococcus Aureus blood stream infections, which has decreased by a further 46% to date, compared to 2018/19, from 2.72 per 100K population to 1.20.
5. Clinical Service Lead from IP to commence non-medical prescribing course to complement future nurse led ward rounds and support to Microbiology services. New Microbiologist started in Central.
6. Snap shot results in for Urinary catheter audit undertaken in September 2019 across every inpatient area. Only 2% of patients had a device related infection.
7. BCU IP team supporting national presentations on ICnet.
8. BCU IP team presenting national in 2020.
9. BCU IP member of staff now a scientific committee member for the International Infection Prevention Society.
10. "Deep dives" have continued and learning in terms of priority focus.
11. Continued support to midwifery colleagues in response to possible caesarean infection numbers and rationale.
12. Mandatory, bespoke and micro teaching sessions continue, with over 100 delivered in Q3.
13. Decontamination Advisor has supported other Health Boards as subject matter expert with Shared Services to overcome Dental issues.
14. The service is 100% compliant with staff PADRs and sickness will resume to <5% commencing Q4 2019-20.
15. The IP team have continued to support the issues surrounding the "Vanguard unit" working to eliminate water failures, decontamination and environmental cleanliness.
16. The IP teams continue to provide support and advice in relation to refurbishments, movement of services and new builds.

IP Service update

Quarter 3 continued with the team focusing on the IP work programme, the locality work plans which incorporate all healthcare provision, and the new IP commitment (strategy on a page). In addition, due to the risk of non-achievement of the six trajectories set out by Welsh Government, 12 Key Actions were promoted across the Health Board in November 2019. This includes a 'one off' sporicidal clean which was implemented and a "back to basics" approach for cleaning. This was supported by a Safe Clean Care (SCC) focus on decluttering and devices in Q3. A reduction was initially seen in November but has since increased in terms of those bacteria associated with gut and skin flora. The level of cleaning in November is not sustainable with vacancies and insufficient resources.

The new combined Local Infection Prevention Groups (LIPGs)

These were all launched during Q3 with an emphasis on collaborative and shared learning. Further amendments to the Terms of Reference for these along with revised memberships will be tabled at the Infection Prevention Sub Group (IPSG) in February 2020.

Antimicrobial Stewardship

Antimicrobial Stewardship continues to be crucial in reducing the incidence of multi resistant organisms, particularly e Coli/gram negative infections which are on the increase. The Central locality continues to have the highest number of infections which are Community onset (75% compared to average 71%), and the most overall (41%) compared to East (32%) and West (27%). Again, this is reliant on appropriate resource and has been placed on the Risk Register.

Considering that 78% of infections overall are unavoidable, and 71% are Community Onset, it is recognised that the focus of the Quality Improvement (QI) work will concentrate on delivering improvements that can be achieved.

PHW have been unable to supply any data in national improvement goals this financial year. A letter explaining this and the future actions by the Welsh Government and PHW is due to be received by all Health Boards in Wales. All data discussed in this section is therefore in house data.

Secondary care – the ARK chart is now fully implemented in YG and Wrexham Maelor and the roll out in central is imminent with the recent appointment of an antimicrobial pharmacist to cover maternity leave. This intervention on Wrexham and YG has improved the review of antibiotics in our patients to over 90% (baseline 22% in YG, 69% in WMH). Plans to launch in YGC from March 2020. Restriction policy live across BCUHB, showing overall reductions in broad spectrum antibiotics including piperacillin/tazobactam (Tazocin®) and meropenem.

Primary care – Q3 data available on our database. Reductions seen in overall prescribing for BCU in 4C antibiotics of 2.41% on last year, but not in total prescribing compared to last financial year Q3. Currently due to absences, there are limited antimicrobial pharmacists in primary care. Recruitment underway to replace in east, no appointment in central (Denbighshire in Q3 the highest prescribing cluster). BCU maintain the position in Wales compared to other Health Board (only Powys and C&V are lower prescribers).

Considerations from Deep Dives and Performance

YGC continues to see the most activity in relation to infection numbers, this continued in Q3. Of the 302 infections in Q3, the majority were admitted to YGC, then WMH and lastly YG. Overall, the numbers of infections in Q3 were as follows: 39% Central, 31% in West and 29% in East. East are under trajectory for 5/6 organisms and Central are over for 6/6.

There is unwarranted variation in catheter care and the rationale for catheterisation. However less than 2% of patients in hospital during the September inpatient audit had a Catheter Associated UTI (CAUTI). Work needs to be considered with the Continence Service and Quality Improvement to implement a Trial Without Catheter (TWOC) initiative and a review of all devices to remove where possible, including urinary catheters.

A group is being convened to hold a 'Catheter Amnesty' – this to focus on the management of urinary catheters and the documentation surrounding this to include a catheter passport. The group will also agree the launch of the 'HOUDINI' tool, to empower nurses to remove a urinary catheter at the earliest opportunity.

Safe Clean Care (SCC)

SCC continues as an initiative supported by the IP agenda, strategy and work programmes. This is reinforced by the Board, Executive team and the staff at BCUHB. Highlight reports continue to be received, updating the Health Board (HB) and the Infection Prevention Sub Group (IPSG) on the

continued positive progress. Both internal and external audits and reviews have increased assurance around IP during 2019/20.

Winter pressures

Q3 has been challenging, during the winter season, particularly in Central where there has been significant difference in numbers of trajectory infections (348) compared to East (274) and West (231) and also higher numbers in Influenza Like Illnesses (ILI).

Influenza activity was more intense this year at weeks 4 and 7 (Christmas and New Year), particularly in Central at YGC. There were 283 confirmed flu cases during Q3, 125 at YGC, 81 at Wrexham Maelor Hospital (WMH) and 77 at YG. This is in addition to the increased cases of RSV, Rhinovirus, Coronavirus and Norovirus seen across the same period.

Outbreaks

Q3 saw several outbreaks of infection. Ward closures remained low and cohorting to assist flow remained the IP focus. There was one Period of Increased Incidence in YG relating to Vancomycin Resistance Enterococci that was scrutinised and there has been no further incidence. Ward 19 in YGC also experienced higher volumes of Norovirus. The environment is difficult to clean and the move to Ward 2 is still awaited.

Decontamination and Environmental programmes

There is still a need to have a robust uninterrupted environmental decontamination programme in place, however, a permanent decant facility is required to be made available for WMH, YGC and YG before this can take place.

Infection trajectories, position to date and considerations

Trajectories were set and published in July 2019 by Welsh Government. Due to performance in Clostridium difficile reduction in 2018/19, the trajectory for 2019/20 has been reduced by a further 10%, plus achievement in 2018/19 performance equating to a decrease of 19 cases. Consideration should also be given to the testing process with microbiology sensitivities which have increased therefore we are detecting more and reporting more than previously.

Normal fluctuations in infection rates are expected and this is seen in the graphs below. Overall, there is a definite decrease in Clostridium difficile and MRSA infections. However there is an increase in gram negative organisms and Meticillin Sensitive Staph Aureus (MSSA) which is unfortunately a national picture (see graphs below, page 4). The Health Board is working hard to reduce these numbers, with a focus on antimicrobial stewardship, urine and biliary associated E coli blood stream infections and wound associated MSSA blood stream infections.

The IP team commenced "a deep dive" approach in April 2019 to all those trajectory organisms, which are followed up with scrutiny, Post Infection Reviews and Executive Led Reviews, chaired by the Executive Director of Nursing & Midwifery were required.

The deep dive analysis to date suggests that in the majority of cases, these infections are unavoidable (approx.78%). There are lessons to learn and there is some detail below which should give some assurance of the Health Boards response.

In addition, as seen in the graphs below, the Community Onset infections are increasing (approx. 71%) and Hospital Onset infections decreasing (approx. 29%). Approximately half of these Community

Onset infections to date have had no healthcare intervention in the last 6 months; therefore, they are unavoidable in terms of Health Care Acquired and Infection Prevention.

Approximately 13% of these infections are associated with patients from a Care Home and the team work with staff in the Care Homes to carry out the Post Infection Reviews. The Care Homes also now have access to the IP Link Practitioner programme and education from the Health Board IP team.

There is a definite increase in numbers in the Central locality of the Health Board compared to the others. However, in response to this, the Consultant Antimicrobial Pharmacist and the IP Clinical Service Lead from East will spend two days per week in Central to support and align processes.

Information/Graphs from HARP data
Clostridium difficile:

Chart1. Betsi Cadwaladr UHB monthly numbers of C. difficile by location type, Apr 10 to Jan 20
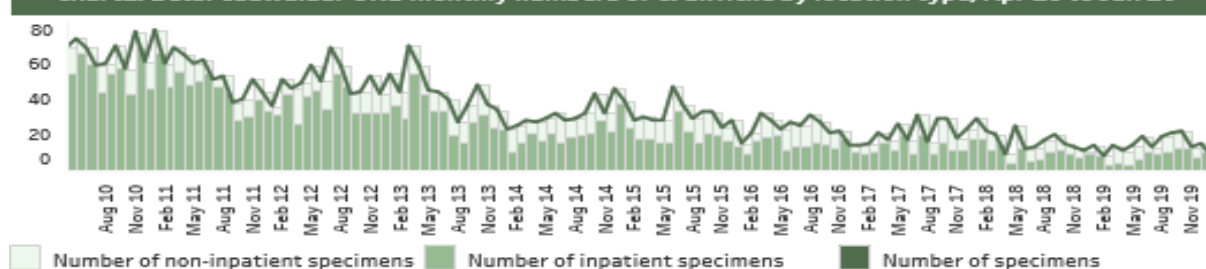
Chart 2. Betsi Cadwaladr UHB monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Jan 20

There is a decrease since Q2 as seen above. The trajectory for 2019/20 is 12% less (19) than the target last year due to good reduction in 2018/19. In addition new molecular testing increases findings by 1-2%.The IP team continue to follow up all CDI cases for a minimum of 4 weeks. 78% of patients had antimicrobials. The highest numbers of CDI cases are in Central (45%) with the highest percentage from Care Homes (15%). The least in East (28%) which has a robust HPV programme, the most resource for Antimicrobial Stewardship and the most resource for Infection Prevention with a full time Quality Support post.

Meticillin Resistant Staphylococcus Aureus:

Chart1. Betsi Cadwaladr UHB monthly numbers of MRSA bacteraemia by location type, Apr 10 to Jan 20

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of MRSA bacteraemia per 1,000 hospital admissions, A... 10 to Jan 20

Rate/1,000 admissions   12 month rolling rate/1,000 admissions
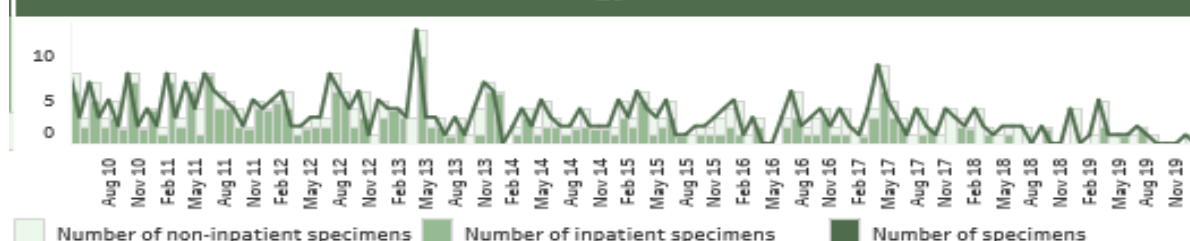
There has been a 46% reduction this year to date in MRSA blood stream infections compared to 2018/19. Interestingly all these infections have been in males over 65 years of age, and all had had healthcare intervention from a urology/device perspective.

Only 3 were known to be MRSA positive on screening. Therefore, there has been an emphasis on screening in Central and West. Screening is higher in East where they have seen the least amount of MRSA infections and work needs to continue to remove any unnecessary devices. There is ongoing work with the Continence service and others in relation to follow up of patients who are catheterised and staying in the Community. Access to Trail without Catheter (TWOCs) and timely Trans Urethral Resection of Prostate (TURP) also needs to be considered.

Meticillin Sensitive Staphylococcus Aureus:

Chart1. Betsi Cadwaladr UHB monthly numbers of MSSA bacteraemia by location type, Apr 10 to Jan 20

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of MSSA bacteraemia per 1,000 hospital admissions, A... 10 to Jan 20

Rate/1,000 admissions   12 month rolling rate/1,000 admissions
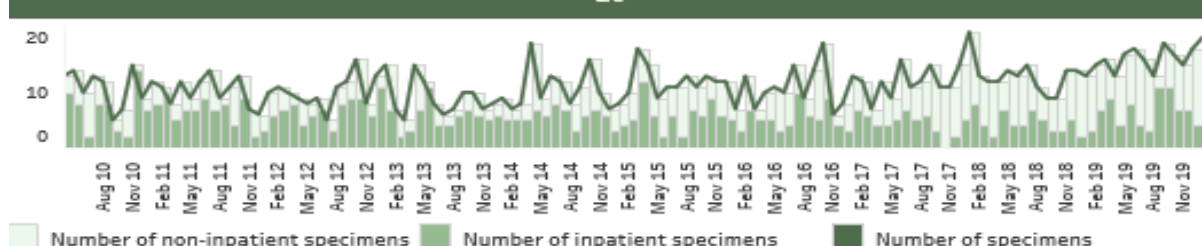
There has been an increase in infection numbers, and from analysis these appear to be related to skin related and skin devices i.e. lines. ANTT and Line care initiatives continue with the emphasis to not insert "Just in Case". The team are focused on collecting Culture and Sensitivity from all open wounds, which are pus related instead of the usual MRSA screening.

The majority of these infections appear to be community onset (82%) and again highest in Central although 68% were considered unavoidable. Considering the relation to skin in a proportion of cases, wound care and tissue viability antimicrobial stewardship is being considered by IP and collaboration of teams and priorities.

Highest numbers of these infections are in East, which are thought to be wound related 58%, compared to 42% in Central and 31% in West. In addition, 19% of Central cases are from Care Homes and the Link Practitioner programme and post infection reviews for learning continue.

E.coli:

Chart1. Betsi Cadwaladr UHB monthly numbers of E. coli bacteraemia by location type, Apr 10 to Jan 20

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of E. coli bacteraemia per 1,000 hospital admissions, A… 10 to Jan 20

Rate/1,000 admissions   12 month rolling rate/1,000 admissions
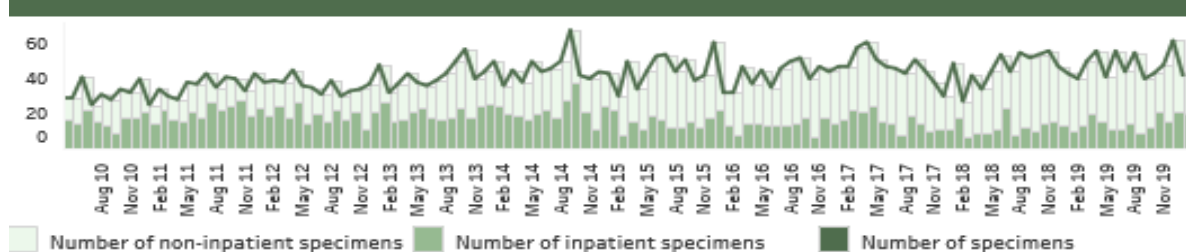
E.coli blood stream infections are 1% higher than the previous year's performance to date. The majority of these are related to Urinary Tract Infections (UTIs) and many are resistant to oral antimicrobials. These infections do not appear to be Catheter Device related. Again, the majority are in Central (40%). The All Wales I hydrate programme has been cascaded for learning across BCU to all Link Practitioners including those in Care Homes.

Klebsiella:

Chart1. Betsi Cadwaladr UHB monthly numbers of Klebsiella sp bacteraemia by location type, Apr 10 to Jan 20

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to Jan 20

Rate/1,000 admissions   12 month rolling rate/1,000 admissions
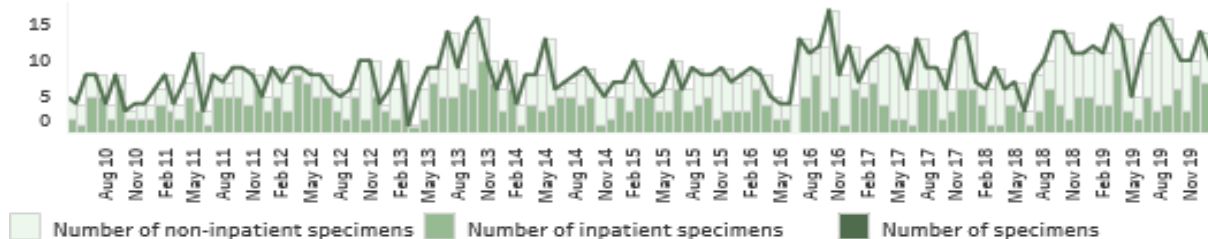
Again, these gram negative infections appear to be related to urinary infections and the majority are Community Onset. There has been a significant increase in Klebsiella, particularly in the East Health Economy. For the majority of these gram negatives only a small amount have had any healthcare interventions. The service is currently analysing these with colleagues from Public Health Wales and the resistance patterns to antimicrobials, particularly for those we use to treat urinary tract infections. The majority of these are in the East and account for 16% of all their infections.

Pseudomonas aeruginosa:

Chart1. Betsi Cadwaladr UHB monthly numbers of P. aeruginosa bacteraemia by location type, Apr … to Jan 20
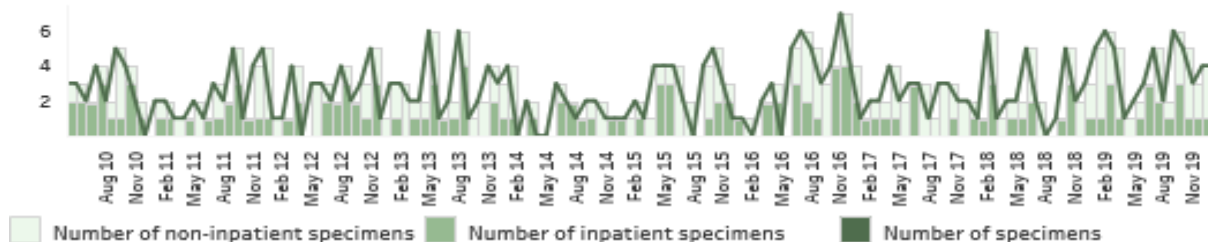
Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens

Chart 2. Betsi Cadwaladr UHB monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to Jan 20

Rate/1,000 admissions   12 month rolling rate/1,000 admissions

On analysis, there is little significance in the numbers and trends of Pseudomonas infections, and consideration must be given to the smaller numbers on the left of the charts in comparison to the other

gram negatives we see from data collation. None of these blood stream infections are related to water. West has the highest numbers and resistance patterns and 76% are in those patients aged 65 years of age and over.

The overall work in terms of proactive and response is detailed earlier. There is little tolerance in the Health Board to avoidable infections, which did reduce over the Q1 and Q2 but appear to have evened out. Therefore, greater priority has been given to the IP teams to focus on those areas where avoidable infections and activity have been noted for Q3. These include key areas in East, West and Central.

Recommendations
IPSG and QSG are asked to note the Infection Prevention Q3 report.

Strategy Implications
To have a zero tolerance to any avoidable infection (I) across the Health Board that is either Community Onset (CO) or Hospital Onset (HO) and Health Care Associated (HCAI). This programme is multifaceted and has a reliance on the wider clinical Multi-Disciplinary Team and other services, in particular Estates and Facilities.

Detail on performance and achievements to date are considered and detailed within the Q3 report attached.

Financial Implications
1. Proposal for Antimicrobial Pharmacy/other for Central Health Community should be considered following the "spend well better care" presentation during Q3 currently not budgeted for by area or pharmacy.
2. Fit Testing equipment for Influenza/respiratory preparedness previously sat with Health & Safety, now in Infection Prevention & Control and not budgeted for.
3. Decant facility for WMH, YG and YGC to allow for an uninterrupted HPV/Deep Cleaning, impact is on flow and purchase/maintenance of equipment.
4. Review of Decontamination facilities across the HB and centralisation.

Risk Analysis
Infection prevention is currently on the Risk Register as is Decontamination of some scopes. The preventative and analysis initiatives accompanied by robust Post Infection Reviews continue to contribute to a reduction in Avoidable Infections.

Legal and Compliance
None to consider.

Impact Assessment
No impact applicable to this report.

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Ward Accreditation Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Diane Read, Head of Quality Improvement Team, Corporate Nursing Sarah Jones, Quality and Practice Development Nurse, Corporate Nursing Alison White, Business Support, Corporate Nursing
Craffu blaenorol: **Prior Scrutiny:**	Quality & Safety Group receive Quarterly updates
Atodiadau **Appendices:**	1) Framework for Support – Red flagged / White

Argymhelliad / Recommendation:						
The Committee are asked to support the ongoing Ward Accreditation process.						
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)						
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Sefyllfa / Situation:
This report provides a briefing on the progress to date for the wards within the Health Board that have been defined as White wards or red flagged. At the end of February 2020, 82 Wards have received their accreditation visit, current validation and scores were awarded as follows:
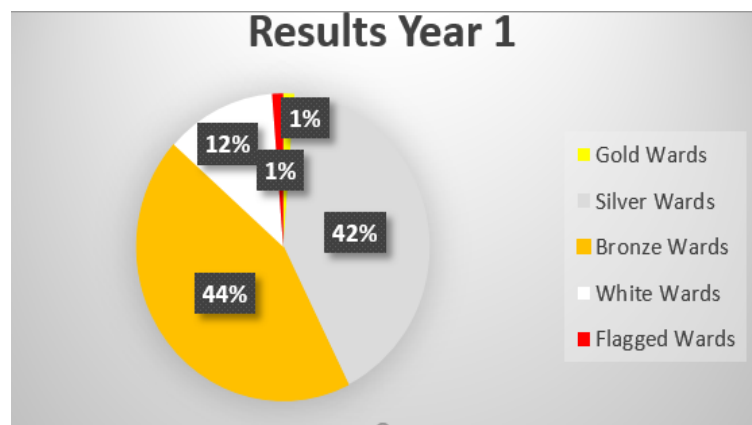
- 1 Gold
- 34 Silver
- 36 Bronze
- 10 White
- 1 Flagged

One other ward was also flagged but following an intensive support programme has been reaccredited as Bronze.

Cefndir / Background:

The Health Board introduced a programme of focused improvement work which included the Ward Accreditation Programme in mid-October 2018. The programme is supported by ehandbooks of standards and web pages developed by the Health Board QI team (Corporate Nursing) for all staff to access and be informed of required standards and criteria by which the wards are accredited.

The Ward Accreditation Programme provides an opportunity for the Health Board to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC).

The Ward Accreditation aims to visit all Acute, Community, Women's, Paediatrics, and Mental Health & Learning Disability Wards on an annual basis. Each unannounced visit / accreditation takes approximately 4-5 hours, with a visit team consisting of a Director of Nursing, Head of Nursing and a member of the Corporate Nursing Quality Improvement Team. Results of visits are then presented to a weekly validation panel (attended by Directors of Nursing) who receive details of the visit and agree / debate the overall accreditation score as being Gold, Silver, Bronze, White or Red Flag, this meeting is key to achieving consistency of scoring.

Asesiad / Assessment & Analysis

The accreditation domains assessed during the visit are as follows:

WELL LED TEAMS
Leadership and Team Culture
Governance, data and improvements
Staffing and Training

COMMUNICATION WITH MDT
Patient Flow and Discharge
At a glance boards,
MDT huddles & handover

PATIENT COMMUNICATION
Patient focused communication
Staff attitudes and behaviours
Responding to our patients

NURSING CARE AND PROCESSES
Nursing processes (meals, medicines)
Needs specific care
Record keeping

HEALING ENVIRONMENTS
Clean and well organised
Patient-friendly spaces
Patient activities

White and Red Flag outcomes:

A White ward is defined as "*Has not achieved the Health Board minimum standards in at least one area and are not completing appropriate actions to address this issue – some additional support is required*".

A Flagged / red ward is defined as "*Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support*".

Of the 10 white wards and 1 flagged ward, common themes identified during the accreditations are as follows:

- Information Governance (e.g. patient notes left unattended / open);
- Medicines Management (e.g. Medicines left unattended)
- Documentation & Record keeping (e.g. Risk Assessments, Care plans, What Matters record not completed);
- Handover / Safety Brief non-compliant with BCUHB standards;
- PSaG Boards non-compliant with BCUHB standards;
- MDT Board Rounds non-compliant with BCUHB standards;
- Leadership concerns (e.g. PADR compliance);
- Patient Rounding (not in place and no plan to implement);
- Resus trolley checks non-compliant with BCUHB standards;
- CoSHH items not secured (e.g. Clean utility unlocked and antichlor on side);
- Safety briefs not taking place.

However, it should be noted that although the accreditation identified these wards as white / flagged, areas of good practice were also noted such as:

- Staff accessing, understanding and using Harms data for improvement;
- QI projects in progress;
- Patient and relative feedback positive (but not always captured);

- Positive feedback from members of the MDT;
- Positive feedback received from student nurses;
- Staff observed being compassionate and caring toward patients.

Support for these wards is provided primarily from the local Matron, Head of Nursing & Director of Nursing – however a member(s) of the Quality Improvement Team maintains contact with the Ward Manager and Leadership Team to provide structured support and additional advice.

Of the 10 White Wards, 4 have been re-accredited, resulting in Bronze Awards for each. The remaining 6 White wards are due to be re-accredited by May 2020. The 1 Red Flagged Ward (Visit December 2019) is due to be re-accredited in March 2020.

Analysis of the White Wards revisited and validated to date:
- domain scores within the accreditation criteria have positively improved in particular in the Well Led section and record keeping
- one ward showing improvement in all domains
- provided a robust baseline for ward managers and their teams to work from
- provided opportunities for networking, benchmarking, peer support, leadership development and shared learning across the Health Board

Strategy Implications

The accreditation methodology is aligned to elements of strategic and business plans. An example of this is contained within the MDT communication domain, whereby implementation and monitoring of SAFER principles and structured MDT Board rounds are observed and assessed during the visit. This has a positive effect on ensuring each patient has a Predicted Date of Discharge (PDD) for managing timely discharge, or appropriate transfer of care. Thereby ensuring that the 'home first' mind set will become embedded.

In addition Ward Managers have access to their ward Data through the recently launched Nursing Intelligence Information Portal which supersedes the basic Harm dashboard. This allows for analysis of harms, incidents, concerns, monthly audits, and patient experience feedback, ensuring lessons learnt are shared and actions taken. This drives Quality Improvement Initiatives locally and Health Board wide.

Financial Implications

Some wards / areas requests for resources (to meet the Health Board's agreed standards as defined in the Ward Accreditation E-Handbooks) have been declined as part of the current procurement process. For example labelling resources for ward stores to reduce staff time lost searching for items, washable noticeboards to meet Safe Clean Care principles, colour printing of data for ease of visibility and interpretation by the public. The ward teams have been advised to escalate via internal processes initially.

Risk Analysis

When a Ward is Accredited and found to be Red Flagged or White, a 'Framework for Support' is actioned (appendix 1). This ensures that any concerns raised are escalated immediately to minimise any risk. Issues raised can be rectified appropriately and in a timely manner ensuring

safety. A detailed action plan will support the improvements needed and monitor progress from a risk perspective.

For Red Flag wards the DoN will provide weekly updates to the Validation panel for 4 weeks to ensure risks are managed. Red Wards will be re-accredited after 8-12 weeks from initial visit.

White wards will be re-accredited after 6 months from initial visit.
There have been no risks identified which have required escalation to the Risk Register, all risks have been locally managed and rectified.

Board and Committee Report Template V1.0 December 2019.docx

Framework of Support: White Wards

Criteria: **The Ward has not achieved the BCUHB minimum standards in at least one area and are not completing appropriate actions to address this issue.**

1

Following agreement at Validation Panel:

- #1 and #3 to meet with Ward Manager to feedback the outcome of accreditation / validation panel / full report within 10 working days.
- Following feedback meeting, Ward Manager to develop an action plan based on accreditation outcome(s).
- #3 to offer QI Team support (if required).

Notes:

2

Action plan to be sent to Diane Read, Head of Quality Improvement Team* (Corporate Nursing) within 10 working days of feedback meeting (as noted in section 1).

*diane.read@wales.nhs.uk

Notes:

3

Member of Quality Improvement Team (Corporate Nursing) to contact / check in* the Ward Manager every 4 weeks (for the next 12 weeks). These sessions can be increased if required / requested by Ward Manager.

*via Telephone, skype, face to face or e-mail.

Notes:

4

After 24 weeks, (post feedback as detailed in section 1) Director of Nursing & Head of Quality Improvement Team (Corporate Nursing) to confirm (in writing / by e-mail) if Ward is ready for re accreditation.

Notes:

GIG | Bwrdd Iechyd Prifysgol
NHS | Betsi Cadwaladr
       | University Health Board

Framework of Support: Red Flag

Criteria: Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support.

Notes:

1

If Red Flagged during visit:
- #1 to feedback to Nurse in Charge during visit Red Flag status.
- #1 to contact Director of Nursing - DNS (if unavailable, Head of Nursing—HoN / Matron) for ward / unit during visit to confirm red status / escalation.
- Assurance gained that ward is safe
- #3 to send e-mail to Ward Manager / Matron / HoN / DNS to confirm rationale of red flag status (within 24 hours).

If Red Flagged at Validation Panel:
- #1 to contact DNS (if unavailable, HoN / Matron) at end of panel.
- #3 to send e-mail to Ward Manager/Matron/HoN/DNS to confirm

2

#3 to FastTrack writing / sign off of the report.

#1 (or #3 if #1 unavailable) to feedback report / red flag status to the next available Validation Panel.

3

#1 (or #3 if #1 unavailable) to feedback full report to Ward Manager within 5 working days (full report then e-mailed to Ward Manager / Matron / HoN / DNS).

4

Following feedback meeting, Ward Manager to develop an action plan based on accreditation outcome(s).

Action plan to be sent to Diane Read, Head of Quality Improvement Team* (Corporate Nursing) within 10 working days of feedback meeting (as noted in section 1). *diane.read@wales.nhs.uk

5

DNS to provide weekly updates to Validation panel for 4 weeks (post validation panel) to provide assurance / support.
Action plan to be sent to Diane Read, Head of Quality Improvement Team* (Corporate Nursing) 24 hours pre validation panel.

6

After 8—12 weeks, (post feedback as detailed in section 2) DNS & Head of Quality Improvement Team (Corporate Nursing) to confirm (in writing / by e-mail) if Ward is ready for re accreditation.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – January and February 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Assistant Director of Patient Safety and Experience
Craffu blaenorol: Prior Scrutiny:	Review by the report author and responsible director
Atodiadau Appendices:	1) Serious Incident Report – January and February 2020

Argymhelliad / Recommendation:

The QSE Committee is asked to note the report.

The QSE Committee is also asked to note the ongoing improvement work including review of various Health Board processes and implementation of the Datix IQ Cloud

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		✓	Er gwybodaeth For Information	

Sefyllfa / Situation:

This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months (since the Committee's last meeting) although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the Patent Safety Report.

Cefndir / Background:

A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in: the unexpected or avoidable death of one or more patients, staff, visitors or members of the public, another serious occurrence from a specified list or one of the specified Never Events.

Asesiad / Assessment & Analysis

Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.

Serious Incident Report
January and February 2020

Produced by the Patient Safety and Experience Department,
Office of the Executive Director of Nursing and Midwifery

1.1   A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;
- the core set of 'Never Events' as updated on an annual basis.

1.2   Never Events are defined as Serious Incidents that are wholly 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 serious 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 as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require full investigation under the Serious Incident Framework.

1.3   Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be done with 24 hours of the incident. The Welsh Government respond within 24 hours and set-out a grade of the incident:

- Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with the Welsh Government is required.
- Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board organisation within 2 calendar months. In order to close this incident the Welsh Government require confirmation that an appropriate investigation has been undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.
- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure.

Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

1.4 This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months (since the Committee's last meeting) although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the Patent Safety Report.

1.5 Statistical process control (SPC) charts or run charts are used were appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicted by dotted grey lines.
- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

1.6 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is capable of achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

1.7 Please note: due to paper deadlines, the data for February includes data up to and including noon on 27 February 2020 (which will affect the final February position).

2. OVERALL SERIOUS INCIDENTS

2.1 During January and February 2020, 90 serious incidents were reported compared to 49 in the comparable prior period. The data for the previous 14 months (allowing period on period comparison) shows a statistically significant shift which requires further review (and is underway with the aim of a verbal update available for the meeting).

Serious incidents-BCUHB starting 01/01/19
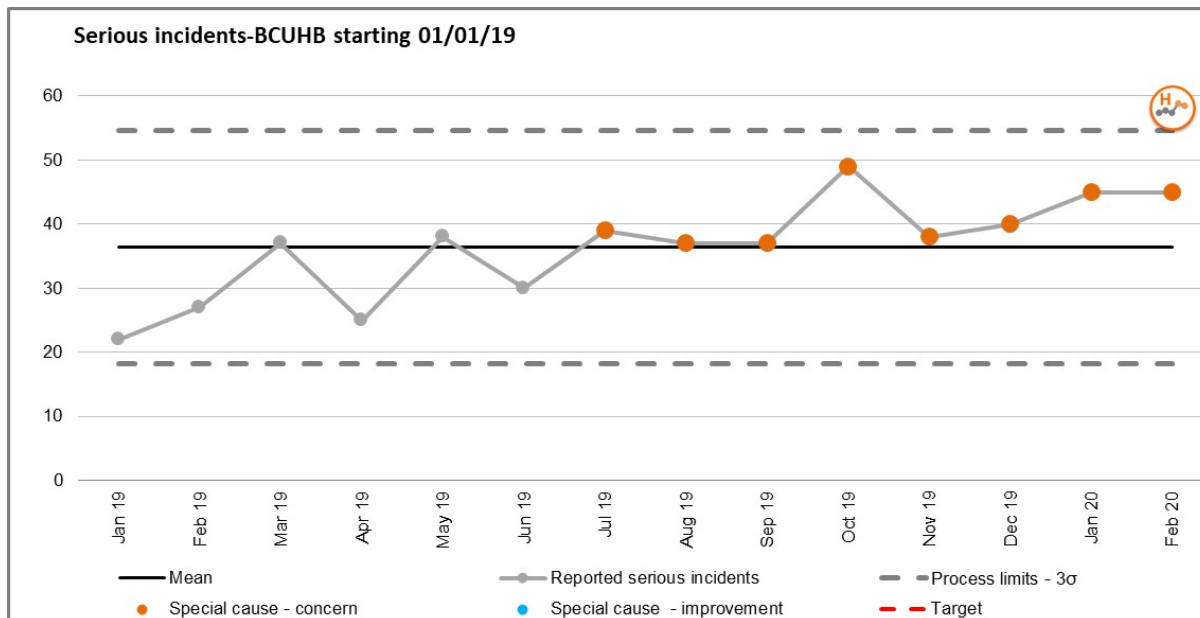
2.2 The common categories of reported serious incident are as follows (this includes every category where 5 or more serious incidents have been recorded) – at the time of writing investigations are underway:

- Unexpected death whilst under the care of a health professional – the significant predominance of these incidents are deaths reported by the Mental Health and Learning Disability Division who are required to report all unexpected deaths of patients open to services. This is regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework). During the period under review all deaths in the division occurred in community services and there is a largely even spread across localities. 38 incidents fitted into this category during the reporting period and are subject to a Serious Incident Review if the raid review identifies care and service deliver issues, or in all other cases a mortality review.
- Patient falls resulting in severe harm or death. 19 incidents fitted into this category during the reporting period all resulting in major harm (i.e. fractures such as a fractured neck of femur). During the period under review, Ysbyty Glan Clwyd reported the highest predominance of incidents (6) followed by Ysbyty Alltwen (2), Wrexham Maelor Hospital (2) and Heddfan Older Persons Mental Health Unit (2).
- Mental health inpatient attempted suicides. 7 incidents fitted into this category during the reporting period. 4 incidents occurred at the Heddfan Adult Mental Health Unit however no hot spot wards within the unit have been identified. Data for the previous year has been reviewed to confirm there is no longer term trend.
- Avoidable grade 3 or grade 4 pressure ulcers. 5 incidents fitted into this category during the reporting period. No hot spot areas have been identified.

2.3   At the time of writing, 119 serious incidents remain open with Welsh Government of which 30 are overdue (down from 41 in the last report). Of these, the predominance of overdue incidents relate to Ysbty Glan Clwyd (10), Central Area (9), and Corporate (5). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (3) and these relate to matters subject to police investigation. A number (6) are overdue by 6-12 months and a slightly larger number (8) are overdue by 3-6 months. It is of note that West Area, West Secondary Care and Women's have only one overdue incident each.

2.4   The Patient Safety and Experience Department is planning a comprehensive review of the serious incident process (including incidents and safety alerts) and this will be conducted in co-production with divisions and other stakeholders. This work is commencing in March 2020. Running parallel to this will be the development and implementation of the new Datix IQ Cloud system and implementation of the anticipated Duty of Candour and a new national Serious Incident Framework (currently under review). The work underway in the Health Board will place a significant focus on human factors/ergonomics and system thinking approaches to investigations rather than a focus on root cause analysis, and the enhancement of a just culture based approach.

3.   SPECIFIC SERIOUS INCIDENTS

3.1   The following serious incidents reported during January and February 2020 are being specifically highlighted for the attention of the Committee:

- Case notes stored in a staff members car boot and overnight the car was stolen. The notes were later found in a field by a member of the public and it is believed the files were unopened prior to this. In addition to reporting as a Serious Incident, the Information Commissioner has been notified.
- A patient awaiting a mental health bed attempted to hang themselves in a toilet at Wrexham Maelor Hospital. This was not reported immediately on Datix by the general hospital staff and the Mental Health and Learning Disability Division were unaware of the incident until some time afterwards. He was transferred to the Psychiatric Intensive Care Unit in the Heddfan Adult Mental Health Unit on an informal basis due to escalating complex behaviours, aggression, a need for rapid tranquilisation and police intervention.
- Death of patient from HMP Berwyn at the general hospital who had been referred by the prison GP. The patient was under review by cardiology and respiratory teams.
- Informed by relative of a patient that when an inpatient on AMAU they got their foot caught in the cot side of bed and their leg then went into spasm, and that the patient rang their call bell but waited 15 minutes for a nurse to attend and no examination was made. The patient was then discharged home and when her leg became painful and swollen, she was seen by their GP and given oral antibiotics but due to increase in symptoms attended the ED at Ysbyty Gwynedd where an x-ray confirmed a fracture of the ankle.

4. NEVER EVENTS

4.1 During January and February 2020, zero Never Events were reported.

4.2 Since September 2019, the Health Board has reported 5 Never Events. Over the last 2 years the Health Bard reported 16 Never Events, therefore the number of recent incidents is noticeable. The serious incident investigations are ongoing but at this stage, there does not appear to be a consistent underlying theme or recurring issue. Once all individual investigations are completed, the Patient Safety and Experience Department will conduct a thematic review to provide assurance around this.

4.3 During January and February 2020, two Never Events were closed. The key learning points from these completed investigations are:

Incident Overview	Key Learning	Improvement Actions
The patient received an appointment for an upper and lower endoscopy that they did not require. The investigation concluded that the patient was incorrectly referred for endoscopies after the incorrect address label was placed on the referral form.	The referral was completed during administration time. No second checker was available to confirm patient details. There was personal anxiety resulting from workload and team management. There is a lack of a mechanism to second check referrals that are not completed during clinic appointment with the patient.	The service have developed two actions: • Clinicians reminded of their responsibility to check patient identity when writing referrals. • Reaffirm the need to complete referrals in clinic before the patient has left.
A patient was listed for a left below knee amputation as an emergency. Patient was taken into theatre and during the Time Out (third part of the WHO checklist) it was discovered the block was inserted on the wrong side.	The operating surgeon did not attend the Safety Brief and communicate pain relief preferences as other patients took clinical priority and a change to plan only discussed between operating surgeon and consultant anaesthetist. The block was administered into the wrong side due to failure to say 'Stop Before You Block,' failure to follow WHO checklist correctly, and presence of wound dressings on both legs.	The service have developed eight actions: • Theatre Manager raised awareness of incident with East and West Theatre Managers. • Laminated poster to be attached to ultrasound machine used for patient procedures. • Updated induction form for all new or visiting theatre staff to include 'stop before you block' to raise awareness. • World Health Organisation (WHO) checklist training update – including Stop Before

		You Block and patient handover.
		• Update to anaesthetic staff in Clinical Governance meeting on importance of following 'Stop Before You Block' procedure.
		• Clinical lead for Anaesthetics and Surgery to discuss and highlight importance for all senior staff to attend the safety briefing.
		• Junior Anaesthetist who administered the block to undertake reflective practice to ensure learning from the incident.
		• Block Trolley to be placed in theatres that routinely use block anaesthetics and visual prompt to 'Stop Before You Block' added to trolley.

5.   LEARNING FROM SI REVIEWS

4.1   The current serious incident process requires the completion of a Rapid Review (RR) process and then in some cases a full Serous Incident Review (SIR) process. The investigating officer and chair of the review will complete standard documentation and each division has a process for review and approval of these and the sharing of learning. Pan-Health Board learning can be shared through a monthly Patient Safety Issue notice which is reviewed at the Quality and Safety Group and thereafter cascaded. As mentioned above, these processes are planned for review.

4.2   During November and December, 76 serious incident closure forms were submitted to Welsh Government. Following the process mentioned above, the responsible division submits a closure form summarising the investigation and action plan to the Assistant Director of Patient Safety and Experience who reviews (on behalf of the Executive Director of Nursing and Midwifery) before onward submission to Welsh Government. The following high-level themes have been identified from a review of these forms:

• 21 closure forums identified no learning – these mostly related to unexpected deaths in mental health or substance misuse services where the cause of death

was not connected to healthcare services and have been subject to a mortality review;

- 5 closure forms identified issues with the completion, review and updating of pressure ulcer risk assessments, Maelor scores and care plans;
- 2 closure forms identified issues with the completion of falls risk assessments;
- 2 closure forms identified issues with WHO surfical checklist compliance.

6. CONCLUSION AND RECOMMENDATIONS

6.1   This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months (since the Committee's last meeting) although 14 months of overall trend data is included (section 2.2) to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patent Safety Report.

6.2   The QSE Committee is asked to note the report.

6.3   The QSE Committee is also asked to note the ongoing improvement work including review of various Health Board processes and implementation of the Datix IQ Cloud.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Monitoring of actions from Internal Audit (limited assurance) report into WAST Handover at Emergency Departments
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Deborah Carter, Director of Operations / Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Mr Trevor Hubbard, Deputy Nurse Director
Craffu blaenorol: Prior Scrutiny:	None – this is a 6 monthly update report to Quality Safety Experience Committee
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

That Quality Safety Executive Committee is provided with assurance that

1. Regular review of the ambulance handover performance and actions are embedded within existing process.
2. Structures are in place to effectively monitor patient safety within the ED particularly in times of escalation.
3. Systems are supporting data capture to identify harm and recording performance impact.
4. The Health board is engaged in programmes locally and nationally to support pathways, processes and quality improvement to ensure that patient quality, safety and experience is maintained within our ED's

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		⚐	Er gwybodaeth For Information	

Sefyllfa / Situation:

Ambulance Handover across Wales remains a significant issue with patients still remaining in the back of ambulances outside of Emergency Departments for considerable lengths of time. As winter has continued and the pressures on Emergency Departments have increased the ability of departments to offload ambulances in a timely way has been impeded.

Following the improvements made in reducing ambulance handover within BCUHB in 2019 concern was raised at Quality Safety & Executive Committee over the impact of the improvements to overcrowding within Emergency Departments across North Wales. This paper provides assurance that the Health Board response and management of overcrowding is keeping patients safe.

Cefndir / Background:

Within BCUHB and in particular in the East area, there had been a number of historical incidents resulting in patient harm, which were also the focus of the Coroner who identified that harms were not only due to the care within the ED, but also the delays either for the patient in the ambulance outside the department, and the patients in the community, where an ambulance has not been able to respond for significant periods of time resulting in poor clinical outcomes and in certain cases is thought to have contributed to patient death.

Most of the recommendations identified by the audit were for WAST to implement alongside Health Boards. BCUHB participated in the response to the audit and there was, and continues to be, a mixed impact from BCUHB at the time on the improvements required. The implementation of the Building Better Care programme within BCUHB and latterly the national Emergency Department Quality Delivery Framework (EDQDF) programme has maintained a focus on Ambulance Handover and in particular the measurement of patients waiting over 60 minutes. Further work undertaken by the 'Gold Command' approach to supporting individual departments has focussed attention of staff on preventing long delays in ambulances, providing early assessment and clinical intervention in order to facilitate the release of ambulances to manage the community demand where the highest risk lies due to patients not having had any clinical assessment.

WAST performance has deteriorated this winter across Wales with a 20% increase in Category 1 demand nationally. The delays have increased significantly since November 2019 which has caused queuing at hospitals. The decline is also disproportionate with the highest delays seen at Ysbyty Glan Clwyd (YGC) and Ysbyty Gwynedd (YG) with a smaller increase on the Wrexham site showing that the improvement identified last year is being sustained but potentially the learning across the system is not. The crowding in the departments has remained despite the decline in ambulance handover and therefore the measures in place to improve safety within the crowded departments are still as important to keep our patients safe and provide timely quality care.

A review of harms over the past 6 months has been undertaken to provide assurance that the safety and quality of patients has been maintained. Five complaints and 107 incidents (22 at YGC, 13 at Wrexham Maelor and 72 at YG) were recorded in the previous 6 month period. None of the incidents were deemed a serious incident although one (the pressures in YGC at the start of the year) triggered a no surprises notification to WG.

Four incidents were reported to BCUHB by WAST under the joint protocol for ambulance delays, this is where WAST report a serious incident and identity as a contributory factor ambulance handover delays impacting on their resource availability, and we then undertake a joint investigation. There have been no coroner referrals relating to serious injury or death within the EDs as a result of harm due to crowding, corridor nursing or ambulance delay in the past 6 months.

This update report provides information to support the continuing assurance that the care of patients was not being compromised and that mitigation was in place to ensure that patients had a good experience and safe care.

Asesiad / Assessment & Analysis

Assessment

The following assessment is an update on the recommendations from the audit and the current experience of patients within ED in BCUHB and the mitigation to ensure safety.

Recommendation 1

1.1 *All health boards should ensure that their Emergency Department Standard Operating Procedures are current and reflect actual practices regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.*

All Emergency Departments have an Intentional Rounding process in place for patient safety and comfort. This includes assessing nutritional, hydration needs, pain management, pressure area care and clinical observations. The triage process has been moved away from the back of ambulances to being undertaken within the ED in all cases although on occasions patients are assessed and moved back into the ambulance due to corridor capacity. This only occurs when sites are operating at a level 4 escalation and the department is completely full.

During Winter 2018 NHS Wales implemented the Red Cross scheme to support patients within the ED and this continues. Red Cross volunteers do regular hydration and nutrition rounds for patients and also provide pastoral support ensuring that they are comfortable and can signpost patients and relatives to staff for advice and support. This scheme has continued with NHS Wales funding.

The ED safety Checklist (SHINE document) to ensure the timely and safe care provision to the patients was introduced across all sites in 2019. The SHINE document is embedded in order to improve the patient care experience and reduce the risk of dehydration/ pressure ulcer development. Sites have undertaken a recent audit on the document and it is notable that there is a decline in adherence to the completion of this document when the acuity in the department increases or there is a drop in nurse staffing numbers. Further work is underway to review the document to make it easier to complete and to look at working practises to support improvement

1.2 *All health boards should undertake compliance checks to confirm that Emergency Department staff are acting in accordance with Standard Operating Procedures regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.*

The ED safety checklist audit (SHINE) is performed by the Matrons to ensure the patient's care needs are met effectively and in a timely manner.

Implementation of patient focussed rounding which aligns to the Bristol model developed in association with an ambulance trust in England is now embedded within our ED's. The ED Matrons undertake audits to ensure that there is compliance with the rounding process and identify if harm has been caused that can be associated with long delays within the department and patients waiting on trolleys.

Recommendation 2

2.1 *Health boards, in conjunction with WAST, should evaluate the results of the trials in ultimately reducing conveyance to Emergency Departments, and where found successful, extend the trials across Wales, where appropriate.*

BCUHB currently has 3 trials which impact on patient handover and ambulance conveyance.

a) SICAT – Single Integrated Clinical Assessment Triage continues to work working alongside the WAST control room to provide clinical support to decision making, telephone triage and clinical advice by a GP. They field 600 calls a month with ¾ being managed with a different pathway and preventing an ambulance conveyance to ED. This is not a funded service but the model is recognised by WG as being exemplary and is being rolled out in other formats across Wales. Additional funding identified through the EASC process was due to pilot care home and community hospital support over Winter which was anticipated to reduce moving frail elderly patients across the Health board and unnecessary admission to hospital but this did not proceed due to operational issues between WAST and BCUHB.

b) 24 hour Alltwen – Expansion of the community MIU at Alltwen to 24 hours to provide local community support, prevent transport to YG and provide local treatment plans for patients preventing admission has continued over Winter.

c) Llandudno Ambulatory Emergency Care Unit – Primary care focussed alternative to ED providing point of care testing and treatment for ambulatory conditions – identified as a site of best practice by the Delivery Unit

2.2 *Health boards should work closely with primary care service providers to ensure that patients are being referred appropriately and in line with the health boards' demand and capacity.*

SICAT challenges calls by Health Care practitioners to identify alternative pathways or treatments that could prevent admission.

A pilot of increasing out of hours GP / ANP support at Wrexham Maelor saw an impact on reducing delays for patients presenting who needed primary care input.

2.3 *The health boards in collaboration with WAST should assess the impact of any pilot to reduce the number of patients being conveyed to the ED by a WAST vehicle on the demand and capacity of the hospital.*

There is ongoing monthly reporting of the impact of the demand elements as part of the Health Board performance reporting and the demand element of Building Better Care programme.

Recommendation 3

3.1 *Each health board, in conjunction with WAST, should proactively assess whether pathways are being correctly applied*.

SICAT have developed a Directory of Services which can be applied by WAST and are testing these on a daily basis.The Every Day Counts initiative by the NHS Wales Delivery Unit has reviewed the pathways in place for discharge to assess and recover models and the safety netting of patients to ensure that they remain safe at home with appropriate support reducing the reliance on emergency care, in particular for patients with long term conditions and palliative care. BCUHB is actively engaged in this programme and some excellent examples of home first models have been showcased at national events.

In the West 'Tuag Adref' / 'Homeward Bound', works slightly differently to support admission avoidance. This has also supported patients referred from the ambulance service and has potentially saved a number of bed days as the patients were likely to require a long stay waiting for local authority support. However it has been possible to support the patients to remain at home.

Groups already exist within each department with multi-disciplinary review (including WAST) of Frequent Attenders or users of services to manage these patients better clinically.

3.2 *Where the application of an incorrect pathways is identified, the reasons should be investigated and corrective action taken to ensure that such errors are not repeated and that WAST are always provided with up to date pathway documentation*.

Further work is required to educate the staff within the ED on offering alternative pathways to paramedics when patients are not required to attend ED. There are well established pathways in place in the West however this needs re visiting and all staff to be aware of how to access in order to support flow in ED and to educate WAST colleagues on how to refer to alternative pathways.

A working group to review the pathways for Minor Injury Units is in operation to increase the referral to these facilities and away from ED.

The ICAN services co-located to ED support the pathways for mental health patients known to services and presenting with a crisis and preventing admission

This is undertaken as part of the processes above.

Recommendation 4

4.1 *Health boards should continue to review their handover performance via published AQIs and evaluate how changes in performance achieved over time are a direct result of individual changes in processes and practices implemented.*

The 60 minute handover is monitored by Emergency Care System Delivery Meeting on a weekly basis. The handover performance and process is also reviewed as a part of EDQDF (early adopter site). The BCUHB is an adopter site for EDQDF and as a part of the project is a part of a working group to develop Pathway Improvement Project (PIP) to review and refine the ambulance handover performance and processes. The first workshops to proactively manage the process for handover from WAST to ED has taken place.

As part of the Building Better Care programme a Zero tolerance of 60 minute breaches, paediatric breaches and 24 hour delays was introduced with implementation from September. Datix reporting is already undertaken for any patient wait over 24 hours with indications of harm reported and investigated.

Daily reporting is available via the critical success factors dashboard which is broken down to site level (Chart 1). In addition a monthly report looking back for 24 months has now been added to have a better overview of trends and seasonality.

| 30 days heatmap | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YG | YGC | WMH |

	8 June	9 June	10 June	11 June	12 June	13 June	14 June	15 June	16 June	17 June	18 June	19 June	20 June	21 June	22 June	23 June	24 June	25 June	26 June	27 June	28 June	29 June	30 June	1 July	2 July	3 July	4 July	5 July	6 July	7 July	30 day average
SITREP (mean)	2.4	2.2	3.0	1.7	1.9	1.7	2.5	2.3	2.4	2.1	2.8	2.3	3.0	2.3	2.3	3.1	3.3	3.0	2.8	2.8	2.1	2.5	3.0	3.3	3.2	3.0	3.3	3.0	3.0	3.6	2.7
4 hour (inc MIU)	72%	74%	73%	75%	69%	73%	78%	66%	66%	76%	70%	78%	75%	74%	74%	66%	75%	68%	73%	72%	78%	70%	67%	69%	73%	76%	73%	70%	64%		72%
4 hour (ED only)	62%	66%	60%	64%	59%	62%	68%	57%	56%	64%	56%	69%	64%	62%	66%	55%	62%	53%	61%	60%	67%	60%	56%	54%	63%	65%	59%	58%	53%		61%
Attendances	452	450	493	491	420	448	481	508	464	528	476	483	467	466	500	523	525	512	531	492	475	486	566	568	525	468	491	481	509		476
Attendances - Over 18	374	359	409	404	357	365	407	416	366	429	389	396	367	383	393	424	416	437	449	391	379	379	444	467	427	390	398	376	418		387
Attendances - Under 18	78	91	84	87	63	83	74	92	98	99	87	87	100	83	107	99	109	75	82	101	96	107	122	101	98	78	93	105	91		89
Breaches - Over 18	160	138	181	167	165	160	148	206	182	175	196	142	149	165	158	215	186	228	200	182	142	170	219	245	187	161	188	180	211		174
Breaches - Under 18	10	16	17	12	8	9	5	14	20	14	14	9	20	10	13	18	16	15	8	17	16	24	32	16	9	4	11	22	26	0	14
Admitted attendances	141	129	130	163	150	144	163	148	157	128	151	126	131	176	151	135	133	152	163	152	144	149	128	154	130	140	147	135	145		140
Admitted breaches	93	82	88	115	101	89	95	111	108	84	106	74	83	101	101	92	85	117	119	113	88	96	91	109	101	92	101	93	110		95
Non-admitted attendances	311	321	363	328	270	304	318	360	307	400	325	357	336	290	349	388	392	360	368	340	331	337	438	414	395	328	344	346	364		336
Non-admitted breaches	77	72	110	64	72	80	58	109	94	105	104	77	86	74	70	141	117	126	89	86	70	98	160	152	95	73	98	109	127		93
Over 12 hours	47	20	46	40	28	30	37	44	34	33	53	38	48	41	42	50	49	90	60	60	49	29	57	94	87	58	74	63	79		49
Over 24 hours	1	1	1	3	1	1	0	2	5	11	6	15	7	15	5	0	13	16	11	7	10	12	19	28	26	23	23	13	13	0	10
Admission rate	31%	29%	26%	33%	36%	32%	34%	29%	34%	24%	32%	26%	28%	38%	30%	26%	25%	30%	31%	31%	30%	31%	23%	27%	25%	30%	30%	28%	28%		29%
Average minutes - admitted	512	415	534	500	413	431	449	504	478	525	541	529	542	484	521	506	548	724	573	588	561	459	636	757	780	693	701	627	697		558
Average minutes - not-admitted	195	182	234	176	192	211	183	229	233	227	244	203	207	217	186	252	234	278	219	216	199	222	271	283	243	197	238	240	241		224
WAST arrivals	139	157	145	144	147	148	169	164	148	153	140	164	160	148	162	157	175	155	172	134	135	162	147	156	150	151	146	149	147	151	153
Handover - 15 to 30 mins	56	45	60	78	67	72	73	72	83	84	72	84	80	70	76	67	83	60	72	54	51	67	59	60	77	58	64	58	67	57	68
Handover - 30 to 60 mins	14	5	17	17	14	14	19	26	23	32	24	21	25	26	23	35	21	30	27	17	17	35	30	22	28	30	32	16	22	36	23
Handover - Over 60 mins	9	0	10	0	1	11	8	16	3	10	5	8	16	7	13	20	14	29	26	33	18	20	24	11	19	20					15
Discharges	105	98	226	225	218	211	248	123	98	209	198	186	209	239	96	76	192	207	223	211	225	93	65	212	178	192	209	148	51		166
Discharges pre-noon	27	18	36	38	39	35	47	37	16	28	45	44	38	50	21	14	22	30	43	36	33	15	12	28	24	30	34	31	14		30
LOS>21	309	320	321	313	317	309	310	314	324	311	319	315	311	314	317		325	324	320	321	301	308	304	303	295	300	303	297	297	301	301
LOS>7	723	752	732	731	726	702	718	719	748	714	719	706	713	710	723		754	723	711	695	677	685	729	706	727	729	762	770	765	805	702
MFD patients	125	118	118	135	139	144	147	141	133	132	130	144	146	136	131	130	123	134	138	139	143	136	131	127	123	126	133	139	136	132	134
DTOC patients	22	22	15	22	19	21	20	20	20	21	35	31	31	29	29	29	31	32		59	33	33	32	36	34	31	29	29	29		27

(Chart 1 – CSF screen shot)

IRIS also reports monthly data on key metrics which is used to inform the Finance & Performance reporting internally and the IQPR slides which are used in the board reports and reported to NHS Wales. (Chart 2)

Proactive escalation of ambulance delays to the site teams is now in place on all sites to ensure that delays are able to be managed before they reach the 60 minute trigger.

4.2 Health boards should support and develop successful processes and practices, whilst those deemed unsuccessful should be reviewed and reversed where appropriate.

The Building Better Care programme includes ambulance handover as a key work stream with weekly local review, reporting at the monthly Unscheduled Care board and using 90 day cycles of change to review and implement best practice across BCUHB. In addition the Health Board is an early adopter of the EDQDF (Emergency Department Quality and Delivery Framework) Programme of which ambulance handover is a specific deliverable with targeted intervention from the National Collaborative Commissioning Unit. BCUHB now has a full programme team in place with a programme manager and project manager on each site supported by an informatics analyst to track performance improvement.

Recommendation 5

5.1 Health boards should ensure that all Emergency Department staff are provided with consistent and updated HAS operational documentation and learning by WAST, including any proposed dual pin role out.

The Hospital Arrival Screen (HAS) is available on all sites and provides information on expected ambulances en-route to the department and the ambulances waiting outside. There is a requirement for the WAST crews to log off of the HAS screen at handover. Implementation of dual pin will require BCUHB staff to do this alongside the crew. Dual pin was rolled out in June 2019.

Hand held devices are set to be trialled from 9th March 2020 to ensure the timely handover to improve the lost WAST hours.

5.2 *Health boards should ensure that delayed handover reasons are always entered on HAS and are used to inform discussions with WAST colleagues and develop operating models.*

Reporting from WAST to the Health Board is through the USC Improvement Group.

5.3 *Health boards should consider whether the current option of pre-listed delayed handover reasons on HAS are able to usefully inform health boards' management decision making processes.*

As above.

Strategy Implications
This report relates directly to the Health Boards strategic and business plans to improve core services and improve outcomes for patients.

Financial Implications
Harm to patients can lead to financial risk and actions taken within this report reduce the risks to patient harm.

Risk Analysis
Governance issues relate to improving performance and quality as well as reducing harm. Ambulance handover is a key deliverable to WG.

Legal and Compliance
There are no associated legal implications. Progress against internal trajectories for the key metrics for unscheduled care will continue to be reported to F&P committee, QSE Committee and Health Board in line with the cycle of business.

Impact Assessment
No associated impact or specific assessments required.

Recommendations

1. That Quality Safety & Experience Committee are provided with assurance that regular review of the ambulance handover performance and actions are embedded within existing process.
2. That structures are in place to effectively monitor patient safety within the ED particularly in times of escalation.
3. That systems are supporting data capture to identify harm and recording performance impact.
4. That the Health board is engaged in programmes locally and nationally to support pathways, processes and quality improvement to ensure that patient quality, safety and experience is maintained within our ED's

Board/Committee report template

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Mortality Reporting – learning from deaths
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Dr Melanie Maxwell, Senior Associate Medical Director
Craffu blaenorol: **Prior Scrutiny:**	Reducing Avoidable Mortality Steering Group
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:
The Committee is asked to note the content of this paper and support the proposed way forward.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)				
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	**Ar gyfer Trafodaeth** **For Discussion**	☞ **Ar gyfer sicrwydd** **For Assurance**	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:
There is a concern that deaths, where healthcare is a contributory factor, are underreported and therefore not managed through the Putting Things Right (PTR) system leading to a lack of openness with families and loved ones. This leads to a lack of assurance that lessons are learnt and shared from mortality reviews to enhance care in the future. Over the past three years, the inpatient crude mortality rate has been stable, and fluctuations seen between months are deemed common cause variation and expected. Without risk adjustment, to take account of factors such as age, deprivation and comorbidity comparison with other HBs is unwise. It should be noted that at this time there is no comparable mortality monitoring of community deaths. Whilst there have been attempts to review deaths in community hospitals, this is not as yet established, nor has there been extension further, for example to the level of individual GP practices. Once the Medical Examiner system is fully established, community deaths with be subjected to the same scrutiny as in patient and hospital deaths. It is anticipated this will be implemented by April 2021. Deaths within the maternity and child health services are subject to multidisciplinary review and/or robust external review through the confidential enquiry system. Deaths within mental health and learning disability services (most of which occur within the community) are subject to a review process;

however, anecdotally this is not robust and review is in progress. Dr Alberto Salmoiraghi, Divisional Medical Director will be updating the next Reducing Avoidable Mortality Steering Group (RAMSG) in April 2020.

Most deaths occur within an inpatient setting and that will be the focus of the remainder of this report

Cefndir / Background:

Mortality reviews using retrospective reviews of the medical case record is long established as a governance tool and is mandated within Wales for inpatient deaths. This enables healthcare organisations to learn from deaths and provide assurance. Studies have estimated that approximately 5% of deaths within hospital settings maybe related to substandard care (Brennan et al., 1991) (Hogan et al., 2012). (Hogan et al., 2014)

Asesiad / Assessment & Analysis

A process has been established within BCU to screen all inpatient deaths using the nationally mandated **Stage 1 tool**. Welsh Government set a completion target for Stage 1 of 95% within 72 hours of death has been in place for some years. To date, as a Health Board we have achieved this with some additional effort.

For 2019/20, two of the three sites are delivering the target, with slightly lower performance in Wrexham Maelor (see table below). The quality of those reviews has not been established as they are undertaken by the doctor completing the death certificate and therefore there is variation in knowledge and experience within this group. However, the main purpose of this screen is to identify any cases that may require further investigation under Stage 2 – most of the categories are objective e.g. death following a planned procedure, patient referred to coroner, patient with serious mental illness or learning disability, and so should be relatively easily identified. The proportion of referrals to Stage 2 is approximately 20% and this is similar to other HBs. It should be noted that the introduction of Medical Examiners within the next 18 months will ensure there is rapid and consistent review of all deaths (over time this will include community deaths) as they will complete the Stage 1 process. Therefore completion of Stage 1 is not a major concern going forward.

Site	2018						2019					
	Deaths	Stage 1 complete	% stage 1 completed	Stage 2 required	Stage 2 outstanding	% stage 2 completed	Deaths	Stage 1 complete	% stage 1 completed	Stage 2 required	Stage 2 outstanding	% stage 2 completed
YGC	1038	1017	98%	168	1	99%	1115	1095	98%	205	128	38%
YG	870	818	94%	142	129	9%	842	806	96%	139	137	1.4%
Wrexham	1009	945	94%	224	152	32%	1017	928	91%	218	138	37%

The Stage 2 process, arguably the more important process in terms of identifying opportunities for learning and improvement, is underperforming given the completion rates within sites (see table above). There has been a failure to fully engage clinical staff with this work and despite repeated escalation within secondary care and to QSG, improvements have not been seen.

However, this is complex and the number of incomplete Stage 2 reviews is likely to be exacerbated because of a number of process issues:

1. A process which is paper- based, largely manual, and has multiple steps (and so potential for failure).
   Completed paper forms are submitted for scanning to the clinical audit department. Recently a significant number of forms were retrieved from offices on Wrexham Maelor (WM) and Ysbyty Gwynedd (YG) sites; anecdotally some have been filed within the case notes. It is hard to

estimate this number but probably accounts for 100 records; work is ongoing to remove these from the backlog. Learning from these has not been shared to date but will be after they have been processed.

2. Morbidity & Mortality (M&M) meetings
Across all sites and in most specialities, there are M&M meetings. These are widely recognised as an opportunity to discuss and debate care, identify and share learning.
Whilst the frequency and format of these are not consistent, these may address three groups of deaths; those reviewed as stage 2s; those flagged for their educational value e.g. unusual presentations or pathologies; and those reported through the PTR system. Consistent with other organisations (Orlander et al., 2002), there is no consistent standard. A further concern is a lack of integration into the organisation's governance structure and communication of findings.

Ysbyty Gwynedd (YG) site manage their Stage 2 through M&M meetings. Unless Stage 2 documentation is completed and uploaded they will be considered incomplete and anecdotally this is the case. Investigation is underway to understand where the process is failing and the resulting back-log. Lead by Janette Hamilton, Lead Nurse Clinical Governance at YG and Mel Baker OMD Lead Manager for Quality & Transformation, this will complete by April 2020.

Standardisation of M&M meetings has been associated with improvement (Higginson et al., 2012), including reductions in mortality (Joseph et al., 2018). Currently, M&M meetings are not within formal policy; this will be addressed as the Learning from Deaths policy is updated.

3. There is potential duplication –
The system is predominantly on paper and the current process has no checks in place to ensure that some groups have not been investigated fully elsewhere. Linkages to incident reporting and complaints, PTR processes, are limited. For example, coroner's referrals may have already progressed to full review and lessons learnt. Similarly, family complaints may have prompted a comprehensive review and learning.

Moreover, patients who die having had a Health Care Acquired Infection or fall are also likely to have been through a process.

In hospital deaths for patients with 'learning disability' or 'serious mental illness' are subjected to a dual review if they are known to the services or within 6 months of discharge. This is the only group where significant learning is likely to have occurred but there has not necessarily been cross site sharing.

Dr Brian Tehan, Medical Director for Quality & Transformation will be reporting back on this issue to next RAMSG (April 2020)

We have recently agreed a set of recommendations with Dr Kate Clark, Secondary Care Medical Director on how we will progress (see below).

Actions to date:

Over the past 2 years, action has been taken to deliver a robust review process. This has included: approval of a new Learning from Deaths Policy, at Quality & Safety Group (QSG) in 2017; an updated draft will be considered at the next RAMSG (April 2020) Dr Brian Tehan, Medical Director for Quality & Transformation as lead author.

Establishing a new governance group – the Reducing Avoidable Mortality Group was developed in 2017, but due to poor attendance and following a workshop in Jan 2019, this was replaced by a much smaller strategic group, the Reducing Avoidable Mortality Steering Group. The expectation was mortality would be discussed at all quality meetings from speciality to division and that lessons could then be shared across divisions at RAMSG. This group also has a deaths surveillance function, reviewing statistical data from internal and external systems (using CHKS® software that uses inpatient data to provide external and internal benchmarking information tracked over time). This provides assurance that there are no speciality, procedures or conditions of concern. Ultimately, this group would develop an improvement plan. However, this group has limited attendance outside of secondary care representation. Divisions have not reported their learning; this has hampered the production of a relevant improvement plan. This group reports to QSG currently. The actions outlined above were agreed at the February meeting; in addition Dr Tehan is contacting the other Divisional Medical Directors to review representation and ensure the terms of reference are relevant to them.

At an operational level, a number of activities have taken place:
Introduction of the all Wales DATIX mortality module as the first pilot site in Wales, commenced August 2019. This will move reviews from paper to a digital system, offering opportunities to ensure there is no duplication; all reviews are entered directly onto the system and there is the ability to identify learning, undertake thematic analysis and provide assurance that the process is robust. There is enthusiasm from some of the community hospitals to use this and a training plan is in development. Rollout has been slow, hampered by poor connectivity and the need to link to the patient administration system. These issues need to be addressed at a national level. There is an undertaking that the Medical Examiner system will link with the site DATIX.

We have developed a hybrid stage 2 that includes the All Wales standard stage 2 tool with elements of the structured judgement review used in England and promoted by the Royal College of Physicians. This was introduced because the clinical staff have noted that the all Wales tool (a tick box) does not support learning.
In 2017, a Task and Finish partnership group was set up to review deaths in Ysbyty Glan Clywd (YGC) Emergency Department; this has enabled us to understand the complex issues behind the perceived high crude mortality rate and to set in place robust mortality review within the department ensuring lessons are shared and actions taken. The hybrid stage 2 was piloted there and the department also moved to real time reviews (within 5 days) so they can provide rapid learning to the team at safety huddles, this information is logged and a recent thematic review has been completed. The analysis is with the department for discussion; in particular issues of the poor environment for end of life care delivery was noted. This paper has been shared with the Palliative Care team to support ongoing discussion.

Sepsis diagnosed at time of admission is the second highest cause of patient deaths in BCU. We have been running a sepsis collaborative since November 2018 using quality improvement methodology. Whilst progress has been made, timely antibiotic administration remains an issue on all sites and the focus of continued work. Ysbyty Glan Clwyd and Wrexham Maelor have both reduced 30 day mortality for patients with suspicion of sepsis by 3% over the past year.

Exploratory work has recently started to improve the management of acute kidney disease in primary care.

Recommendations:

1 .There is clarification of responsibilities and accountability

The Office of the Medical Director, holds responsibility for

- Setting and agreeing a strategic direction.
- Working with operational divisions to design and establish systems for mortality review across the health board including leading the development of reporting systems.
- Scrutiny and assurance of both the process and findings

Operational divisions are responsible for:

- Day to day management of the process
- Ensuring sufficient numbers of appropriate personnel are employed to meet need, received appropriate training and time to complete the reviews
- Monitor performance against policy standards - extracting learning, developing and deploying action plans
- Reporting on findings within normal governance processes with escalation as appropriate

2. Divisions confirm approval of the two stage review process

The paper process is as documented in the current policy with the understanding that

- Serious Incident Report- if a death already allocated to PTR processes, then it need not proceed through the Stage 2 process
- All deaths in patients determined at Stage 1 (or Medical Examiner in future) as "Serious Mental Illness" or "Learning Disability", automatically qualify for "Stage 2" review, after which they undergo further review within the Mental Health & Learning Disability Division.

3. Divisions agree and apply a management structure

For example,

a. Each site will appoint a hospital clinical lead for mortality review
b. Each Hospital Management Team establish a Mortality Review Group to performance manage the process. This would report through the relevant site and/or divisional Quality & Safety group.
c. Ensure there is a focus of activity on Stage 2 reviews

4. Systematised linkages are established between M&M and Mortality review

All "Stage 2" reports relevant to individual departments, should be reviewed at the relevant M&M meeting with documentation of discussion, outcomes and learning, including conclusions about outstanding care and sub-optimal care, formally recorded. This information would be shared with the relevant site and/or divisional Quality & Safety group, with cross divisional learning shared at RAMSG.

5. Address the backlog of stage 2 reviews

Ideally we would wish to remove the backlog and work within a 6 week timeframe enabling learning whilst patients are still remembered. It will take approximately 600 hours work to complete the current backlog and so a way to reduce this needs to be found. The suggestions are to:

- Identify those patients in the backlog who have been reviewed through the PTR process, complaints and Coroner's inquests and remove them

- Identify and then remove patients who were referred for HCAI or falls with no other referring criteria, on the grounds that significant numbers of reviews have been completed, the lessons known and action plans are in place to address these.
- Explore opportunities for further reductions

Work has started to reduce duplication in the backlog.

Strategy Implications
Embedding a robust deaths process will support the quality and safety agenda within the organisation. Reducing healthcare associated harm and death is a key aim of the Quality Improvement Strategy. Thematic analysis will enable the development of a robust improvement plan that is relevant to BCU.
The application of this process will ensure the organisation is ready to respond to the potential challenges of the Medical Examiner system (due to commence Summer 2020). Patients will benefit from improved care and increasing openness.

Financial Implications
The expectation is that this work will be undertaken in SPA time for doctors, recognised within job plans.

Failure to have a robust review system will reduce the ability to learning lessons from deaths and may repeat inadequate care across the organisation and limit reduction in avoidable harms and death.
BCU will also risk being inadequately prepared to respond to the introduction of the Medical Examiner.

Mortality reviews have now been entered as a tier 2 risk via the Office of the Medical Director risk register which is linked to secondary care. Currently risk rating remains at 15 with inadequate controls in place.

ID	Ref	Handler	Title	Opened	Closed date	Risk Type	Risk level (current)	Risk level (Target)	Risk Rating (current)	Date of Last Review/Update	Date of Next Review	Area/Secondary/Corporate
3025	OMD QI	Mrs Mel Baker	There is a risk to the organisation around the failure to complete universal mortality reviews	08/01/2020		Tier 2 - Directorate	Extreme	Moderate	15	03/03/2020	31/03/2020	Office of the Medical Director (Corporate)

Legal and Compliance
Compliance with the Medical Examiners system, once introduced will be enhanced.

QSG should receive updates on mortality reviews to be reported on the site and divisional issues of significance (IoS) reports. Any concerns from Deaths statistical surveillance will be highlighted by RAMSG IoS report.

Milestone – redevelopment of the Learning from Deaths policy; reduction in the backlog of Stage 2s

Quarterly mortality report should be available to QSE - including death statistics, lessons learnt and actions taken based on the information above.

Impact Assessment

None required

References
Brennan, T. A., Leape, L. L., Laird, N. M., Hebert, L., Localio, A. R., Lawthers, A. G., Newhouse, J. P., Weiler, P. C., & Hiatt, H. H. (1991). Incidence of Adverse Events and Negligence in Hospitalized Patients. *New England Journal of Medicine*, *324*(6), 370–376. https://doi.org/10.1056/NEJM199102073240604

Higginson, J., Walters, R., & Fulop, N. (2012). Mortality and morbidity meetings: An untapped resource for improving the governance of patient safety? *BMJ Qual Saf*, *21*(7), 576–585.

Hogan, H., Healey, F., Neale, G., Thomson, R., Black, N., & Vincent, C. (2014). Learning from preventable deaths: Exploring case record reviewers' narratives using change analysis. *Journal of the Royal Society of Medicine*, *107*(9), 365–375. https://doi.org/10.1177/0141076814532394

Hogan, H., Healey, F., Neale, G., Thomson, R., Vincent, C., & Black, N. (2012). Preventable deaths due to problems in care in English acute hospitals: A retrospective case record review study. *BMJ Quality & Safety*, bmjqs-2012-001159. https://doi.org/10.1136/bmjqs-2012-001159

Joseph, C. W., Garrubba, M. L., & Melder, A. M. (2018). Informing best practice for conducting morbidity and mortality reviews: A literature review. *Australian Health Review*, *42*(3), 248. https://doi.org/10.1071/AH16193

Orlander, J. D., Barber, T. W., & Fincke, B. G. (2002). The morbidity and mortality conference: The delicate nature of learning from error. *Academic Medicine*, *77*(10), 1001–1006.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Draft 2020/21 Clinical Audit Plan.
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley (Executive Medical Director).
Awdur yr Adroddiad Report Author:	Trevor Smith (Head of Clinical Audit & Effectiveness).
Craffu blaenorol: Prior Scrutiny:	The Draft Clinical Audit Plan will be presented to the Quality & Safety Group meeting on 13th March. The Chair has agreed to circulate the current Plan and an update from QSG be provided at the Committee meeting.
Atodiadau Appendices:	1. Draft 2020/21 Clinical Audit Plan.

Argymhelliad / Recommendation:

The Committee is asked to please approve the draft 2020/21 Clinical Audit Plan for BCUHB.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	Ar gyfer sicrwydd For Assurance	Er gwybodaeth For Information	
	√				

Sefyllfa / Situation:

The draft BCUHB Clinical Audit Plan 2020/21 (Appendix 1) includes the prioritised projects to be conducted within the Health Board in 2020/21.This consists of those projects included within the Welsh Government's National Clinical Audit & Outcome Review Plan 2020/21 (Tier 1) and those prioritised by Executive Directors in relation to service areas falling within their remit (Tier 2).

Cefndir / Background:

National Clinical Audit & Outcome Review Plan (NCAORP) projects are those that have been annually prioritised by Welsh Government and mandated for Welsh Health Board participation.

These mandated audits are referred to within BCUHB as 'Tier 1'. All are included in the Tier 1 element of the BCUHB Clinical Audit Plan for 2020/21, other than the following which are not applicable within our Health Board:
- National Adult Cardiac Surgery Audit.
- National Audit of Congenital Heart Disease (*due to care provided in Manchester*).
- Paediatric Intensive Care (PICaNet).

Also within the plan are the 'Tier 2' Corporate projects which have been prioritised by Executive leads for the services within their remit. Clear identification was requested regarding:
- BCUHB priority that the project will support.
- A specified accountable lead.
- The responsible Corporate Group.
- An assessment of risk (*based upon specified criteria*).

Asesiad / Assessment & Analysis

Strategy Implications

The draft document closely relates to the breadth of topics embraced by the Welsh Government's NCAORP Plan. Also in terms of the implications for BCUHB planning and use of resources, governance, monitoring and reporting:

- Leadership and governance.
- Strategic and service planning.
- Mental health.
- Primary Care, including out of hours services.

Financial Implications

The financial considerations that relate to this document are broad in terms of direct impact upon service delivery or a number of support departments such as Clinical Audit & Effectiveness (CA&E), Medical Records or Clinical Informatics. Clinical Audit enables the measurement of care delivery against evidence-based standards; facilitating optimum use of limited resources and identification of additional resource needs for improvement. These are identified within the individual context of each project.

Also, there is the indirect cost of support services that contribute to successful participation of the projects identified as priorities by each team. These support functions need to be resourced if clinicians are to be able to participate and focus upon improvement activity.

Risk Analysis

The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Tier 2 includes some projects which are required for accreditation, regulation and licensing; along with management of risk, quality, safety and patient experience. Resourcing to support activity corporately is currently under review and is recorded within the Risk Register (reference: 2961) at with a current tier 2 risk rating of 12.

In relation to Tier 1, there are risks associated with potential non-participation with NCAORP projects. These have related to resource challenges (such as data collection support) and lack of identification of project leads within BCUHB.

Participation in respiratory audits remained a challenge throughout last year. The Executive Medical Director is exploring this issue with the Respiratory Consultants to identify a lead. There remains concern about the data collection support required for this audit and this will need to be addressed.

In relation to NACAP projects:
- *Children and Young People Asthma*: Data collection scheduled in-year. However; they have not been participating in Central and East. Partial data collection only has been occurring in West.
- *Adult Asthma*: Data collection scheduled in-year. However; data currently has been collected for Central only (no data for East or West).
- *COPD*: Data collection scheduled in-year. However; data currently has been collected for Central only (no data for East and low data capture for West).

There has been no participation within BCUHB for the *Falls & Fragility Fractures Audit Programme* (*FFFAP*): **Fracture Liaison Service (NCAORP/2019/22)**. The project lead (Dr Swapna Alexander, Consultant: Care of the Elderly) has escalated to request administration support; however, still currently there is no resolution. Discussions with Clinical Lead and Area Managers has been occurring.

Data collection is partial for **NCAORP/2019/30**: **National Vascular Registry Audit** (*including Carotid Endarterectomy Audit*). Data submission is partial in relation to Interventional Radiology. Response from Mr Soroush Sohrabi (Vascular Consultant Surgeon) identified that he is taking this action forward with the Vascular Interventional Radiology Department.

Legal and Compliance
The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Reporting on progress will be scheduled for the Clinical Effectiveness & Audit sub Group (CEAsG) on a quarterly basis leading to a full annual report in Quarter 1 2021/22.

Impact Assessment
An Equality Impact Assessment (EqIA) has been completed for the recently approved BCUHB Clinical Audit Policy which relates closely to participation with the Tier 1 and Tier 2 elements of the 2020/21 Clinical Audit Plan.
The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. The policy would:
- Promote good practice as outlined above and encourages adherence to National guidance and standards.
- Promote standardisation and equality of access to good practice.
- Encourage patient and public involvement in clinical audit activity.

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Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/01	National Joint Registry	No BCUHB lead at present	Mr Stephen Phillips (Consultant Orthopaedic Surgeon)	Mr Ian Smith (Consultant Orthopaedic Surgeon)	Mr Koldo Azurza (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/02	National Emergency Laparotomy Audit	Dr Stephan Clements (Consultant Anaesthetist)	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott / Dr Kiran Dasi (Consultant Anaesthetists)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr. Nik Abdullah (Consultant Surgeon)	Yes	Yes
NCAORP/2020/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	No BCUHB lead at present	Dr Sam Sandow (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Karen Mottart/Alison Ingham, (Consultant Anaesthetists)	Yes	Yes
NCAORP/2020/04	Trauma Audit & Research Network (TARN)	No BCUHB lead at present	Dr Ash Basu (Consultant : Emergency Department)	Mr Mark Anderton (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rob Perry (Consultants: Emergency Department)	Yes	Yes
NCAORP/2020/05	National Diabetes Foot care Audit	Gareth Lloyd Hughes (Head Of Podiatry & Orthotics - East Area)	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician) & Lorna Hicks (Principal Podiatrist)	Prof Dean Williams (Consultant Vascular Surgeon) & Jamie O'Malley/Iola Roberts (Diabetic Podiatrists)	Yes	Yes
NCAORP/2020/06	Diabetes Inpatient Audit (NaDia)	No BCUHB lead at present	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Stephen Wong (Consultant Physician) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/07	Pregnancy in Diabetes Audit Programme	No BCUHB lead at present	Dr Stuart Lee (Consultant Physician), Lynda Vergheese (Locum Physician) , Gill Davies (Diabetes Specialist Nurse), Rao Bondugulapati (Consultant Physician)	Dr Steven Wong (Consultant Physician), Miss Maggie Armstrong (O&G Consultant), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant Physician), Dr Noreen Haque (Registrar),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	No BCUHB lead at present	**Primary Care element**: Dr Gareth Bowdler (Area Medical Director)	**Primary Care element**: Dr Liz Bowen (Area Medical Director). **Insulin Pump element:** Julie Roberts (Lead Diabetes Specialist Nurse), Dr Minesh Shah (Associate Specialist)	**Primary Care element:** Dr Bethan Jones (Area Medical Director)	Yes	Yes
NCAORP/2020/09	National Paediatric Diabetes Audit (NPDA)	Dr Michael Cronin (Consultant Paediatrician)	Dr Kamal Weerasinghe (Consultant Paediatrician), Karen Czerniak (Paediatric Community Nursing Team Leader)	Dr Pramod Bhardwaj (Consultant Paediatrician), Teresa Jones (Paediatric Diabetes Specialist Nurse)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	No BCUHB lead at present	Dr Nick Nelhans (Consultant Paediatrician)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/11	NACAP: Adult Asthma	No BCUHB lead at present	No lead at present	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/12	NACAP: COPD	No BCUHB lead at present	No lead at present	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/13	NACAP - Pulmonary Rehabilitation workstream	Dr Daniel Menzies (Consultant Physician)	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Ffion Edwards (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes
NCAORP/2020/14	Renal Registry	No BCUHB lead at present	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2020/15	National Early Inflamatory Arthritis Audit (NEIAA)	No BCUHB lead at present	No lead at present	Dr Bjaya Roychoudhry, (Consultant Physician)	Dr Yasmeen Ahmed (Consultant Physician)	Yes	Yes
NCAORP/2020/16	All Wales Audiology Audit	Paediatrics: Dafydd Hughes-Griffiths (Head of Paediatric Audiology) & Georgina Parry (Paediatric Audiology Operational Lead) Adult Rehabilitation: Susannah Goggins, Head of Adult Rehabilitation and Balance, Audiology, BCU	Adult Rehabilitation: Anna Powell, Head of Adult Rehabilitation (East)	Adult Rehabilitation: Suzanne Tyson, Head of Adult Rehabilitation (Central)	Adult Rehabilitation: Heidi Jones, Head of Adult Rehabilitation (West)	Yes	Yes
NCAORP/2020/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2020/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	No BCUHB lead at present	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	No BCUHB lead at present	Dr Sara Gerrie & Dr Cameron Abbott (Consultant Physicians)	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes

NCAORP2020/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No BCUHB lead at present	No FLS Service	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Yes	Yes
NCAORP/2020/21	National Dementia Audit	Dr Sean Page (Consultant Nurse)	Prof Anthony White / Dr Sam Abraham (Consultant Physicians)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (SPR) / Delyth Thomas (Clinical Nurse Specialist)	Yes	Yes
NCAORP/2020/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Walid Samra (Consultant Surgeon)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2020/23	National Audit of Care at the End of Life (NACEL)	Dr Helen Mitchell (Consultant Palliative Medicine)	Mrs Geeta Kumar (Deputy Hospital Medical Director - Q&S)	Dr Tania Bugelli (Deputy Hospital Medical Director - Q&S)	Dr Karen Mottart (Hospital Medical Director - West)	Yes	Yes
NCAORP/2020/24	National Heart Failure Audit	Dr Richard Cowell (Consultant Cardiologist)	Fiona Willcocks (Heart Failure Specialist Nurse)	Dr Mohammad Aldwaik (Consultant Cardiologist) / Andy Bennett (Heart Failure Specialist Nurse)	Dr Mark Payne (Consultant Cardiologist) / Nia Coster (Heart Failure Nurse)	Yes	Yes
NCAORP/2020/25	Cardiac Rhythm Management	Dr Richard Cowell (Consultant Cardiologist)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2020/26	PCI Audit (previously Coronary Angioplasty Audit)	Dr Paul Das	N/A	Dr Paul Das	N/A	Yes	Yes
NCAORP/2020/27	MINAP	Dr Richard Cowell	Dr Richard Cowell / Lucy Trent	Dr Paul Das	Dr Mark Payne	Yes	Yes
NCAORP/2020/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director – North Wales Vascular Network) & Joanne Garzoni (North Wales Vascular Network Manager)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes
NCAORP/2020/29	Cardiac Rehabilitation	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Dale Macey (Cardiology Rehab Lead Specialist Nurse) / Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2020/30	National Lung Cancer Audit	Dr Ali Thahseen (Consultant Respiratory Physician)	No lead at present	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2020/31	National Prostate Cancer Audit	Mr Kyriacos Alexandrou (Consultant Urologist)	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes
NCAORP/2020/32	National Gastrointestinal Cancer Audit Programme	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric** Mr Andrew Baker (Consultant Surgeon)	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant Gastroenterologist)	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric:** Mr Richard Morgan (Consultant Surgeon)	**Bowel:** Dr Claire Fuller, (Consultant Oncologist) & Mr Anil Lala (Consultant Surgeon) **Oesophago-gastric:** Dr Rachel Williams (Associate Specialist, Oncology)	Yes	Yes
NCAORP/2020/33	National Neonatal Audit Programme (NNAP)	Mandy Cooke (Neonatal Services Manager)	Dr Brendan Harrington (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician), Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/34	National Maternity & Perinatal Audit	Fiona Giraud (Director of Midwifery and Women's Services)	Maureen Wolfe (Matron)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2020/35	Epilepsy 12 - Clinical	Dr Kathryn Foster (Consultant Paediatrician)	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/36	National Clinical Audit of Psychosis	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Dr Mike Jackson (Consultant Psychologist)	Yes	Yes
NCAORP projects not applicable to BCUHB: (due to commissioned services elsewhere):						
NCAORP/2020/37	National Adult Cardiac Surgery Audit					
NCAORP/2020/38	National Congenital Heart Disease Audit					
NCAORP/2020/39	Paediatric Intensive Care Audit (PICaNet)					

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment (see key below)
Acute/20/01	Ward Manager Weekly Audit			Y	Y	Y	Highly reliable clinical care	Site Directors of Nursing	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/02	Shine Tool (Emergency Department Safety Checklist)	Y		Y		Y	Reduce patient harms	Emergency Quadrant Heads of Nursing	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/03	Outlier Matrix		Y			Y	Reduce patient harms	Site Matrons / CSM's	Secondary Care Quality Group	Yes	Yes	High
Acute/20/04	Oxygen Competencies	Y	Y			Y	Highly reliable clinical care. Reduce patient harms	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Medical Gases Committee	Yes	Yes	High
Acute/20/05	IV Morphine (compliance against guidelines and record keeping)		Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
Acute/20/06	Enhanced Care	Y		Y		Y	Highly reliable clinical care	Site Directors of Nursing	Secondary Care Quality Group	Yes	Yes	Medium
CORP/04/20	Ward Accreditation Monthly Metrics	Y		Y			Highly reliable clinical care. Reduce patient harms	Deborah Carter (Associate Director Of Quality Assurance)	Senior Nursing Team	Yes	Yes	Critical
IP&C/20/01	Hand Hygiene audits	Y	Y	Y	Y		Quality and Safety. Reduction in healthcare associated infections	Amanda Miskell, Assistant Nurse Director: Infection Prevension & Control (IP&C)	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/20/02	Decontamination Audits	Y	Y	Y	Y	Y	Quality & Safety. Reduction in healthcare associated infections	Amanda Miskell, Assistant Nurse Director: Infection Prevension & Control (IP&C)	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
CORP/01/20	Record Keeping	Y	Y			Y	Highly reliable clinical care. Reduce patient harms	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Secondary Care Quality Group	Yes	Yes	Critical
Corp/OMD/Consent/20/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms.	Y	Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Consent and Capacity Strategic Working Group	Yes	Yes	Critical
RES/20/01	2222 Audit	Y	Y	Y	Y	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Christopher Shirley (Professional Development Lead : Resuscitation) Sarah Bellis Hollway (Resuscitation Services Manager)	BCUHB Resuscitation Committee, & Rapid Response to Acute Illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High
HTA/HA/2020	Auditing compliance with the Human Tissue Act - Human application	Y		Y	Y		Highly reliable clinical care.	Enid Lloyd Jones (Stem Cell Specialist Service Manager)	Pathology Management and Stem Cell Service	Yes	Yes	Critical
HTA/PM/2020	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y		Highly reliable clinical care.	Dr Huyam Abdelsalam (Consultant Histopathologist)	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical

Ref	Description						Theme	Lead	Group	Start	Report	Priority
BSQR/2020	Auditing compliance with the Blood Safety and Quality Regulations	Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Blood Bank Managers - Joe Leung (YG), Nicola Polley (YGC) and Tony Coates (WMH)	NWMCS Quality Committee	Yes	Yes	Critical
ISO15189/2020	Annual audit calendar (minimum 12 audits per site/service) Auditing compliance with ISO 15189. Blood Science service on 3 sites, and Cellular Pathology service on one site.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Bernadette Astbury (Head of Pathology Quality and Governance)	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2020	Accreditation and on-going compliance with ISO9001:2015 Quality Management System. External accreditation on 36 month cycle, each section has tailored internal audit schedule.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Mel Lewis, (Medical Physics Quality Lead)	NWMCS Quality Committee	Yes	Yes	Medium
IRR/2020	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by Head of Quality & Governace and Medical physics expert at any site or department in BCUHB where imaging takes place)	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	Overarching Radiation Protection Committee	Yes	Yes	Critical
IRMER/PI/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Patient Identification completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RPD/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/PS/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Pregnancy Status completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RP/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
QSI/2020	Annual audit calendar (minimum 6 audits per site) Auditing compliance with Ionising Radiation (Medical Exposure) Regulations, Ionising Radiation Regulations, requirements for clinical audit and audits of the service as part of the requirements for Quality Standards in Imaging Accreditation	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Helen Hughes (Head of Quality & Governance: Radiology)	NWMCS Quality Committee	Yes	Yes	Critical
P&MM/20/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		Y	Y	Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Charlotte Makanga (Consultant Antimicrobial Pharmacist)	Antimicrobial Steering Group	Nov-19	May 2020 (by Public Health Wales)	High
P&MM/20/02	Antibiotic Review Kit (ARK)/Start Smart then Focus audit via Public Health Wales tool	Y		Y		Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Charlotte Makanga (Consultant Antimicrobial Pharmacist)	Antimicrobial Steering Group	April 2020 provided PHW tool available	Awaiting report scheduling from PHW (May 2021 suggested)	High
P&MM/20/03	All Wales Inpatient Medication Safety Audit	Y		Y	Y	Y	Keeping People Safe from Avoidable Harm	Assistant Directors of Pharmacy and Medicines Management (Susan Murphy, Bill Duffield, Louise Howard-Baker)	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/20/04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Julie Smith (Associate Nurse Director: Quality Improvement - Secondary Care)	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/20/05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y		Keeping People Safe from Avoidable Harm	Dr Berwyn Owen (Chief Pharmacist)	Controlled Drugs Local Intelligence Network	Ongoing quarterly audit	Quarterly	Critical
P&MM/20/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y		Keeping People Safe from Avoidable Harm	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Yes	Yes	High
P&MM/20/07	Best value biologic - audit of Adalimumab biosimilar uptake	Y		Y			Value-Based healthcare	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Mar-20	Yes	Medium

P&MM/20/08	Audit of Prescribing Standards within Cancer Services	Y	Y			Keeping People Safe from Avoidable Harm	Bill Duffield (Assistant Director For Pharmacy-Central)	Pharmacy Cancer Services group	Yes	Yes	High
Research 20/01	Audit and monitoring of hosted studies (for high a nd medium risk categorised studies) following Assess, Arrange, Confirm process	Y			Y	Highly reliable clinical care. Reduce patient harm	Research Manager	Research senior management team group	Yes	Yes	Low
Research 20/02	Audit and monitoring of sponsored studies	Y			Y	Highly reliable clinical care. Reduce patient harms	Research Manager	Research senior management team group	Yes	Yes	Low
Research 20/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y	Reduce patient harms	Research Manager	Research senior management team group	Yes	Yes	Low

Risk classification criteria:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety & Experience Committee 17 March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	BCUHB Annual Quality Statement (AQS) 2019 / 2020
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Deputy Chief Executive / Executive Director of Nursing
Awdur yr Adroddiad **Report Author:**	Deborah Carter Director of Operations / Associate Director of Quality Assurance
Craffu blaenorol: **Prior Scrutiny:**	AQS Editorial Group monthly meetings Stakeholder Reference Group 3 March 2020 Quality Safety Group and Healthcare Professionals Forum 13 March
Atodiadau **Appendices:**	Appendices A to C noted in "Recommendation"

Argymhelliad / Recommendation:
The committee are asked to note the following documents; 1. Annual Quality Statement Editorial Group, Terms of Reference (ToR) - Appendix A 2. Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government - Appendix B 3. Annual Quality Statement 2019/20 working draft (early draft) - Appendix C In addition, the committee are asked to provide suggestions in particular, around the 'Forward Look' section. Please take into consideration any prior scrutiny is yet to be received. Any new content which is under development has been highlighted as 'In Progress'. It is important that attention is given to content and not formatting at this point in time. The Group is asked to note the content of this report and comments to be directed to Erika.Dennis@wales.nhs.uk

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:
The purpose of this paper is to provide an update, to the group, in relation to the progress made with the Annual Quality Statement (AQS) 2019 / 2020. On 23 December 2019, the Health Board received confirmation from Welsh Government that the AQS is scheduled to go ahead for 2019/20. The plan of work commenced and Editorial Group members were approached and proforma's were issued to various services to complete with examples of good practice, of which the majority have been returned.

Since then, the initial meeting of the Editorial Group took place on 21 January 2020. The group agreed the ToR (same as last year) **Appendix A**, and reviewed the Welsh Health Circular from Welsh Government, **Appendix B**. Actions were agreed and work has continued.

The Project Lead is in regular contact with Editorial Group members with meetings scheduled monthly up until May 2020. The Project Lead is liaising with various service leads and corporate leads to ensure information is consistent and to limit duplication of work as some of the information which will be in the statement, is also reflected in other reports such as our Three Year Outlook and 2020/21 Annual Plan, Quality Improvement Strategy and Integrated Quality and Performance Report.

The AQS 2019 / 2020 working draft (early draft), **Appendix C**, is scheduled to be noted at the following meetings;
- Stakeholder Reference Group 3 March 2020
- Quality Safety Group 13 March 2020
- Healthcare Professionals Forum 13 March
- Quality Safety & Experience Committee 17 March 2020
- Audit Committee 19 March 2020
- Local Partnership Forum 07 April 2020

The latest draft will then be noted at;
- Quality Safety Group 30 April 2020
- Quality Safety & Experience Committee 05 May 2020

With the final version noted at;
- Board 14 May 2020
- Audit Committee 26 May 2020

The final approved AQS 2019 / 2020 will then be published on 31 May 2020.

It is important to mention that the Communication Team has monitored engagement levels with the AQS and the last version in 2019, has never been viewed on our website. Almost all of the information included in the AQS is already (or will be at the time of publication), available elsewhere. This feedback has previously been shared with Welsh Government as there does not appear to be a demand which justifies producing the AQS it costs the Health Board in time and resources.

However, the AQS is a requirement and a good opportunity to reiterate all the good work that has taken place in 2019. To date, a great deal of information has been received across the Health Board and the AQS for 2019 / 2020, will confirm how we engage and communicate this work all year round. Furthermore, future reporting for the AQS will change as per new reporting requirements in line with the Health and Social Care (Quality & Engagement) (Wales) Bill, which will build on and replace the existing AQS, as confirmed in the Welsh Health Circular.

Cefndir / Background:

The Welsh Health Circular, **Appendix B**, provides the background for the AQS.

Welsh Government draw particular attention to the Health and Social Care (Quality & Engagement) (Wales) Bill which includes a broader duty of quality. As such, the AQS will need to provide a clear focus on future requirements under the Bill.

The statement incorporates the *Health and Care Standards for Wales* and the *NHS Wales Outcome Delivery Framework*, providing an opportunity to include improvements the Health Board are making in line with *A Healthier Wales*.

There is also an element of looking back at what has been achieved in terms of progress against the priorities outlined in our Quality Improvement Strategy 2017-2020.

Asesiad / Assessment & Analysis

Strategy Implications

The statement will be aligned to the agreed strategic and business plans as it will incorporate progress against our strategic priorities such as Care Closer to Home, Excellent Hospital Care and Improving Health and Reducing Health Inequalities.

The statement will also look back on progress against the priorities outlined in our *Quality Improvement Strategy 2017-2020* and provide a forward look in accordance with our *Three Year Outlook and 2020/21 Annual Plan* echoing the 'Quadruple Aim' in the Parliamentary Review and A Healthier Wales.

Financial Implications

This report is purely administrative, there are no associated resource implications related to this report itself. There may of course be potential financial implications for each Division in terms of resource requirements but this report is not presented to consider these, merely to report on the progress of the AQS.

Risk Analysis

This report is purely administrative providing a working draft of the AQS. There is an associated risk logged as an audit recommendation;
- *The AQS should be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance*.

The update being that the AQS will be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance. The guidance has been received on 23 December 2019.

Legal and Compliance

Compliance with Internal and External Audit requirements.
The completion of the AQS is a requirement of Welsh Government and progress will be regularly reported to committees with the final version for the approval of Board on 14 May 2020.

Impact Assessment

This report is purely administrative. There will however be an EQIA (Equalities Impact Assessment) completed prior to publication of the AQS.

Betsi Cadwaladr University Health Board
Terms of Reference

Annual Quality Statement Editorial Group

1.	ACCOUNTABILITY

The Annual Quality Statement Editorial Group is accountable to the Associate Director of Quality Assurance.

2.	REMIT

To support the Executive Director of Nursing and Midwifery and Quality, Safety & Experience Committee in discharging their responsibilities for the production of the Annual Quality Statement.

3.	CHAIR

Chair held by the Corporate Nursing and Vice Chair held by Corporate Nursing.

4.	LEAD DIRECTOR

Executive Director of Nursing and Midwifery.

5.	MEMBERSHIP

Members

Corporate Nursing Team (Chair)
Primary Care representative
Service User Experience representative
Head of Performance Assurance
Communications Team Representative
Head of Equalities and Human Rights

6. AUTHORITY

6.1   The group are authorised to seek any additional information it requires from any employee of BCUHB and all employees are directed to co-operate with any request made by the Group.

7. Quorum and Attendance

7.1   Due to the tight timescale of this years AQS and feedback from the Editorial group, the group will review the AQS electronically/virtually and feedback comments within the time scale set by Chair once draft document available.

7.2	Any member of BCUHB staff can, where appropriate, be invited to be part of the Editorial panel by the Chair.

8. CONDUCT OF MEETINGS

7.1	Due to the tight timescales for publication the Editorial group will be conduct business electronically following development of a draft document to review and comment.

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9. RESPONSIBILITIES & FUNCTIONS

8.1	To provide leadership, commitment and operational support to the Annual Quality Statement process.

8.2	To co-ordinate the development of the BCUHB Annual Quality Statement.

8.3	To ensure systems are put in place to review and monitor the ongoing submissions of reports including developing and implementing a system for urgent escalation to Director of Quality Assurance.

8.4	To ensure the timetable for completion is adhered to and deadline for the production of the final document is met.

8.5	To ensure all information provided has been agreed through local governance processes relevant to the area work.

8.6	To ensure appropriate and relevant stakeholder engagement prior to publication of the final document.

8.7	To ensure final publication of the Annual Quality Statement within the Welsh Government timescales in adherence with guidance available at time of publication.

## 10.	REPORTING

9.1	Issues of significance from the Editorial Group will be escalated to the Director of Quality Assurance throughout the process of the development of the document.

## 11.	CHAIR'S ACTION ON URGENT MATTERS

10.1	There may, occasionally, be circumstances where decisions which would normally be made by the Editorial Group need to be taken in between correspondence. In these circumstances, the Chair, will update the Director of Quality Assurance.

Date:

Chair of Group signature:

WELSH HEALTH CIRCULAR

Issue Date: 23 December 2019

Llywodraeth Cymru
Welsh Government

<u>STATUS</u>: INFORMATION

<u>CATEGORY:</u> QUALITY & SAFETY

Title: Annual Quality Statement 2019 / 2020 Guidance

Date of Expiry / Review March 2021

For Action by:
NHS Wales

Action required by: 29 May 2020

Sender: Jan Firby
Healthcare Quality Delivery
Population Healthcare

DHSS Welsh Government Contact(s) :
Mandy Stone
Population Healthcare
Health and Social Services Group
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Enclosure(s): Annual Quality Statement 2019-20 Guidance

The Annual Quality Statement 2019-20

1. Background

The Annual Quality Statement (AQS) provides an opportunity for organisations to 'tell the story' of good practice and initiatives being taken forward, as well as confirming what **went well** and what **not so well** and the **actions being taken as a result**. All NHS organisations are required to publish an AQS, as part of the annual reporting process.

NHS organisations need to be mindful that the Health and Social Care (Quality & Engagement) (Wales) Bill includes a new, broader duty of quality which requires NHS bodies in Wales to exercise their functions with a view to securing improvement in the quality of health services.

The Bill is at a relatively early stage in the Assembly's legislative scrutiny process. If the Bill is passed by the Assembly, we hope to bring the new duty into force in Summer 2021.

Detailed guidance will be developed with stakeholders to support its implementation. The Welsh Government will also supply training materials so staff are aware of the new duty and what it means in practice.

The Bill contains annual reporting requirements which require NHS bodies to assess the extent to which the steps they have taken to comply with the new duty of quality have led to improvements in outcomes. This new reporting requirement will build on and replace the existing Annual Quality Statement to form the basis of the mechanism through which the duty will be reported. Revised guidance will be co-produced ahead of the new requirements being introduced.

In the interim, annual quality statements will continue very much as in previous years but with an eye on the future requirements under the Bill. This Welsh Health Circular therefore provides guidance on the content and structure of the statement for 2019-20.

2. What should a Statement include and look like?

The AQS is for each organisation's resident population and provides an opportunity to let the public know, in an open and honest way, how it is doing to ensure its services are addressing local need and meeting high standards. Bringing together a summary highlighting what has been done to improve the quality of the services it provides and commissions, in order to drive both improvements in population health and the quality and safety of healthcare services. In developing the AQS it should enable LHBs and trusts to:

- provide an assessment of how well they are doing across all services, across the patient pathway, including social care and the third sector;
- promote good practice to share and spread more widely;
- confirm any areas which need improvement;
- build on the previous year's AQS, report on progress, year on year;
- account to its public and other stakeholders on the quality of its services; and
- engage the public on the quality of services received from their health board / NHS Trust to help inform the AQS content.

Engagement with the public will be important to understand what matters to them and what they would like to see in their local quality statements.

The statement needs to encompass all key themes in line with the *Health and Care Standards for Wales* and the *NHS Wales Outcome and Delivery Framework.* It also provides the opportunity to reflect improvements being made to services in line with the expectations set out in *A Healthier Wales*, the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

It should be presented in a way that can be understood by those who use the services provided, written in plain English and be jargon-free, using visual graphics to underline key messages. To ensure national consistency in approach, more detailed advice is provided in annex 1.

Organisational communications leads will need to work closely with their quality and safety colleagues to ensure the content and format of the statement is as would be expected of a public-facing report. We expect the communications departments to be actively involved and engaged with the promotion of the AQS through the use of internet, intranet and approved social network sites such as Facebook and Twitter.

A communications strategy should also be developed to aid publication and promotion of the AQS.

3. What does it need to cover?

The AQS should combine an element of looking back at what has been achieved with a forward look using data and information available for the reporting year. In looking back, LHBs and trusts should seek to answer the following questions:
- are we meeting standards and delivery requirements and are we improving outcomes, across the whole patient pathway?
- are we genuinely seeking to understand the patient/user experience and is it improving?
- are we meeting or exceeding our improvement goals?
- are we being open and learning from errors and concerns?

Examples of initiatives or work to demonstrate commitment to the following should also be included:

- Wales for Africa and other international health partnerships
- embedding a rights based approach which challenges ageist attitudes and stereotypes, making rights real in public service.
- mitigating risk in achieving high quality care and being honest about performance.
- identifying and celebrating areas of local innovation in service delivery and transformation to ensure spread and sustainable improvement
- integration and partnership working.

4. Publishing the AQS

As the AQS is a public document it should be presented in a way which is accessible to all. A bilingual AQS must be published electronically on organisations' websites, with hard copies being made available on request. Organisations should also take into account the needs of their local populations and consider making the statement available in other formats or languages where there is a need to do so, considering going beyond meeting the legal requirements in such matters.

Organisations may want to consider using a number of ways to 'tell the story'. This could be through a mix of case studies and patient stories as well as quantitative data presented clearly and succinctly, signposting the reader to more detailed or technical information as required. It should provide a balance between positive information and an acknowledgment of where services need to improve.

The AQS must be produced on a financial-year basis, which aligns with the financial and performance data reporting periods within NHS organisations' Annual Accounts. Statements must be published no later than **29 May 2020**, in line with the annual accounting and reporting timetable.

It is recognised that this can present difficulties in accessing timely data at the year end to meet publication deadlines. To overcome this it is suggested that quantitative information be presented in one of three ways, depending on data availability at the time of reporting:

1. If a full financial year of data is available, then data for the 1st April to 31st March should be included.
2. If a full financial year of data is not available, data for a calendar year, 1st January to 31st December, should be used to show performance trends supported by commentary on projected end of year delivery where possible.
3. If the measure is qualitative in nature or the data is not available either on a financial or calendar year basis then NHS organisations should provide commentary on past and anticipated end of year delivery. Cross correlation, where appropriate with your Annual Report is recommended to reduce duplication and to provide more collaborative approach.

5. Assuring the Annual Quality Statement

The Board is accountable for each organisation's quality statement and must therefore assure itself, through its internal assurance mechanisms, including internal audit, that the information published is both an accurate and representative picture of the quality of services it provides and the improvements it is committing to. The Chair and Chief Executive will need to include a statement confirming this. Organisations may also wish to include statements demonstrating engagement from other stakeholders, such as Community Health Councils and social care when agreeing their statement.

**Annual Quality Statement
Template for 2018/19**

1. **Statement from the Chair and Chief Executive**

2. **Introduction**
    This section should set the context, describing the population needs of the organisation which have been identified and how these will be meet. Summarising the steps being taken to engage with its population and users and the improvement priorities set last year and any in-year challenges including unexpected events which may have influenced this.

3. **Looking Back Over the Past Year**
    This section should be set out in line with the individual themes below. It should aim to ensure a consistent national approach as far as possible, whilst at the same time providing the opportunity to reflect local priorities. When providing specific examples, it is suggested they are chosen to reflect the local context. **Not all of the areas set out below will be relevant to each organisation, so organisations should draft their response in the spirit of this guidance and adapt their content to suit the services or programmes which they provide.**

    Each theme should provide examples of achievements and improvements as well as challenges, including actions in response to any quality triggers or external reviews which may have taken place during the year. It should show how the organisation has listened to, learnt from and is working with all its partners including social care and the third sector.

    ➢ **Staying Healthy**

    Examples of actions to promote and protect health – examples drawn from obesity, smoking, alcohol, exercise, immunisation rates etc. and/or examples of health improvement programmes implemented. Examples of innovative services in primary and community care to help people maintain good health and live independently.

    ➢ **Safe Care (Services)**

    This section should specifically include examples of actions to improve safety, including nutrition and hydration, falls, pressure ulcers and progress in reducing healthcare associated infections. Progress and learning from case note mortality reviews and other sources of mortality data, serious incidents, safeguarding issues and independent reviews and descriptions of any never events and learning should be included in this section.

    ➢ **Effective Care (Services)**

    Examples of achievements and challenges across individual service delivery plans in providing evidence based effective pathways of care, including efforts to ensure integration and joint working with social services. This section may

need to signpost to more detailed reports for some areas e.g. cancer, stroke, mental health, primary care, children etc. A few examples of participation and learning from national clinical audit, clinical outcome reviews and peer review. This could be linked to local improvement priorities also participation in and learning from research, development and innovation.

> **Dignified Care**

A summary of progress against actions agreed in 'Dignified Care', as well as examples of improvements or challenges which have impacted on meeting the needs and overall experience of patients with dementia, cognitive impairment or sensory loss. Summary of actions being taken to ensure the provision of good continence care, including improvement actions where needed. Improvements made following inspections undertaken by Healthcare Inspectorate Wales.

> **Timely Care (Services)**

A summary of progress and actions taken to improve timely access to and discharge from services including GP access, unscheduled care, ambulance handovers, delayed transfers of care and preventing late night/early hours discharges from hospital, working with social services where required. This could include a summary of participation in the national unscheduled care programme. Examples of actions taken to reduce risk of harm associated with delays in accessing services/care, including participation in the national planned care programme.

> **Treating People as Individuals**

Examples of services/care designed to meet individual need e.g. communication needs, sensory loss, disability and maintaining independence, supporting carers as well as improving services for vulnerable groups. Listening and learning from individual feedback, including the Evans Review of Putting Things Right (PTR) and progress and examples in implementing the National Service User Experience Framework. This should include or signpost to PTR data and learning.

> **Our staff**

A summary of the workforce profile and challenges e.g. actions taken to ensure safe staffing levels, tackle recruitment difficulties, etc. and numbers of and the support provided by volunteers. Examples of actions taken following staff feedback/surveys etc. Examples of actions to develop and support staff to deliver compassionate care and make improvements: including through the provision of training and development in areas such as dementia, cognitive impairment and sensory loss, as well as staff appraisal. This section should also include progress in embedding the Improving Quality Together Framework (IQT), individual and team awards.

The OPC also sets out 3 areas relating specifically to staff, including staffing levels, training and responding to the views of staff. LHBs and trusts should increasingly demonstrate how such issues are considered throughout the year

and how findings etc are brought together to support the evidence provided within the Annual Quality Statement. These expectations align with those set out within the Health and Care Standards Framework.

It is suggested the Wales for Africa disclosure is captured within this theme. You may wish to include reference to information such as the number of staff granted 'volunteering' time, number of staff otherwise engaged with health links work, or any international learning opportunities undertaken. This section also provides an opportunity to draw attention to any other wider strategic international links and projects, and to draw attention to activity undertaken locally to implement the principles of the Charter for International Health Partnerships in Wales:

http://www.internationalhealth.wales.nhs.uk/sitesplus/documents/1100/IHCC%20Charter%20for%20IHP%20%28Interactive%29%20E.pdf

4. Forward Look

This section should summarise how each organisation has used this process to identify areas for focus and improvement for the coming year, working with all its partners including social services. It should set out clear, measurable improvement actions against each of the themes above. It should also describe how the organisation will track progress during the year, including evidence from how it listens and learns to drive continuous improvement.

5. Engagement and Feedback

The document should also be seen as a tool for engagement and a key element in the organisation's communication strategy. Organisations are encouraged to engage with all their stakeholders or partners in agreeing the final statement and include any endorsements/engagement statements as appropriate. They should also include details of how the reader can contact the organisation to comment on the statement or to seek further information.

Annual Quality Statement

1 April 2019 – 31 March 2020   WORKING DRAFT

Health Improvement,
Health Inequalities

Care Closer to Home

Excellent Hospital
Care

Contents

Where is the information you want to know?

"The different colours represent the 7 areas of the Health Care Standards."

About this report

The Annual Quality Statement is an opportunity for us to share what we have been doing to improve the quality of our services over the last year. This report follows the format of the Health and Care Standards[1] themes:

Staying Healthy - you are well informed and supported to manage your own physical and mental health.

Safe Care - you are protected from harm and protect yourself from known harm.

Effective Care - you receive the right care and support as locally as possible and contribute to making that care successful.

Dignified Care - you are treated with dignity and respect and treat others the same.

Individual Care - you are treated as an individual with your own needs and responsibilities.

Our Staff - we have enough staff with the right knowledge and skills available at the right time to meet your need.

The standards come into force from 1 April 2015. They bring together and update the expectations previously set out in "Doing Well Doing Better Standards for Health Services in Wales", and the "Fundamentals of Care" in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

They also establish a basis for improving the quality and safety of healthcare services by providing a framework, which can be used in identifying strengths and highlighting areas for improvement.

Thank you for taking the time to read this report.

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[1] Published by the Welsh Government on the 1st April 2015. For further information about the standards please use the following link:
http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

Introduction and Welcome

The purpose of our Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of the care that we provide. For more information about BCUHB Board Members, please find us on our website: **www.bcu.wales.nhs.uk**

Statement from Simon Dean, Interim Chief Executive and Mr Mark Polin, Chairman

Statement from Mrs Lucy Reid, Vice Chair / Independent Board Member and Mrs Gill Harris, Deputy Chief Executive / Executive Director of Nursing & Midwifery

In Progress

Betsi Cadwaladr University Health Board (BCUHB)

The purpose of the Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of care that we provide. For more information about Board members, please use the following link:
http://www.wales.nhs.uk/sitesplus/861/page/40836

This document forms part of our annual reporting. In addition to this report, our Annual Report and Annual Governance Statement can be found at the following link:

www.wales.nhs.uk/sitesplus/861/page/40903.

This report and supporting documents can be made available in other languages or formats on request from the Corporate Communications Team:

Email: bcuhbpressdesk@wales.nhs.uk

Telephone: 01248 384776

Address: Communications Team
Block 5
Carlton Court
St. Asaph Business Park
St. Asaph
LL17 0JG

There are many opportunities to get involved and share your ideas about how we can improve health in North Wales.

We are keen to hear from you, whether as a member of the public, patient or carer, or if you have a compliment or a suggestion.

It is your local health service.
Help us to help you!

You can also sign up to our involvement scheme. By registering, (please use the link below) you will get our newsletter, hear about how you can share your views and ideas and get updates on activities and events. We want to involve everyone irrespective of age, disability, gender, gender identity, race, religion or belief or sexual orientation.
http://www.bcugetinvolved.wales/register

In Progress

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

About BCUHB

BETSI CADWALADR UHB
POPULATION

698,400 persons

North Wales has an increasing and ageing population. The population is expected to increase to 734,700 by 2036; the percentage of the population aged 85 years and over is expected to increase by 154% between 2011 and 2036.

LIFE EXPECTANCY

BCUHB

82.4 YEARS   78.9 YEARS

The difference in life expectancy between the most and least deprived is 7.4 years for men and 6.1 years for women. In Wales, there has been a plateauing in increasing life expectancy since 2011.

OLDER PEOPLE
15% of households in BCUHB are occupied by one person aged 65 years and over, which is just above the average for Wales (14%). Conwy has the highest percentage of one person households with people aged 65 years and over (17%).

Isle of Anglesey, Gwynedd and Denbighshire are also higher than the BCUHB average.

CHILDREN & YOUNG PEOPLE
Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. Across BCUHB, this ranges from 18% in Gwynedd to 25% in Denbighshire.

70% of 5 year olds in BCUHB are of healthy weight compared to 74% in Wales.

88% of 4 year olds in BCUHB are up to date with vaccinations. This ranges from 84% in Denbighshire to 90% on the Isle of Anglesey.

BURDEN OF DISEASE
This chart shows the greatest cause of Disease burden in Wales, as measured by Disability Adjusted Life Years (DALY).

'Other conditions' includes mental & substance use disorders, other non-communicable diseases and neurological disorders.

Disability-adjusted life years [2]: Cancers 19%, Cardiovascular diseases 18%, Musculoskeletal disorders 11%, Other conditions 52%

FALLS
1 in 3 older people will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care.

DEPRIVATION
Around 12% of the population of BCUHB live in the most deprived fifth in Wales. The Health Board has some of the most deprived areas in Wales, particularly along the North Wales coastline.

MAIN CAUSES OF MORTALITY
Heart disease, cancer and respiratory disease are the leading cause of death in BCUHB.

This chart shows the main causes of death as a percentage of all deaths in BCUHB

Cancer	28
Cardiovascular	26
Respiratory	14
All Other	32

CANCER
4 in 10 cancers are preventable.

MENTAL WELLBEING
16% of people in BCUHB report feeling lonely which is lower than Wales (17%). Across the Health Board, this ranges from 13% in Flintshire to 20% in Wrexham. 83% of people in BCUHB report having a high sense of life satisfaction compared to 81% across Wales.

BEHAVIOURS AFFECTING HEALTH

	BCUHB (%)	Wales (%)
Smoking	18	18
Use e-cigarettes	7	6
Drinking above guidelines	18	18
Physical activity	55	53
Fruit & vegetable consumption	23	24
Overweight/obese	54	60
Follow 0/1 healthy behaviours	10	10

696,300 North Wales Population
17,000 Staff Members
78 Optician Practices
86 Dental Surgeries
105 GP Practices
153 Pharmacies
14 Community Hospitals
3 District General Hospitals

● Put patients first   ● Work together   ● Value and respect each other   ● Learn and innovate   ● Communicate openly and honestly
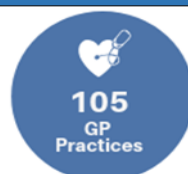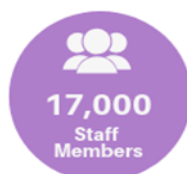
Your Feedback over the last year

The Patient and Service User Experience team has collected 22,247 real-time survey responses from patients, cares and relatives across North Wales, about their experiences of using our services within 2019. In addition to providing feedback in relation to the all Wales NHS Patient Related Experience Measures, the survey asks service users to share their opinions about:

- 'What was good about your experience'
- 'Was there anything that could be improved' and
- 'Promoting Equality in everything we do'

Feedback provided from Patients and Service users provide us with the vital information on how we are doing which enable us to share what is working and make improvements where necessary. Overall, the feedback told us that our services contribute to a positive experience, with an overall satisfaction rating of 8.97/10. In addition to real time feedback, the Patient and Service User Experience Team received 2,201 comment cards, emails, letters, responses and feedback received by our Patient Advice Liaison and Support (PALS) officers.

Your feedback is extremely important to us and is used to focus service improvement efforts. We continue to aim to develop patient and service user feedback in order to listen to the voice of all of our patients in all of our care settings, from the very young to the older person. Feedback from patients and service users will continue to be the most valuable source of information which helps inform the development of services.'

2019 saw the launch of PALS officers in Ysbyty Gwynedd and Ysbyty Maelor Wrexham following a successful pilot of the PALS service in Ysbyty Glan Clwyd. All three localities have three PALS officers based in accessible hubs located in each main entrance of the hospitals and two Patient Experience Co-ordinators. Following the launch of the PALS hubs we have seen a significant increase of patient liaison due to the prime locations and have formed / strengthened good working relationship with our colleague's.

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Looking Back Over the Past Year

We have made significant progress against the priorities outlined in our **Quality Improvement Strategy 2017-2020**.

The key priorities include reducing avoidable deaths, reducing harm and providing reliable care by strengthening our patient care pathways through our services and delivering what matters to patients accessing our services. Among the key things we have done to support these improvements are:

-
-
-
-
-
-
-

Looking ahead to the coming year, the aim is to complete a review of progress against the Quality Improvement Strategy and plan for the next three years by engaging with our patients, staff, partners and our communities. We will also reshape our Quality Improvement Strategy by May 2020.

In Progress

Performance Analysis

	Improved performance	Sustained performance	Decline in performance	Target Summary	Target Achieved
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health	2 measures	0 measures	1 measures	⬆	
SAFE CARE - I am protected from harm & protect myself from known harm	11 measures	1 measure	3 measures	⬆	6 measures
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful	6 measures	0 measures	1 measures	⬆	2 measures
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same	1 measure	0 measures	2 measures	⬇	
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care	11 measures	1 measure	11 measures	⬌	5 measures
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities	2 measures	0 measures	3 measures	⬇	2 measures
OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on use of resources & I can make careful use of them	8 measures	0 measures	3 measures	⬆	3 measures
SUMMARY	**41 measures**	**2 measures**	**24 measures**	⬇	**18 measures**

Our performance is measured across seven key domains or areas, aligned to the Welsh Government's Health Care Standards and National Performance Frameworks.

The summary dashboard (left) shows our performance across the range of indicators the Welsh Government uses to measure all Health Boards in Wales (link).

We have demonstrated overall improvement in relation to helping people to stay healthy and in delivering dignified and individual care. However our performance has declined in respect of delivering timely care and when measured against the indicators for safe and effective care.

Each month we provide detailed briefings to our Board on our performance, outlining the Key Actions being taken to address poor performance, what the Outcomes of those Actions are and the Timeline for when we expect performance to consistently achieve the target.

For 2019/20, we have only included the nationally mandated Measures in our reporting to reflect the priorities of the organisation and improve the health, care and experience of the North Wales population.

● Put patients first   ● Work together   ● Value and respect each other   ● Learn and innovate   ● Communicate openly and honestly

Progress against our strategic priorities

Improving Health and Reducing Health Inequalities	Care Closer to Home	Excellent Hospital Care
• We achieved the Platinum Health at Work standard, recognising our commitment to staff and population well-being and our overall social responsibility. • We introduced the "Let's Get North Wales Moving" collaboration with partners. • The tier three Weight Management Service was implemented. • The "Help me Quit for Baby" smoking cessation support approach was embedded in Community Midwife Teams. • The hospital based smoking cessation service commenced. • An alcohol licensing framework was established. • The 'Made in North Wales' network developed an approach to social prescribing and an asset-based approach to well-being.	• The new healthcare centre at Flint opened, delivering a range of services and fulfilling commitments previously made by the Board to the local population. • The redevelopment of Corwen Health Centre was completed, an important milestone in care provision for the local rural community. • Recent developments such as Llangollen Health Centre, Canolfan Goffa Ffestiniog and the new wing of Tywyn Hospital now provide a range of services providing benefits for the whole community. • More advanced practitioner nursing, physiotherapy, audiology and pharmacy roles were introduced in primary care settings. • Primary care clusters developed a range of innovative services, such as Advanced Nurse Practitioner roles in care homes, family practitioner and specialist diabetes care.	• The new Sub-Regional Neonatal Intensive Care Centre was opened at Ysbyty Glan Clwyd. • The vascular centre development at Ysbyty Glan Clwyd progressed, with full implementation due in April 2019. • The major refurbishment programme for Ysbyty Glan Clwyd has been completed, bringing major improvements to the environment for patients and staff.

In Progress

Staying Healthy
You are well informed and supported to manage your own physical and mental health.

Smoking

In October 2019, the management oversight for smoking cessation services was transferred from Public Health Wales to BCUHB, which creates an opportunity to review service provision across the four teams that deliver smoking cessation services. This provides opportunity to review the service offered and maximise reach.

Respiratory Health Project

20% of the population of Blaenau Ffestiniog have been identified as being smokers. This, combined with the legacy of the slate mining industry has contributed to poor respiratory health and 11% of those patients registered at the GP practice (Canolfan Goffa Ffestiniog) were identified as suffering from chronic respiratory conditions.

The practice were identified as one of the highest prescribers of inhaled corticosteroids within the health board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health.

Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included:

- Identification of patients and inviting patients to respiratory clinics

- Education and training of healthcare professionals in COPD diagnosis and management

- Review and improve inhaler techniques

Protecting people against Flu

Protecting people against the risk of flu is a major element in helping the NHS reduce the demand for emergency care over the winter period. The number of people eligible to be vaccinated and receiving vaccinations has increased year on year in both the under 65 and over 65 age groups. The increased volume of vaccinations given demonstrates the hard work our staff have done to promote the need for vaccination. As a result, by 31st March 2020, over ## more people in North Wales had been vaccinated compared to the year before.

The national target is for 75% of the eligible groups (people aged over 65, and those aged below 65 who are at greater risk from infection) to be vaccinated. North Wales had the highest take up rate in Wales, at ##% for those over 65 and ##% for those under 65. This is an improvement for the over 65 age group. However, the increased number of people aged under 65 who were eligible to be vaccinated last year meant that the take up rate fell, even though the number of people in this group who were immunised increased. This shows that we need to continue our efforts to encourage people to protect themselves.

Prevention

Three Year Strategic Immunisation Plan 2019-2022

Betsi Cadwaladr University through the development of its three year Strategic Immunisation Plan (2019-22), has committed to protecting and improving the health of the population through maximising uptake of vaccines for eligible groups across the life course.

This will be achieved by focussing on reducing variation in uptake, sharing learning and further embedding a culture of quality improvement, strengthening governance arrangements, improving how we communicate and engage key stakeholders and taking every opportunity to immunise our public, patients and staff. The Health Board's improvement priorities are shown below.

1 Transforming Culture
2 Strengthening the Workforce
3 Monitoring Impact
4 Raising standards, Achieving Impact and Outcomes
5 Measuring Improvement and the Quality of our work
6 Working Collaboratively

A range of routine vaccinations programmes are being delivered across North Wales by BCUHB and primary care contractors. Further selective, medical, occupational and travel immunisations are also provided, including influenza vaccinations for pregnant women and people with chronic conditions; Tuberculosis, Hepatitis B and influenza vaccinations for staff involved with direct patient care; and travel vaccines for people travelling to certain countries.

Childhood Immunisation

BCUHB has historically performed better than the national average for uptake of most childhood immunisations, although there is variation based on geographical area and uptake rates decline from infancy through to later childhood.
In 2018/19, 89.7% of resident children in North Wales were up-to-date with scheduled vaccines on reaching their fourth birthday. This is higher than the other health board areas and Wales. However, uptake in the least disadvantaged areas in BCUHB is generally much higher than in the most disadvantaged areas and so there is an inequity. We have appointed a further two immunisation co-ordinators who are targeting the areas most in need.

Measles, Mumps and Rubella (MMR)

Uptake of the first dose MMR vaccine in children aged two years in BCUHB was just above the 95% target in 2018/19.The highest uptake was in Isle of Anglesey. MMR uptake at age five years in BCUHB was just below the 95% target in 2018/19. However, Isle of Anglesey, Flintshire and Wrexham all reached the target. We continue to work with our communities to promote immunisation and dispel myths.

Healthy Weight Services

BCUHB continue to progress towards establishing a tier 2 service with the inclusion of a commercial weight provider as part of the package of service options. The Kind eating and Foodwise programs have expanded during 2019/20 with an increase in patient contacts.

We have been scoping models of good practice and performance to develop our tier 3 children's obesity service during 20/21. This work will contribute to the delivery of 'Healthy Weight: Healthy Wales' long term strategy to reduce and prevent obesity.

During 2019, our Infant Feeding Strategy was launched The vision is to create a supportive culture in North Wales that enables parents to make the choice about infant feeding in an informed way that optimises nutrition and helps develop close, loving relationships with their baby.
Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in early childhood.

Let's Get Moving North Wales collaboration continues to work together to improve the health and wellbeing of the population of North Wales, through increasing opportunities to be more active.

Winter Wellness Campaign

Our East Area Team's Winter Wellness Campaign was a public facing awareness raising campaign provided to offer advice and support to members of the community on the importance of keeping well particularly through winter. The campaign covered five themes which include: Skin Care, Hydration, Falls Prevention, Choose Pharmacy and Flu Vaccination and Supporting Carers.

Initially, a week of Roadshow events were held in Wrexham and Flintshire. Subsequently members of the team have been promoting the campaign in Food Festivals and Bite Size Health in the Workplace events.

Young People for Young People

Hannah Mart, Children and Young Person's Sexual Violence Adviser, based at the Amethyst Sexual Assault Referral Centre has been working with a group of young people to develop a resource booklet entitled 'Sharing Stores / Rhannu Straeon'. The aim of the resource was to provide information and advice to other young people about and the criminal justice process and how to cope with it, to support their recovery, reduce their isolation and increase their resilience. In addition, it can be used to help professionals to understand the experience of the CJS journey from the perspective of the survivor and better support them.

The project developed momentum and in addition to the booklet a film and podcast was developed. The 'Sharing Stores / Rhannu Straeon' film and podcast was launched officially in September 2019. The project was submitted as an application to the Problem Orientated Police Awards (POP). Hannah and some of the young people involved were invited to the Awards ceremony to present the project, although it didn't win the judges were so impressed with the work they decided to award the judges discretionary fund of £3000 to the project.

Safe Care
You are protected from harm and protect yourself from known harm

Safe, Clean Care

There has been continued focused improvement and reactive work relating to infection prevention, as well as the inclusion of the Safe Clean Care campaign for the past year. This includes reducing unwarranted variation, developing a link practitioner programme, with our first in house educational event.

Janice Stevens revisited the Health Board and gave a positive report back to the Executive team on progress in the last year. In addition internal audit revisited and assurance levels overall were increased from the previous year in relation to Safe Clean Care and Infection Prevention & Control. A snap shot audit on urinary catheters took place in September 2019 and preliminary results suggest less than 2% of those patients had an infection associated with urinary devices. This is alongside the achievements to date in reduction of Meticillin Resistant Staphylococcus Aureus blood stream infections which has decreased by a further 46% to date compared to 2018/19, from 2.72per 100K population to 1.20.

However, we recognise there are still particular infections to concentrate on, such as gram-negative bacteraemia and collaborative work programmes in primary and community care with other specialist services.

GOFAL
DIOGEL
GLÂN

SAFE
CLEAN
CARE

Chart1. Betsi Cadwaladr UHB monthly numbers of MRSA bacteraemia by location type, Apr 10 to Jan 20

Number of non-inpatient specimens   Number of inpatient specimens   Number of specimens
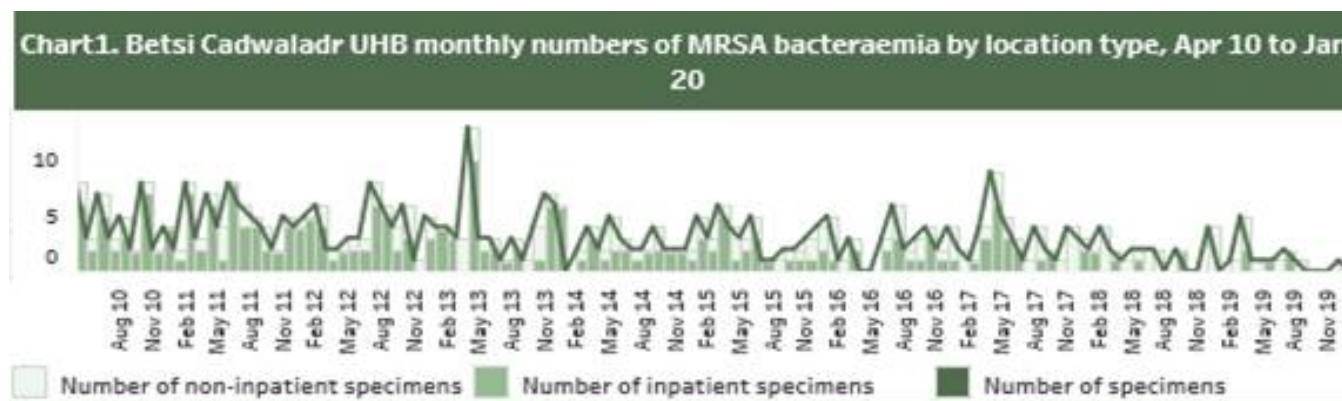
Focus on Quality Improvement

The Health Board introduced a programme of focused improvement work that includes the Ward Accreditation Programme, which commenced mid October 2018, quickly followed by the Hospital Acquired Pressure Ulcer Collaborative (HAPU) in late November 2018 and then the Inpatient Falls Collaborative in June 2019.

All key programmes of focused improvements provide an opportunity for the Health Board to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC).

A collaborative approach to reducing harm

By using a collaborative approach, we have focused improvements relating to our key harms (Inpatient Falls and Hospital Acquired Pressure Ulcers). The collaborative is a small number of identified wards who have come together with support from Quality Improvement team & subject experts as a faculty through a planned sessions face to face and virtually has led the embedding of a common language and understanding of quality improvement for all levels of ward staff. It has helped us identify standards for all our the wards to follow in terms of identifying and reducing harm from Hospital Acquired Pressure Ulcers and then for Inpatient falls once collaborative completed.

Outcomes to date include standardise reporting of incidents, streamlining and easy access to educational resources, development of chair awareness audit engaging visitors and the public in reducing harm from falls.

Link to HAPU collaborative films to be received

Falls: DATIX reporting SBAR

S	**Situation:** What is the immediate situation? • Identify self, unit, patient & room number. • Briefly state the problem.
B	**Background:** What led to this situation? • Admitting diagnosis and date of admission. • Current medications, allergies & IV fluids. • Brief history. • Current treatment.
A	**Assessment:** What do you think the problem is? • Explain your assessment of the patient and how you came to this assessment e.g. stable or deteriorating.

R	**Recommendation / Request:** What do you recommend should happen next?
	 • Review / see the patient now.
	 • Perform / review tests.
	 • Reassess / consider:
	   o Foot wear;
	   o Location of patient on ward;
	   o Mobility aids;
	   o Falls Pathway;
	   o Inform family and members of MDT;
	   o Visual cues.
	 • Complete the post falls checklist / documentation.

Ward Accreditation

Launched in November 2018, our Ward Accreditation programme assesses wards and units across the region on a range of quality measures. Wards which demonstrate excellent care are awarded a bronze, silver or gold award following an in depth assessment by nursing leaders.

Work of the Ward Accreditation programme continues with all wards having received an unannounced visit. To date 95 wards have been visited of which one has received a Gold ward. The programme will continue and is fully embedded within the Health Board as a way of supporting our teams with implementing a set of standards, sharing improvements and celebrating success.

Gold Award

Staff on Hydref Ward at the hospital's Heddfan Psychiatric Unit have been awarded Betsi Cadwaladr University Health Board's Gold Accreditation for providing the highest standards of care. Hydref Ward is the first in North Wales to be awarded the gold accreditation. The ward provides support for older adults living with a range of mental health conditions, including bipolar disorder, severe depression, personality disorders and schizophrenia

Gill Harris, BCUHB's Executive Director of Nursing and Midwifery, said: "The staff on Hydref Ward are a real credit to the Health Board and I'm very proud of the high standards of care they deliver, and the positive impact this has on patients and their loved ones. "The accreditation scheme is about celebrating and recognising where excellent quality care is being delivered, and learning how we can do more to support frontline staff.

Rachel Turner, Ward Manager on Hydref Ward, said: "We want our ward to be the best it can for our patients and everyone who visits the ward, and this award really demonstrates the hard work we have put in. "Everyone has contributed to us achieving this - our students, housekeepers, registered nurses, our activity coordinators and healthcare support workers, it's been a real team approach and I want to thank everybody for their hard work."

Psychiatric Intensive Care Unit staff named Nursing Times' Team of the Year

Our Wrexham based Psychiatric Intensive Care Unit staff were named the Nursing Times' Team of the Year for their work to bring laughter and joy to people most seriously affected by mental ill health. Staff from Tryweryn Ward at Wrexham Maelor Hospital's Heddfan Unit beat stiff competition from NHS teams from across the UK.

The prestigious award has been given in recognition of "incredible" changes the team have made to the eight-bed Tryweryn Pychiatric Intensive Care Ward, which provides care and support for people who are so acutely unwell that they cannot be safely treated on a general mental health ward. This has seen the introduction of a of a range of new activities and therapies on the ward, including joint yoga sessions, hand massages and baking, as well as a new 'rant and relax room', which has been designed by patients.

Caniad Service Manager Denise Charles said: "Different people let off steam in different ways. If someone is feeling like they're not able to express themselves, they may become very distressed. Instead of needing to safely restrain them, we can guide people towards the safe room and encourage them to either let it all out, or just lay under the weighted blanket. We comfort them".

"Since introducing the changes, Tryweryn Ward staff have managed to halve the number of restraints performed, while patient satisfaction scores have increased significantly in the same time. "There is now much more laughter on the ward because it's patient-led".

Ward Manager Matt Jarvis said: "It's all very simple really – just asking how we can support people's individual needs, and actually listening to what they have to say".

Safeguarding

In Progress

Effective Care
You receive the right care and support as locally as possible and contribute to making that care successful

Emergency Department Pathway Redesign for Management of Specific Fractures

The purpose of the Emergency Department (ED) Direct Discharge for the East area, was to redesign the pathway of care for the management of six specific fractures and injuries. All patients with acute fractures have traditionally been referred to a fracture clinic soon after injury. However, many simple stable fractures and injuries can be discharged from the ED with standardised advice leaflets, access to telephone advice and no further follow up in fracture clinic.

➡ Implementation commenced on the 1st Oct 2018 and data was collected prospectively for 12-months. Patients diagnosed with one of the six specific injuries were put onto the 'Self Care Pathway' (SCP) receiving the appropriate treatment and an advice leaflet, prior to being discharged from the ED.

➡ The ED physiotherapist collated patients put onto the SCP, reviewed the notes/X T Rays with an Orthopaedic Consultant on a weekly basis, to ensure patients' were safely, and appropriately discharged from the ED. Patients either remained on the SCP, were referred to Occupational Therapy (OT) for onward management (mallet injuries only) or were recalled to attend fracture clinic. At 8 weeks post injury, the ED physiotherapy practitioner carried out a telephone review for patients who remained on the SCP without any routine follow up. Additionally, the ED software system was used to examine how many patients were referred to fracture clinic with one of the 'six' injuries, rather than being treated on the SCP:

➡ 255 (67%) out of a possible 378 patients were put onto the SCP, with 231 (91%) remaining on the SCP after the orthopaedic review. Only 2 (1%) patients who were accurately put on the SCP, re-attended the ED with ongoing pain/disability and were subsequently seen by an orthopaedic consultant and fracture clinic respectively. Of 62 patients contacted on the telephone review, 98% reported normal function and near/full recovery from their injury. 231 fracture clinic appointments were not needed.

This work has improved the pathway of care without compromising the overall outcome and subsequently, less travel time and time off work for the patients' to attend an appointment and fewer fracture clinic appointments, thus reducing the workload of the fracture clinic.

Wrexham Maelor Hospital Annual Symposium: Quality Improvement (QI) and Audits

This was the second "Annual QI-Audit symposium" at Wrexham Maelor, which was attended by 94 staff members from various disciplines. It included 10 selected QI projects/audits presented by medical and nursing staff and was very well received by all attendees with excellent feedback. Three prizes were awarded for the best projects and the first prize was won by the orthopaedics team for their brilliant results with "Personalised total hip replacement pathway" at Maelor. Quotes from attendees included:

➤ "Excellent. A wide range of subjects and inspirational for innovative change".
➤ "Good practice to carry forward. Very informative and current, pro-active projects, very encouraging and a pleasure to hear".
➤ "A variety of projects from various specialities! Wonderful presentations given throughout. Good quality projects! Excellent-excellent!".

'One Stop Shop' – Shoulder Clinic
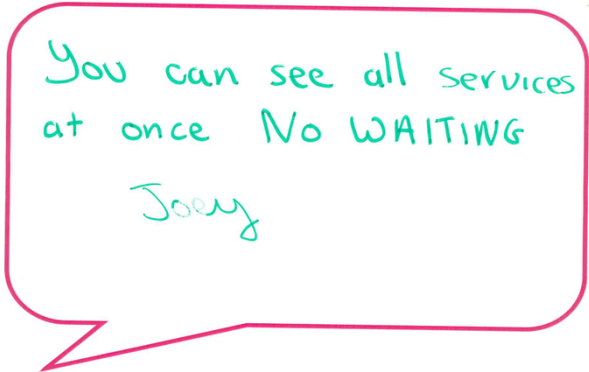
Implementation of the 'One Stop Shop Shoulder Clinic' started on 1st April, 2019. The purpose of implementing a 'One Stop Shop' shoulder clinic within the musculoskeletal triage service (CMATS) was to improve the pathway of care for patients with shoulder conditions. This service enables patients to attend one appointment and receive a musculoskeletal assessment with immediate access to diagnostic ultrasound scanning and injection if indicated.

➡ Between April 2018 and August 2019, 131 patients were seen in the one stop shoulder clinic. Following clinical assessment, 61% of these patients proceeded to ultrasound scan, 39% of patients did not require a scan.

➡ There were 142 GP referrals for shoulder ultrasound to the radiology department. There has been a 44% reduction in shoulder ultrasound activity when compared scans performed between April 2019 and August 2019.

➡ The average waiting time for ultrasound within the radiology department between April 2018 and August 2018 was 9.4 weeks. The average waiting time between April 2019 and August 2019 was 6.1 weeks. This demonstrates a 35% reduction in patient waiting times during April 2019 and August 2019.

"Everything! One-stop service. Excellent consultation. Explained what was wrong with me – able to have tests, exam and ultrasound all in one visit. Brilliant! Can't fault".

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Community Care Hub

The Community Care Hub is led by Dr Karen Sankey and Dr Dewi Richards and was established in the Salvation Army, Wrecsam in January 2017. Dr Sankey has been a GP for 25 years, but she feels modern general practice is "not fit for purpose", particularly for vulnerable groups, who tend to "just fall through the cracks".

You can see all services at once No WAITING

Joey

The Community Care Collaborative Hub provides a one-stop shop for every service that people may need. It's a drop-in session which happens every Friday bringing together 29 agencies. The 'Everyone in the Room' model brings together all the agencies that people need in the same room, at the same time every week. This system means people do not have to worry about missing appointments or needing paperwork they don't have access to. On average it supports 60 people each week who are homeless, sleeping rough or have mental health or substance misuse problems. In the last financial year, 850 people accessed its services. The PALS have been working alongside the other 28 agencies since September 2019.

Dignified Care
You are treated with dignity and respect and treat others the same

A peaceful setting

In early 2019 we introduced a new care suite at Wrexham Maelor Hospital which will provide a peaceful setting for people with dementia to spend their final days. The facility at the hospital's Heddfan Older Persons Mental Health Unit will ensure that people with dementia can receive end of life care in a dignified setting away from the main hospital environment, if this is their wish and that of their family.

The refurbished suite, which will support patients on Gwanwyn Ward, has dedicated facilities to enable families to stay close to their loved one and follows our commitment to John's Campaign, which advocates for carers' right to stay. It forms part of our efforts to improve the quality of Older Person's Mental Health services and act on the recommendations of external reports by the Health and Social Care Advisory Service and health investigator Donna Ockenden.

"People with dementia have as much right as any other person to a dignified death with an assurance of compassionate and high quality care. As a health board we recognise the need for preferences and decisions about end of life care to be identified as early as possible and we advocate for people to be able to have these conversations when they feel the time is right. As such we are supporting our staff to have the knowledge and skills that are needed." Sean Page, Consultant Dementia Nurse at BCUHB

Reviewing the way we work

Health Care Inspectorate Wales

In Progress

North Wales Community Health Council (NWCHC)

The North Wales Community Health Council (NWHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use our health services.

The NWCHC monitors and scrutinises our health services to improve the patient experience; one of the many ways the NWCHC does this is by visiting health premises. All visits are undertaken by NWCHC volunteer members.

During the year, NWCHC members visited all of our main hospital ….

NWCHC reports now form part of our Ward Accreditation Programme and we look forward to working with the NWCHC to develop this programme into other service areas.To find out more about the work of the NWCHC please contact:

- Email – admin@waleschc.org.uk

- Telephone – 01248 679284 (ext 3)

- Website – www.communityhealthcouncils.org.uk

- Write to – NWCHC, Unit 11, Chestnut Court, Parc Menai, Bangor LL57 4FH

In Progress

Timely Care
You have timely access to services based on clinical need and am actively involved in decisions about my care

Advanced Paramedic Practitioner Project

**CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL**

CIC GOGLEDD CYMRU / NORTH WALES CHC

Advanced Practice Paramedics provide a rapid response service to patients requiring home visits, which would previously have been provided by their GP. The purpose of this project is to support GP practices in North Wales to improve the quality of care, transform the way that care is delivered in the community, and help sustain Primary Care services by reducing emergency admissions, improving patient access, releasing capacity for GPs to focus on planned care appointments in their Practices.

The scheme will support Primary Care sustainability, improve patient access, and deliver more services in the community.

Improving emergency access for children

Child and Adolescent Learning Disability Service

Building Better Care

In Progress

Treating People as Individuals
You are treated as an individual with your own needs and responsibilities

Improving services for vulnerable groups

In 2019, a Wrexham based health visitor was named the winner of the Advancing Equality Award at a glittering gala evening at Venue Cymru to mark the Betsi Cadwaladr University Health Board Achievement Award 2019. The awards, sponsored by Centerprise International, celebrate the outstanding achievements of NHS staff from across North Wales.

Jackie has been recognised for what colleagues describe as an 'inspirational' commitment to providing health and wellbeing support to asylum seekers and refugees from Syria and other war torn countries. Since 2001 Jackie has supported the resettlement of hundreds of asylum seekers, trafficked women and refugees in the Wrexham area. Wrexham is one of four dispersal areas in Wales and the only area in North Wales which receives asylum seekers from the Initial Assessment Unit based in Cardiff. On arrival in Wrexham, Jackie coordinates their health and wellbeing assessments and provides ongoing support to ensure that asylum seekers can access a range of health services. She also runs drop in sessions which bring a range of support services together under one roof.

In Progress

"It Makes Sense"

● Put patients first   ● Work together   ● Value and respect each other   ● Learn and innovate   ● Communicate openly and honestly

On November 28th 2019, the fifth hosting of the All Wales Sensory loss conference that precedes the "It Makes Sense" annual campaign took place. The purpose is to highlight provision of care, service and support for the sensory loss community and shine the spotlight on those who provide vital support. The event this year was hosted by Betsi Cadwaladr University Health Board and organised by the Patient and Service User Experience Team.

The event was compromised of guest speakers and presenters to showcase their specific sensory loss organisation or supporting elements, there were updates of developing awareness of sensory loss groups, supporting mechanisms and roles specific organisations have with providing such things as accessible Health care, patient support, carers and relative support and training. The event also provided workshops to aid in the understanding of sensory loss across the spectrum of sight loss, blind, visually impaired, deaf, hearing loss and the mental health of those who have a sensory loss.

The event was also planned as a unique networking meeting for delegates, health care professionals and the sensory loss community to come together under one roof for the purpose of sharing, supporting and highlighting changes, updates or new innovation for sensory loss.

The event attracted over 140 delegates from all over Wales and England who had an interest in sensory loss ranging from service users to Ophthalmic consultants and University students, supporting organisations, National Charities and regional and local third sector groups who provide for specific sensory loss communities within their areas.

Support for individuals with Learning Disabilities

There are specialist learning Disability Acute Liaison Nurses (ALNs) covering the 3 District General Hospital's, within office hours, in BCUHB. They provide support to individuals with learning disabilities, their families and carers when they are accessing mainstream hospital services. This service was introduced as a result of a plethora of evidence which highlighted that having a Learning Disability means that hospital services are not always aware of how to meet the care needs. This can result in delays in treatment, and worse case scenario, lead to premature, avoidable deaths (Confidential Inquiry into premature deaths of people with Learning Disabilities 2013, Death By Indifference MENCAP 2010) The ALNs also provide education and training to hospital staff at all levels, and have also trained around 120 Learning Disability Champions with plans to continue to recruit more.

BCUHB also has a Patient Contact Notification system. This e-mails the ALNs when a person who is known to have a Learning Disability is admitted. This ensures that the person is identified as having a learning disability early in their admission to hospital. There are also Learning Disability Primary Liaison Nurses and skilled Health Care Support workers in the community. Their role is to improve access for individuals with a Learning Disability to mainstream primary care services and to improve the uptake of the annual health checks by working with service users, carers and families as well as services.

Supporting Welsh Speakers

The Health Board's Language Choice Scheme has been greatly expanded during the past year and is now in operation on wards within all three BCUHB acute hospitals and at numerous community hospitals. Orange magnets – adorned with the instantly recognizable orange 'Working Welsh' logo – are placed on bedside white boards (and also on staffing boards), in order to identify Welsh speakers and facilitate the process of pairing patients and staff who can speak the language.

Welsh language training has developed to be an integral part of developing Welsh language skills of BCUHB staff. Our comprehensive programme has attracted funding of over £200,000 a year from Gymraeg Gwaith/Work Welsh, a scheme funded by Welsh Government, which also includes funding to employ a Welsh Language Training Support officer for BCUBH since April 2018. Since being part of the Cymraeg Gwaith / Work Welsh scheme in April 2018, 9.4% of the workforce have registered, completed and received Welsh language training.

As well as the work welsh initiative our BCUHB Welsh Language Tutor offers courses tailored to the needs of BCUHB staff members - on a language level, and to the type of work they undertake from day to day, allowing staff members to gain the relevant Welsh language skills in order to offer a bilingual service and therefore meet the needs of their patients.

Our staff
We have enough staff with the right knowledge and skills available at the right time to meet your need

Challenges recruiting and retaining our staff

As at January 2020, BCUHB employed 18178 staff of which 15594 are full time equivalent (FTE). However, recruiting and retaining key staff remains a challenge. This is reflected in our vacancy rates.

At present the Health Board has a 9.1% overall vacancy rate.

Nursing and Midwifery
- Vacancy rate of 11.3%, which has been reducing in recent months. However, this has been helped by the recruitment of 50 FTE Nursing and Midwifery staff in the final quarter of 2019
- Across 2019, overall growth in the Nursing and Midwifery workforce was just 18.5 FTEs whilst the budget increased by 67 FTEs. This demonstrates the struggle for recruitment to keep pace with increased demand
- A similar picture is presented at a national level where Nursing and Midwifery workforce FTEs increased by just 144 across the period January 2019 to November 2019

Medical and Dental
- Vacancy rates are at 9.7% (Dec 2019) but some specialisms face particular challenges; consultant vacancy rates are at 8.6%.
- Similar to the picture with Nursing and Midwifery, demand is outpacing recruitment with the Medical and Dental workforce growing by 34.5 FTEs over 2019 whilst budgets increased by 59.6 FTEs
- At a national level, Medical and Dental workforce FTEs grew by 176 across the period January 2019 to November 2019.

Recruitment to Nursing, Midwifery, and Medical & Dental staff groups remains a challenge for BCUHB, as it for other Health Boards, owing to a general shortage of skilled staff. This issue is particularly acute within the following hard to fill specialisms; GPs, Mental Health and Learning Difficulties, General Surgery, Rheumatology, Care of the Elderly, Radiology (particular the specialisms relating to Breast), Gastroenterology and Obstetrics and Gynaecology.

So what are we doing about it?

Retaining our staff

In light of the challenges above, retention of skilled staff remains a key priority. Numerous improvement actions have been enacted since the NHS Wales Staff Survey 2018 organisational improvement plan was approved by the Board in March 2019. All Divisions also have also developed their local improvement plans. In order to ensure staff feedback is a continuous process the organisation invested in a tool which has been branded as 'ByddwchynFalch/BeProud. The tool offers a simple way to understand the science behind staff engagement in terms of cause and effect; provides clear practical recommendations to improve staff engagement; provides regular trend analysis and organisational and team level diagnosis of culture.

BCUHB remains committed to investing in developing our staff. All Leadership & Management Development programmes have been reviewed to ensure compassionate leadership is threaded throughout each programme. Senior leadership development includes a suite of masterclasses and a network which brings together the most senior clinical and non-clinical leaders to develop relationships and develop a cohesive team to ensure organisational and service objectives and improvements are met. Appraisals have increased by 8.6% since April 2019 to 75.5% in January 2020. Processes have been reviewed to ensure compassionate and values based conversations take place at appraisal.

Promoting Train/Work/Live

In order to address the challenges for Nursing & Midwifery recruitment, BCUHB will continue to market itself through Welsh and UK wide recruitment events, promoting the Train/Work/Live North Wales brand. At a local level, the health board is planning this year's calendar of recruitment open days where candidates can be interviewed on the day and walk away with an offer.

➡ Specific focus is being placed on wards with high vacancy numbers where social media campaigns will be run through Facebook, Twitter and Instagram.

➡ Whilst we hope to address the majority of our recruitment needs locally, we accept that there is still a need to source candidates from further afield so in Q1 2020/21 BCU will commence a 12 month international recruitment campaign to source circa 200 RNs.

➡ For Medical and Dental staff a dedicated weekly Medical Recruitment Panel meets to plan and speed up recruitment activity. BCU are also working with external recruitment specialists to help source new recruits into hard to fill specialisms.

Wales for Africa

In Progress

Newly Qualified Nurses

From September, those student nurses on a Welsh Bursary will be expected to remain in Wales for 2 years post qualifying. They do not have to stay in an NHS role but this will improve our retention of students in particular in Paediatrics where we often lose staff to tertiary settings in England.

Supporting staff to deliver compassionate care and make improvement

Improving Quality Together

Through the BCUQI hub improvement, training has been delivered for the last 18 months. So far 123 staff have signed up for Silver IQT, with 73% of them completing all study days. The Silver IQT training now forms part of ward managers training, with two cohorts of managers attending training to date. The improvement training has been standardised through the development of standard operating procedure.
The BCUQI hub has opted to go live earlier than launch date (April 2020) of the new improvement in practice training which is replacing Silver IQT with the first cohorts (17 staff) now half way through their face to face training.

As part of the improvement training the BCUQI hub has developed a QI database for improvement projects to be loaded to and shared across BCUHB so others can adopt and learn, the database is also open for others to load there improvement work to as well. The database can be accessed via https://www.bcuqi.cymru/database-1.

Chaplains and Spiritual Care

The Chaplaincy Service delivers pastoral care to staff as well as our patients and their families. In addition, daily pastoral care of our staff, the Chaplaincy, over the last year has introduced new initiatives that encompass a wider spectrum of our world of spirituality. The introduction of guided mindfulness sessions and spiritual concerts have enhanced our service. One such initiative is the monthly gong bath for staff members at Ysbyty Gwynedd - which has proved very successful. These teatime sessions have been over-subscribed and planning is underway for the introduction of yoga sessions soon. Our new Chaplaincy Centre at Ysbyty Glan Clwyd is now operational and provides a modern, multi-faith spiritual centre. The Chaplaincy Centres have also been opened out for use by community self-help groups such as Alcoholics Anonymous and community choirs.

Volunteers

In Progress

● Put patients first   ● Work together   ● Value and respect each other   ● Learn and innovate   ● Communicate openly and honestly

Celebrating success

International Year of the Nurse and Midwife

The World Health Organisation (WHO) has declared 2020 as the International Year of the Nurse and Midwife, in honour of the bicentenary of the birth of the founder of modern nursing, Florence Nightingale.

Worldwide, nurses and midwives play a vital role in providing health services, and they can often be the first and only point of health care in their communities.

Nurses and midwives are the largest workforce globally and provide support across the life course for individuals, families and communities and provide invaluable leadership for health protection and preventative healthcare.

BCU employs over 6000 nurses and midwives across various roles and this is testament to the vital role nursing plays in shaping public health policy and providing leadership to improve the health of the nation.

Throughout 2020, we will be:

- Celebrating the contribution of nurses and midwives in improving global health by supporting national and international events and also holding a number of locally led initiatives
- Attending public events and schools to educate future health professionals on the varying roles available.
- Developing and publishing the BCUHB Nursing strategy

Blwyddyn y Nyrs a'r Fydwraig

2020

Year of the Nurse and Midwife

Staff Awards

In Progress

Seren Betsi Awards

The Seren Betsi Awards is presented every month to recognise an individual or team that goes above and beyond to demonstrate our organisational values. We also present a Seren Betsi Gold Award at the Annual Achievement Awards where an overall winner for the year is selected by public vote.

In Progress

Equality: Fairness, Rights and Responsibilities

● Put patients first　　● Work together　　● Value and respect each other　　● Learn and innovate　　● Communicate openly and honestly

At BCUHB our vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, and helps towards reducing health inequalities.

To inform the health board's strategic direction it is essential that we have a clear overview and understanding of the major issues facing people with different protected characteristics. This year we have undertaken a review of our equality objectives. We have drawn on evidence from a range of sources including the Equality and Human Rights Commission research 'Is Wales Fairer?', gathered and analysed relevant information and maintained engagement with communities, individuals and experts to help to further inform our priorities and objective-setting. The SEP can be accessed (link)

The promotion of equality and human rights in everything we do is a key underpinning principle within all health board plans and the responsibility of the whole organisation. Progress and more information about the work we have done to advance equality this year is published in our Annual Equality Report 2019-2020 (link)

More details about the work we do to promote and support equality can be found in our Annual Equality Report 2019 – 2020.

Concerns and Incidents

As a Health Board, we strive to provide safe, high quality care and treatment to all, but sometimes things can go wrong and we let our patients down. If this happens we respond to the concern (complaint, claim & serious incident) raised in line with the 'Putting Things Right' Regulations (PTR).

Serious adverse incidents

Where serious adverse incidents occur, it is important that these are thoroughly investigated, that we learn from what has happened and put in place measures to prevent them recurring and improve patient safety.

The Health Board reports serious incidents to the Welsh Government, and on completion of our investigation we report summary of the findings, lessons learned and actions taken to them. Investigations should normally be completed within 60 days. Serious incident investigations are undertaken by trained and experienced clinicians and managers with a view to identify opportunities for learning and improvement.

Over the year the Health Board has placed a significant focus on improving the timeliness of investigations and we have seen a noticeable improvement in investigations being completed within 60 days. We will continue this focus recognising further work is needed to achieve the national target.

In addition, the Health Board recognises that its process could be improved and that the sharing of learning and monitoring of improvement actions could be strengthened. A re-design of the serious incident process started in March 2020 and will be continue over the spring and summer with a new approach being designed in co-production with all stakeholders. A new online lessons learned library will be developed, called Safety Net, to provide easier access to information across the Health Board. This re-design and improvement work will be reported to and overseen by our Quality, Safety and Experience Committee.

Awaiting data

In Progress

Never Events

Never Events are defined as Serious Incidents that are wholly 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 serious 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 as a result of a specific incident for that incident to be categorised as a Never Event.

During 2019 year, 5 Never Events occurred. This compares to 8 in the previous year.

Each Never Event is investigated under the serious incident process as outlined above. Additional scrutiny from our clinical Executive Directors and Independent Members is also provided. No underlying themes or trends were identified in the 5 Never Events occurring within the year and in each case improvement actions have been developed and are being implemented. Awaiting data

Complaints

Awaiting narrative and data

In Progress

Listening and Learning from Individual Feedback

As a Health Board, we are committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.

Examining patient and service user feedback provides direct insight into what is working well and not so well in the way we are delivering care.

Our Patient and Service User Experience Improvement Strategy 2019-2022 will drive Patient and Service User Experience to reflect the voice of our patients and service users who use our services. You can read more about the strategy and how we gather feedback and learn at; add link

Awaiting further narrative

In Progress

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Special Measures

The Health Board has been in special measures since June 2015. Work has been ongoing to make improvements in line with the expectations of the Special Measures Improvement Framework (SMIF) issued by Welsh Government. During the first half of this reporting period, the Framework covered four themes: leadership & governance, strategic & service planning, mental health and primary care. In November 2019, the Minister for Health & Social Services issued a revised SMIF covering the four themes of leadership and improvement capability, strategic vision and change, operational performance and finance and use of resources. This latest version of the SMIF is split into Part A: expectations to be met as a minimum in order to be de-escalated from special measures, and Part B: characteristics the Health Board will need to demonstrate it is sustaining and building upon in order to step down to routine arrangements status.

The organisation undertook a self-review in December 2019 against Part A expectations. The self-review identified progress made over the past year. This included quality improvements such as the increased use of integrated dashboards for a range of data/intelligence; the requirement under the Ward Accreditation Programme for wards to undertake quality improvement projects driven by concerns and patient feedback and a range of "Going for Gold" quality improvement roadshows.

Initiatives to improve patient safety during special measures include the launch of an upgraded Harms Dashboard; establishment of the In-Patient Falls Collaborative to support areas with higher levels of harm, and delivery of winter plan initiatives such as increasing multidisciplinary team capacity and projects to support patients' recovery in their own homes. Infection control work has led to a reduction in the number of cases of MRSA.

The work undertaken has led to a variety of improvements to the patient journey, such as the launch of the new Patient Advice and Liaison Service with hubs established at each District General Hospital; reconfiguration of beds and processes on the Wrexham site to create ambulatory and short stay medical capacity located close to the Emergency Department; and the SiCAT model of assessment and triage which has demonstrated a significant contribution to signposting patients to alternative care pathways.

Despite the progress made against the expectations of the revised Special Measures Improvement Framework, that a number of milestones, most notably in the key areas of finance, planning and performance (planned and unscheduled care), have not been fully achieved and it is recognised that there is considerable further work to be done to address the ongoing challenges. The Board remains fully committed and determined to achieve the required improvement in order to secure de-escalation from special measures.

In Progress

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Forward Look 2020/2021

Putting quality first in everything that we do to deliver outstanding healthcare to our local population is essential, and we will continue to do so. We have seen so many members of staff embrace quality improvement, and continuously raise standards and improve outcomes for our patients. In 2020/21, we will:

- Revise and reshape our Quality Improvement Strategy by May 2020 – informed by our Internal Audit Review.

- Develop our Patient Safety Strategy to strengthen governance across the organisation

- Strengthen the composition of our local governance teams informed by our local governance review

- Apply the learning from the HIW review of maternity services and birth centres to strengthen internal processes

- Broaden the visibility of our Quality and Patient Safety Experience reporting dashboard alongside the development of our Clinical Strategy.

- Place greater emphasis on the *learning element of listening to patients and services users* throughout 2020 as described in the Patient Experience Strategy, this will include the *You said, We did* approach.

- Working with Community Health Council, we will review our processes for concerns (incidents, complaints, claims, etc.)

- Review our clinical audit plan and reporting arrangements to facilitate quality improvement activities across the organisation.

- Enhance the training programme for concerns and learning approaches to investigations

In Progress

● Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Our **ambition** for 2020/23:

Exit Special Measures

Maximising our partnership working to deliver on the health inequalities and health improvement agenda	Implementing our model of Primary Care to ensure people have easy and timely access to services and deliver health and care support as close to people's homes as possible	Implementation of digitally enabled clinical pathways supporting timely access to safe and effective planned and unscheduled care in accordance with clinical need with the best possible outcome

Engage more widely and refine our digitally enabled clinical strategy proposals. Resources will be required for delivery of this ambitious strategy, which will include investment in digital systems and the requisite supporting staff, new workforce skills and capabilities, organisational development support, and a steering group to oversee the development of the strategy.

Our priority for action in **2020/21** is to make significant progress towards achievement of the following objectives.

Quality Improvement	
Strategic Vision and Change Developing a digitally enabled clinical strategy with our staff and partners	**Improved Operational Performance and Governance** Focussing our improvement in the following key metrics: - Planned care / Referral to treatment - Unscheduled care
Strengthened Leadership and Improvement Capability Supporting our key service transformation programmes: - Health inequalities and health improvement - Care closer to home	**Financially Sustainable** - Using our resources effectively - Moving towards a sustainable financial position

In Progress

Engagement

In Progress

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Experience Report – Q3 2019/20
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Assistant Director of Patient Safety and Experience Carolyn Owen, Head of Patient Experience
Craffu blaenorol: Prior Scrutiny:	Review by the report authors and responsible director
Atodiadau Appendices:	1) Patient Experience Report – Q3 2019/20

Argymhelliad / Recommendation:
The Quality, Safety and Experience Committee is asked to receive this report for assurance.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	

Sefyllfa / Situation:
The Quality, Safety and Experience Committee is the delegated Health Board committee with responsibility for seeking assurance on patient experience. This report provides the committee with information and analysis on significant patient experience issues arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway.

Cefndir / Background:
This new format report is designed to offer improved information and analysis in relation to patient experience, in order to improve the assurance received by the committee. The period under review is primarily October 2019 to December 2019 (inclusive); however, longer-term data for the previous 30 months (allowing period on period comparison over two years) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

Asesiad / Assessment & Analysis
Assessment and analysis is included within the report including a breakdown of complaints, details of the most common type of reported patient experience feedback and a high-level summary of identified learning.

Patient Experience Report Q3 2019/20

Produced by the Patient Safety and Experience Department,
Office of the Executive Director of Nursing and Midwifery

1. INTRODUCTION

1.1 Patient experience is what receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe and clinically effective care.

1.2 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient experience issue arsing during the quarter under review, alongside longer-term trend data, and information on the improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.

1.3 The Health Board has responsibilities for improving patient experience under the following key statutory responsibilities and policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

1.4 The Health Board approved its current Patient Experience Strategy in June 2019 and this can be accessed on its web site. The strategy is planned for a refresh in spring 2020 to capture learning from the first year of implementation and to consider integration of wider issues such as carer engagement, involvement and support.

1.5 Statistical process control (SPC) charts or run charts are used were appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicted by dotted grey lines.
- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

1.6 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

2. COMPLAINTS

2.1 Complaints are received and responded to in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly known as Putting Things Right – PTR) and/or Health Board policy and procedure. Information is also included in this report to enable triangulation of patient safety issues arising from complaints.

2.2 The Patient Safety and Experience Department is planning a comprehensive review of the complaints process and this will be conducted in co-production with divisions, patients and carer's and other stakeholders including Community Health Council (CHC) and Public Services Ombudsman for Wales (PSOW). This work commenced in February 2020 and will include review of the redress process. Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

2.3 During the quarter under review, 472 complaints were received (compared to 335 and 285 in the comparable prior periods).

2.4 The data for the previous 27 months (allowing period on period comparison over two years) shows a statistically significant shift which requires further review (and is now underway). The shift identified is partly reflected in On the Spot (OTS) concerns (see below) but this has now returned to a more normal rate, and has not been reflected in a commensurate rise in enquiries from the Ombudsman (see below). This shift also reflects a similar shift seen in reported patient safety incidents however a link cannot be drawn until the further analysis mentioned is complete.

Complaints-BCUHB starting 01/10/17

Legend: Mean — Complaints — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target
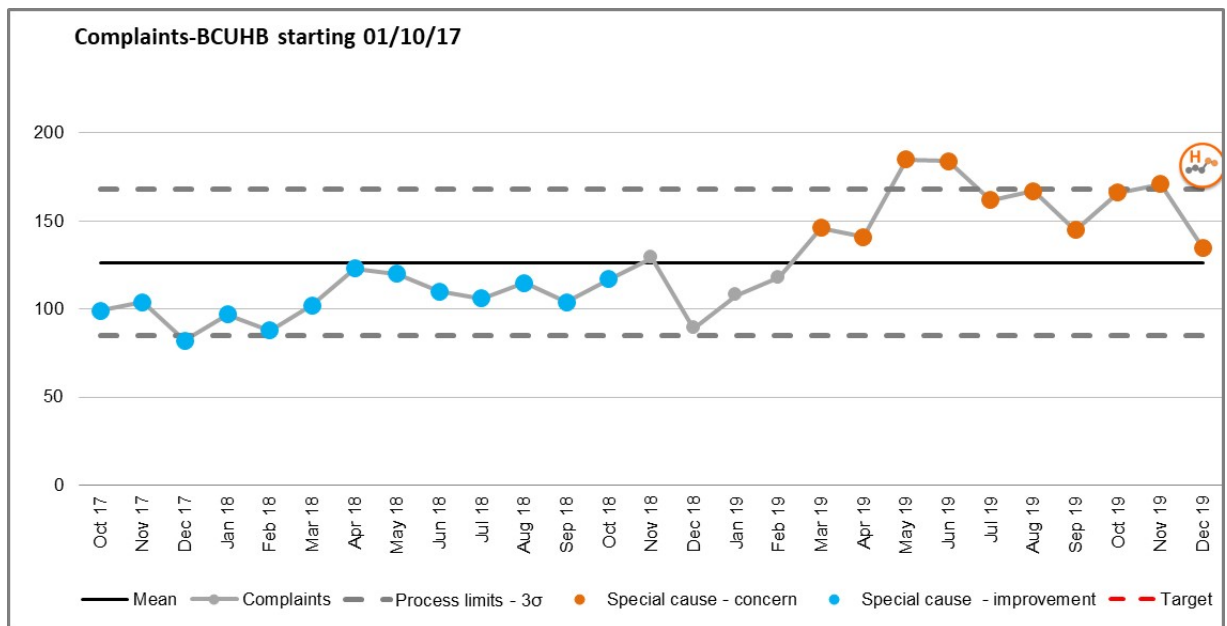
2.5 As mentioned above a deeper dive into the data is underway but initial review shows that during the overall 27 month period the number of complaints has increased in relation to the three district general hospitals with Ysbyty Glan Clwyd experiencing the largest increase. This was most noticeable at the start of 2019 and correlates with the overall increase shown in the graph below. Of these, the increase is largely attributed to three categories: Communication with the patient, Unacceptable waiting times and Co-ordination of treatment. A smaller increase was also noted in community mental health services. The increase for these services is shown in the chart below.

Services with the greatest increase in complaints

Legend: Mental Health Community Services — Wrexham Maelor Hospital - Acute — Ysbyty Glan Clwyd Hospital - Acute — Ysbyty Gwynedd - Acute
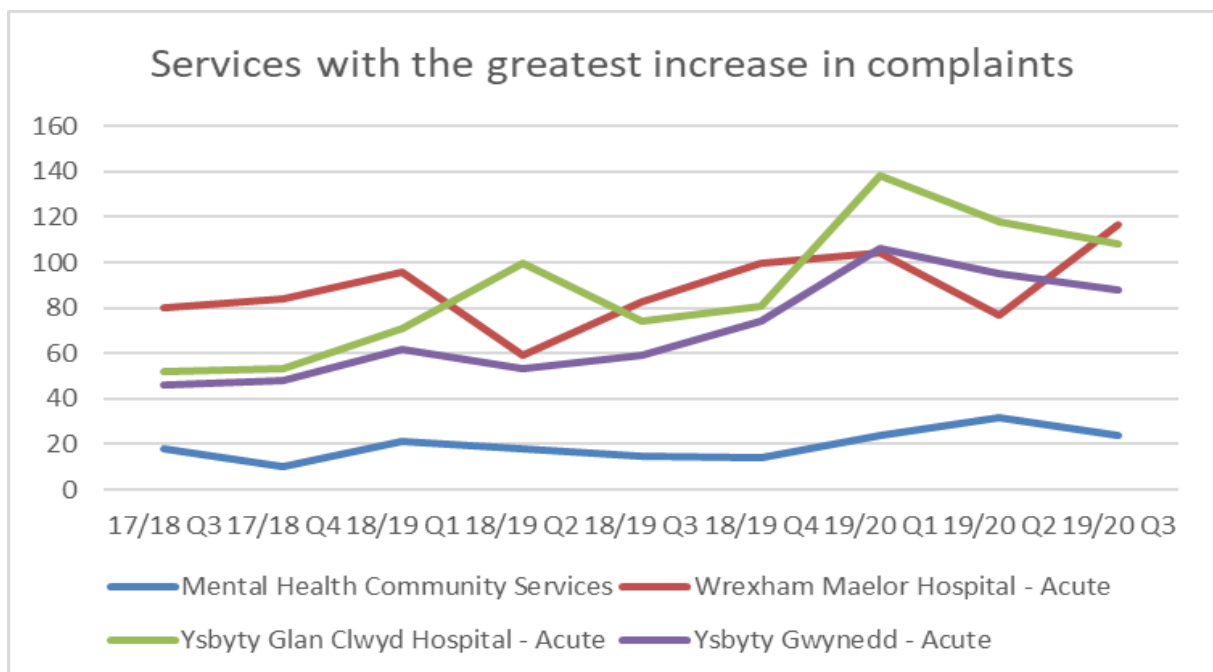
2.6 Complaints raised at the point of service delivery, and resolved satisfactorily within an agreed timeframe (ideally one working day), are referred to as "On the Spot" (OTS) concerns or "Early Resolution" concerns. These concerns are dealt with outside of the PTR process for complaints. During quarter 2 and 3, 1,453 OTS concerns were received. Where a concern cannot be resolved on the spot it will be upgraded to a

formal complaint. Some OTS/Early Resolution concerns are recorded by the Central Secondary Care Governance Team within the Datix PALS module due to a pilot project and these are excluded from the data below; the Head of Patient Experience is undertaking work to standardise practice.

On the Spot/Early Resolutions-BCUHB starting 01/10/17
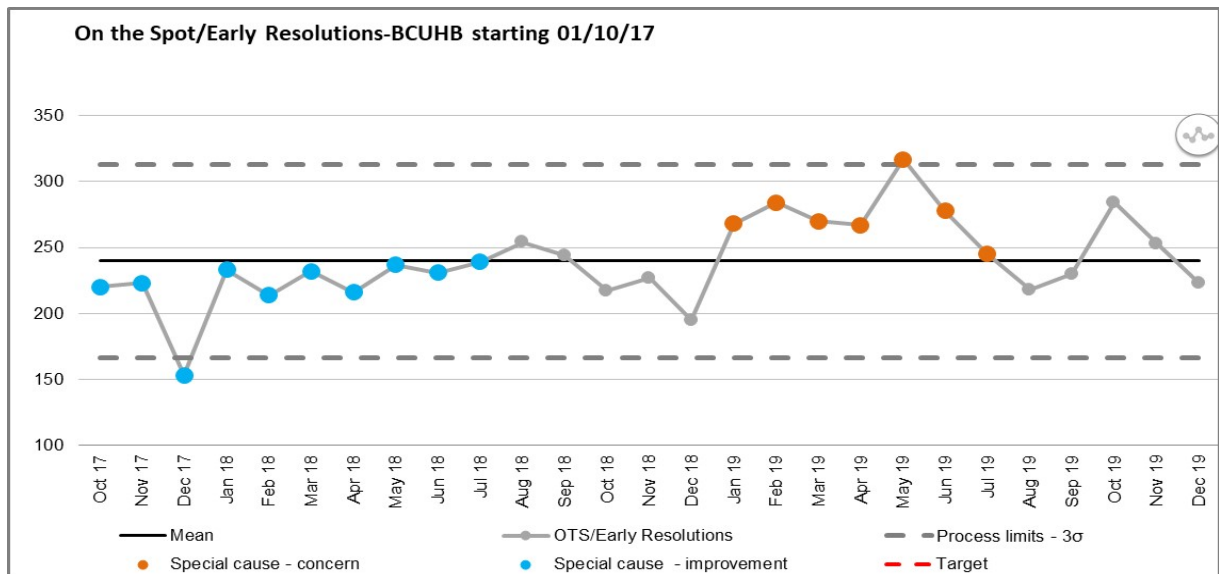
3. COMPLAINTS PERFORMANCE

3.1 In respect of complaints performance, 99% of complaints were acknowledged within 2 working days (against a target of 95%) and 51% of complaints were closed within 30 working days against a target of 75% and an agreed recovery target with Welsh Government of 60% by the end of March 2020 (at the time of writing the latest validated data was up to 31 November 2019).

Complaint performance-acknowledged-BCUHB starting 01/10/17

Complaint performance-responded-BCUHB starting 01/08/17
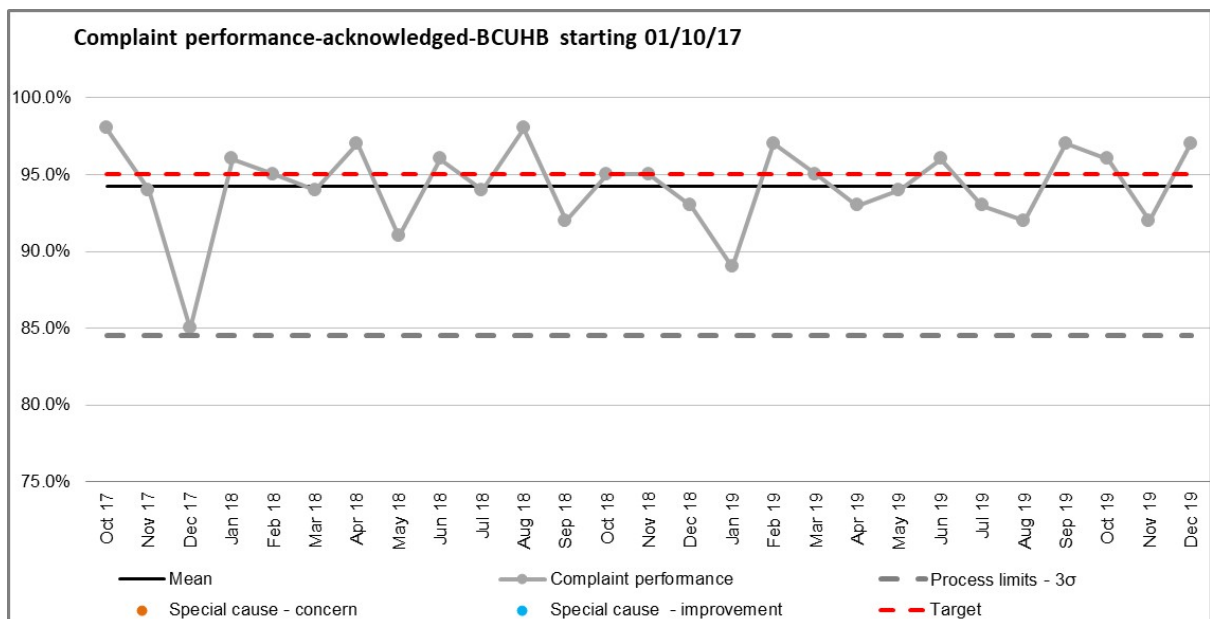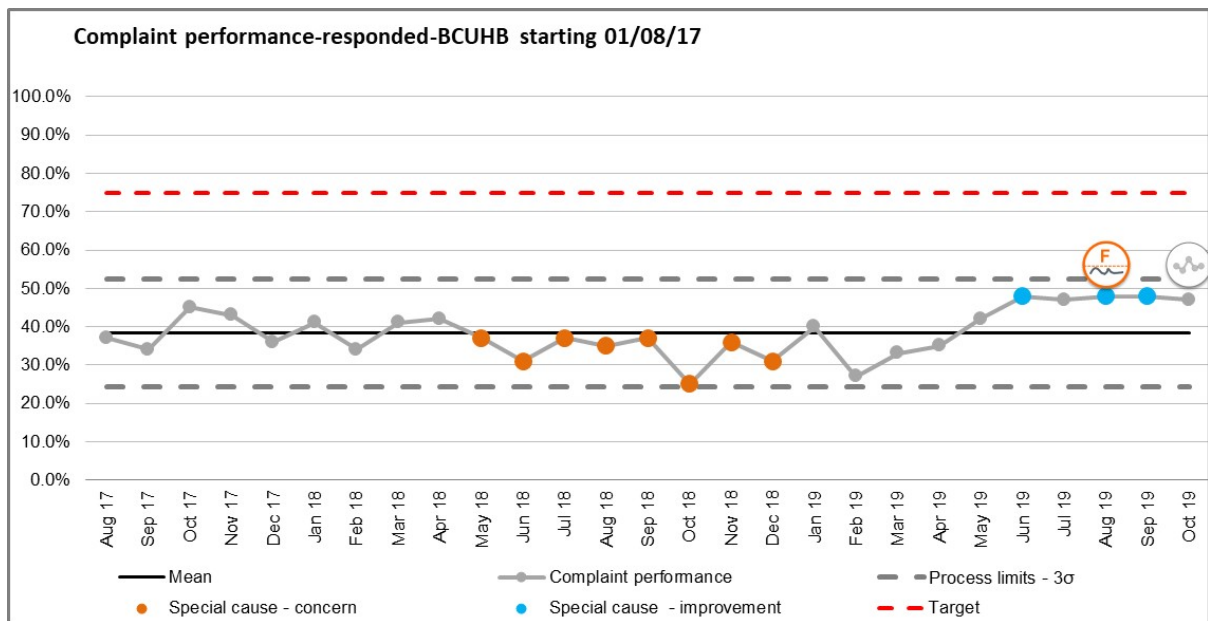
3.2 At the time of writing, 288 complaints were open of which 129 complaints were overdue (45%). Of these 71 related to Secondary Care (22 West, 32 Central, and 17 East) with Central having a noticeable deterioration in performance from 16. Other divisions with a number of overdue complaints includes Central Area (27, up from 8), East Area (10, up from 6) and Women's and Maternity (10, up from 7)

4. OMBUDSMAN

4.1 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales.

4.2 During the quarter under review, 50 Ombudsman enquiries were received (compared to 40 and 40 in the prior comparable periods).

Ombudsman Enquiries -BCUHB starting 01/10/17
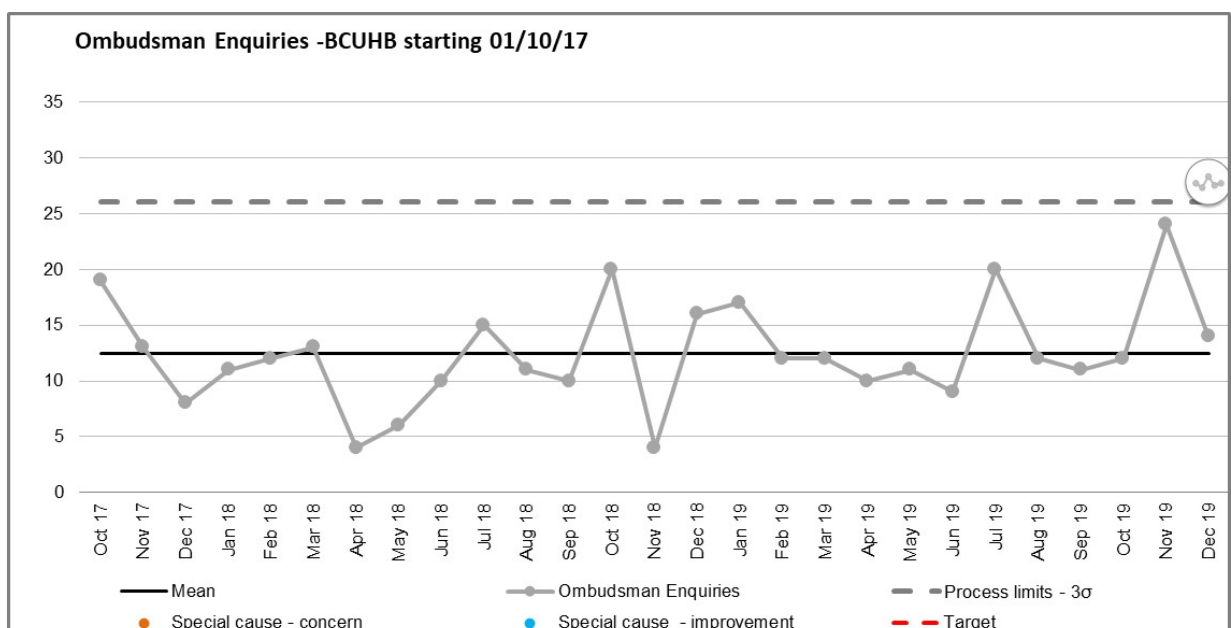
4.3   During the quarter under review, 1 Section 16 Report was received by the Health Board relating to a complaint in the Mental Health and Learning Disability Division. A Section 16 Report is a case which the Ombudsman considers has public interest and will be published openly. The primary issue arising from this was strengthening the contract management arrangements in cases where both the Heath Board and local authority has co-commissioned packages of care. The division has developed an action plan in response to the Ombudsman's findings and this includes a letter of apology to the family of the patient. This is the only Section 16 Report received by the Health Board since 2017.

4.4   The Health Board is aware of one upcoming Section 16 Report which will be included in the next report subject to the Ombudsman's publication date.

4.5   The Ombudsman, Nick Bennett, met with the Chief Executive on 20 December 2019 for their annual meeting following his annual letter to the Health Board. No issues or concerns have arisen from that meeting.

4.6   The Assistant Director of Patient Safety and Experience met with the local PSOW Improvement and Investigation Officer on 12 November 2019 and no issues or concern arose. The number of complaints to the Ombudsman has decreased and the Health Board intervention and resolution rate is broadly in line with other health boards.

4.7   The Assistant Director of Patient Safety and Experience met (along with the Head of Complaints) the new PSOW Complaints Standards Authority team on 06 December 2019. This new team is part of the Ombudsman's new powers and the team are working to standardise complaint handling across Wales, focusing initially in 2020 on local authorities. Following the meeting, the Health Board will seek opportunities to participate in this training during 2020 alongside our local authority partners (where possible).

4.8   The Health Board Vice Chair/Chair of QSE Committee, Assistant Director of Patient Safety and Experience and Senior Complaints Manager met with the local PSOW Improvement and Investigation Officer on 24 February 2020 and no significant issues or concern arose. The local officer highlighted the number of concerns relating to unsatisfactory second response letters from the Health Bard and it was confirmed this was being considered as part of the complaints process re-design. Issues will be explored in relation to a small number of cases were incomplete patient records have been submitted; this is believed to be a result of multiple paper files across sites and possible issues with the scanning and collating service.

4.9   The Patient Safety and Experience Department is planning a comprehensive review of the Ombudsman process and this will be conducted in co-production with divisions and other stakeholders including PSOW. This work is planned to commence in spring 2020 (due to the various other reviews underway as detailed in this report). Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

5. COMMUNITY HEALTH COUNCIL

5.1 The Assistant Director of Patient Safety and Experience met with the Chief Officer and Deputy Chief Officer of the North Wales CHC on 04 December 2019. A number of issues were highlighted covering the way in which the Health Board invites and responds to complaints and its openness and candour.

5.2 During the quarter under review, the CHC conducted visits to 14 wards and alongside these undertook associated site, care, food and infection control observations (known as Site Watch, Care Watch, Food Watch and Bug Watch surveys). The reports from these visits are received centrally and cascaded to the relevant divisions for review and where appropriate action planning, with a completed action plan being submitted in response to CHC. This approach to site visits and surveys will be discussed at the collaboration workshop mentioned above and the Patient Safety and Experience Department will develop a new process and procedure in co-production with the CHC and divisions.

5.3 The Patient Safety and Experience Department held a joint workshop with North Wales CHC on 29 January 2020 to begin discussions on improving collaborative working. Areas of focus will include strengthening learning from CHC visiting activity and involvement of CHC in the complaints process review.

6. PATIENT FEEDBACK

6.1 To ensure all areas are progressing to achieve the 20% experience feedback, the Patient Experience Team will continue to support all services ensuring every opportunity is taken to capture feedback from a minimum (1 in 5) patients. The aim is to improve quarter on quarter and year on year feedback.

6.2 Patient, carer and visitor feedback is collected through the CRT View Point system which allows feedback to be entered via an online web form or via terminals within clinical areas. During the quarter under review the following feedback scores have been received though the system with previous scores shown in brackets.

Service	Number of Responses	Mean Satisfaction Score (/10)
Ysbyty Gwynedd	963 (589)	9.25 (9.03)
Ysbyty Glan Clwyd	1225 (507)	9.19 (9.32)
Wrexham Maelor Hospital	1409 (885)	8.95 (9.06)
West Women's and Maternity	62 (37)	9.27 (9.68)
Central Women's and Maternity	138 (87)	9.41 (9.20)
East Women's and Maternity	187 (92)	9.45 (9.45)

Service	Number of Responses	Mean Satisfaction Score (/10)
West Community Hospitals	77 (44)	8.83 (8.30)
Central Community Hospitals	245 (97)	9.52 (9.42)
East Community Hospitals	242 (110)	9.14 (9.03)
West Mental Health & Learning Disability	2 (12)	5.5 (9.58)
Central Mental Health & Learning Disability	2 (2)	10.0 (8.00)
East Mental Health & Learning Disability	24 (29)	9.21 (7.66)

6.3   In relation to comment cards, during the quarter under review, the following feedback has been received:

- Ysbyty Gwynedd – 46 comment cards were received relating to a positive experience reflecting; *'Basic Nursing Care', 'Communication', 'General Facilities', 'Quality of Care' & 'Staff Attitude and Approach'*. With the negative themes relating to *'Waiting Times', 'Staff Attitude and Approach' & 'Wayfinding'*.
- West Community Hospitals – 11 comment cards received reflecting the positive themes *'Staff Attitude & Approach' & 'Basic Nursing Care'*.
- Ysbyty Glan Clwyd - 78 comment cards were received relating to a positive experience reflecting; *'Basic Nursing Care', 'Staff Attitude & Approach', 'Coordination of Care', 'Communicating with a Sensory Loss' ,'Miscellaneous' & 'Nutrition'*. With the negative themes relating to *'Infection Control', 'Facilities', 'Miscellaneous', 'Nutrition', 'Receiving Information', 'Staff Attitude and Approach' & 'Waiting Times'*.
- Centre Community Hospitals – 17 comment cards were received relating to the positive sub-theme *'Basic Nursing Care'*. With negative sub-themes relating to *'Facilities' & 'Receiving Information'*.
- Ysbyty Wrexham Maelor – 98 comment cards were received relating to a positive experience reflecting; *'Basic Nursing Care', 'Coordination of Care', 'Receiving Information' & 'Staff Attitude & Approach'*. With the negative themes relating to *'Communication', 'Coordination of Care', 'General Facilities', 'Miscellaneous' & 'Staff Attitude & Approach'*.
- East Community Hospitals – 4 comment cards were received relating to the positive sub-theme *'Staff Attitude and Approach'*. With negative sub-themes relating to *'Staff Attitude and Approach' & 'Waiting Times'*.

6.4   The Patient Advice and Liaison Service (PALS) across BCUHB actively listen, learn and act on the feedback gathered by our service users through a variety of methods such as; early resolutions, Care2Share and direct contact. The following feedback has been collected within the quarter.

WEST			
Care2Share - Subthemes		**Other Activity - Subthemes**	
Basic Nursing Care +ve	77	Basic Nursing Care -ve	10
Basic Nursing Care -ve	3	Receiving Information -ve	9
Communication -ve	3	Communication -ve	6
Staff Attitude and Approach +ve	3	Coordination of Care -ve	6
Coordination of Care -ve	2	General Facilities -ve	4
Infection Control -ve	1	Waiting Times -ve	4
Receiving Information -ve	1	Basic Nursing Care +ve	3
Receiving Information +ve	1	Receiving Information +ve	3
		Communication +ve	2
		Miscellaneous -ve	2
		Staff Attitude and Approach -ve	2
		Coordination of Care +ve	1
		Miscellaneous +ve	1
		Parking –ve	1
CENTRE			
Care2Share - Subthemes		**Other Activity - Subthemes**	
Basic Nursing Care +ve	1	BLANK	70
Coordination of Care +ve	1	Coordination of Care –ve	52
Staff Attitude and Approach +ve	1	Receiving Information -ve	15
		Basic Nursing Care -ve	13
		Communication -ve	11
		Waiting Times -ve	9
		Staff Attitude and Approach -ve	7
		General Facilities -ve	4
		Miscellaneous -ve	4
		Miscellaneous +ve	2
		Coordination of Care +ve	1
		Infection Control -ve	1
		Nutrition -ve	1
		Staff Attitude and Approach +ve	1
EAST			
Care2Share - Subthemes		**Other Activity - Subthemes**	
		Staff Attitude and Approach -ve	42
		BLANK	16
		Communication -ve	11
		Staff Attitude and Approach +ve	8
		Coordination of Care -ve	7
		General facilities -ve	7
		Receiving Information -ve	5
		Basic Nursing Care -ve	4
		Basic Nursing Care +ve	4
		Miscellaneous -ve	4
		Waiting Times -ve	4
		Receiving Information +ve	2
		Communication +ve	1

		Miscellaneous +ve	1
		Parking -ve	1

6.5 The Health Board is involved in the all-Wales Emergency Department Quality Framework (EDQF) which saw the implementation of a standardised patient feedback system across the country in February 2020 called 'Happy or Not.' Overall data from the system covering all three Health Board emergency departments is available below for the partial month of February 2020 (covering from the date of implementation on 18 February 2020).

Positive			Negative	
Staff **	74.1%		Something else **	34.6%
Communication	10.3%		Staff **	32.4%
Something else	9.2%		Communication	23.9%
Environment	6.4%		Environment	9.1%

Location	Score
Ysbyty Gwynedd - Minors	75
Ysbyty Gwynedd - Handheld	73
Ysbyty Gwynedd - Waiting room	68
Glan Clwyd Hospital Minors area	65
Glan Clwyd Hospital Handheld- Majors Area	60
Wrexham Maelor Hospital - Minors Corridor	50
Wrexham Maelor Hospital - Main ED exit	49
Glan Clwyd Waiting room	45
Wrexham Maelor Hospital - Handheld device (Majors area)	17

6.6 The Health Board is also involved in the all-Wales procurement of a new national patient feedback system. The Health Board's current contract with CRT View Point is likely to expire before the new national contract is in place and the Patient Safety and Experience Department is undertaking an assessment of options.

6.7 Patient and carer feedback is a key component of the Ward Accreditation process, this seeks to ensure that feedback is being sought and also that it is being acted upon to provide improvments.

6.8 The Friday Feel-good Comment of the Week provides feedback to the ward/department who are deemed to have had the most motivational feedback comment of the week. They are selected by the Patient Experience Team in each of the regions every Friday and publicised on the Health Board's social media. The ability to utilise patient feedback to increase staff motivation, well-being and job satisfaction is an extremely important consideration for the Health Board. Over the three months a total of 97,923 audience 'hits' were counted.

7. PATIENT STORIES

7.1 During the quarter under review, the following patient stories were presented to the Quality, Safety and Experience Committee:

Community Care Collaborative Hub – East

Key Themes;	Learning/Actions;
- Service users do have a mistrust of "authority". - The hospital set up as a whole presents multiple barriers, ie appointment letters are sent but patient is homeless. - Because of their lifestyle they may not attend appointments, they are then removed from the waiting lists - Appointment times can be difficult to adhere too.	Development of 'one stop' interdisciplinary health care in a socially welcoming environment, ensures access to health care services in a non-judgemental manner for service users who would otherwise find it difficult to access traditional health services which involve multiple access points.

• Patients feel the experience in hospital is negative, they are treated differently.	

Helen's Story - I am not a service user; the role of ICAN within ED

Key Themes;	Learning/Actions;
• Patient voice not being listened to • Terminology used to label patient • Needs of the individual not being recognised due to demand on the service • Different service received after 7pm. • Training for external agencies	• Ensure people are listened to and respected, whilst having their individual needs understood • Promote and develop the ICAN service it changes and saves lives. • Further training and information for external agencies. • Include increased awareness of the ICAN services within the PALS operational model.

8. ACCESSIBLE HEALTHCARE

8.1 The fifth annual all-Wales sensory loss conference was held in the quarter which precedes the "It Makes Sense" annual campaign to highlight provision of care, service and support for the sensory loss community and shine the spotlight on those who provide vital support. The event this year was hosted by the Health Board and organised by the Patient Experience Team. The event was held on 28 November 2019 at Conwy Business Centre.

8.2 153 delegates registered (out of a maximum 160 places). A summary of the key note speakers and workshop leads is below:

Guest speaker	Organisation	Presentation

Paul Redfern and Roger Hewitt	British Society for Mental Health and Deafness (BSMHD)	Information relating to Mental Health first aid for sensory loss sufferers (Deaf/hearing loss) and the role BSMHD plays in supporting the deaf community
Sarah Thomas	Centre for sign-sight-sound (COS)	Information about COS and the role it plays within the local community, facts and figures about sensory loss and the service users they encounter.
Dr Christopher Shank	School of Languages, Literatures and Linguistics Bangor University	Research paper titled Health and Wellbeing for Deaf Communities in Wales: Scoping for a Wales-Wide Survey
Michael Wycherley	Deafblind Cymru	Information relating to the support mechanisms that Deafblind Cymru can provide to the sensory loss community
Miriam Jones	Vision Support	Information relating to the help they have provided for visually impaired service users and support available.
Billy Baxter	Blind Veterans UK	The history of the formation of BV, its founder and early days. Billy then presented his own story of his traumatic sight loss, his battle to adjust and accept and where he is now.
Holly Cuffin	Centre of Sign-Sight-Sound	BSL taster session for basic sign language.
Mark Gill	National Deaf Childrens Society	Communicating with people who have hearing loss/deafness and cannot use BSL, such as lip reading, body language, facial expressions and objects
Dr Katherine Rogers	British Society for Mental Health and Deafness (BSMHD)	READY (Recording Emerging Adulthood in Deaf Youth) following young people who have a hearing loss as they become Independent adults.
Nicola Clough and Billy Baxter & Nursing staff	Blind Veterans UK	How BV support veterans and their families at their centres, roles and responsibilities and open question forum.
Kirsty James	Royal National Institute of Blind (RNIB)	Organisations role and supporting visual impairment/blind.

9.   LEARNING FROM PATIENT EXPERIENCE

9.1   The Health Board's Patient Experience Strategy and the national frameworks commit to using patient experience information for improvement. The overall reporting of this information across the Health Board to the QSE Committee for assurance is more difficult due to a large amount of improvement work taking place locally without a central system to capture this. To help address this the Patient Experience Group was

re-launched in October 2019 to help facilitate the sharing of patient experience information and improvement with ach division reporting into the group. The first meeting was held during the quarter under review with future meetings planned quarterly.

9.2 The following table shows a selection of improvements made following patient experience information being collected.

Service	Feedback	Improvement
HMP Berwyn	High waiting list to access the dental team.	All men on the waiting list will continue to be sent leaflets – urgent appointments are available if required.
HMP Berwyn	The medication optimisation policy is not popular amongst the men at HMP Berwyn and is the theme amongst the large majority of complaints.	Leaflets available and information shared with all men who arrive at HMP Berwyn. Continue to share message and inform men of the rationale behind policy.
Central Area	Feedback from a number of Sexual Health Service clients who were frustrated phoning to book an appointment for a coil to be fitted and were advised that they needed to attend for a pre coil assessment appointment. Some felt that this was unnecessary and had difficulty in attending.	Staff agreed that the number of appointments were limited but felt the information prior to the coil fit was important and reduced the risks to clients by ensuring information was given to clients and ensuring all aspects of the insertion risk had been addressed. A 'script' was developed for admin staff to read to clients wishing to attend for a coil insertion, this highlights the risk factors to clients and allows them to self-select if they require a pre insertion appointment. The script explains the requirement for contraception if sexually active and the potential requirement for a bridging method, also the potential for risk of sexually transmitted infection/ any risk of pregnancy.
East Secondary Care	Infrastructure – broken TVs.	Review of available charitable funds to provide additional resources or patients (TVs, radios).
East Secondary Care	Dementia friendly care and environment.	Roll out of dementia friends training. Planned 12 days of Christmas for dementia friendly care.

Service	Feedback	Improvement
Central Secondary Care	Infrastructure – car parking.	Car parking on the agenda for HMT. Park and ride available in YGC until March 2020. Consideration being made in relation to car sharing with teams and utilisation of park and ride by 0900-1700 workers to free capacity for relatives on site. In addition, communication about parking for relatives with access to the park and ride is given at ward level when patients are admitted.
Women's and Maternity	Partner visiting restrictions.	The division is evaluating having 24 hour visiting for partners.
Women's and Maternity	To plan care in greater partnership and to be listened to more.	Plans to: 1) Present birth stories consultant meetings and midwife meetings. 2) Encourage use of BRAIN acronym – women and midwives/obstetricians and to use it to document care.
Mental Health and Learning Disability	Feedback through Caniad and other patient feedback sources that patients are bored on the wards (in West) and do not have enough activities. Activity co-ordinators are employed during office hours only.	Inpatients in Hergest Unit are now able to access community wellbeing groups with support from the occupational therapists
Mental Health and Learning Disability	Caniad feedback from patients that many do not know if they have care plans or aren't familiar with the content. Care and Treatment Plans are recorded on a multi-page, multi-topic document, much of which may not be relevant to individual patients, but which is a statutory all-Wales document and cannot be altered. This makes it difficult for patients to feel engaged with the document.	Caniad are completing a piece of work with community patients to collaboratively design an addendum to the statutory care plan documentation, which will include what the patient needs to know and what is important to them.
North Wales Managed Clinical Services	On-going difficulties with locating Department on the YG site, lack of clear signage.	Revised bilingual map and directions mailed out to all patients with their appointment letters.

10. CONCLUSION AND RECOMMENDATIONS

10.1 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient experience issues arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.

10.2 The QSE Committee is asked to note specific highlighted areas: overall increase in complaints, engagement work with the CHC, It Makes Sense Conference and Section 16 PSOW Report.

10.3 The QSE Committee is asked to note the ongoing work planned improvement work including review of various Health Board processes and implementation of the Datix IQ Cloud.

10.4 The QSE Committee is asked to receive this report and provide feedback on its evolved content and layout.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Pharmacy & Medicines Management Annual Report 2019-20
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Mrs Louise Howard-Baker Assistant Area Director Pharmacy & Medicines Management
Craffu blaenorol: Prior Scrutiny:	Pharmacy Professional Advisory Group
Atodiadau Appendices:	1) Pharmacy & Medicines Management Annual Report.

Argymhelliad / Recommendation:
The Quality Safety & Experience Committee is asked to note the report for information

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)						
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	✓

Sefyllfa / Situation:
This annual report has been set around the themes of the Health and Care Standards framework to deliver person-centered care by ensuring that BCUHB handles medicines safely and securely, in accordance with legislative requirements and best practice and ensures safe and effective medicines use for optimal outcomes in accordance with medicines optimisation best practice.

Cefndir / Background:
The annual report for 2019-20 covers the systems, processes and support in place for Pharmacy and Medicines Management to ensure the quality, safety and cost-effectiveness of medicines selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. It also highlights the red (≥15) risks on the service risk register.

Asesiad / Assessment & Analysis

The safe and secure handling and optimisation of medicines on both the hospital and primary care settings requires appropriate policies, procedures and quality assurance systems to be in place. It covers processes throughout the organisation, not just in pharmacy.

Strategy Implications

The annual report demonstrates the strategic and business plans of BCUHB and Welsh Government:

- Care closer to home
- Unscheduled care
- Financial balance
- A Healthier Wales

Financial Implications

As an annual report, it contains some finance information, but has no financial implications.

Risk Analysis

The medicines governance focuses on the safety and risk management issues concerned with medicines and importantly, systems risks that can lead to error and resultant adverse incidents.

This report describes the high (≥15) risks on the Pharmacy & Medicines Management risk register. Although all have mitigation, most are waiting for capital funding, investment from others service, or a national solution, such as electronic prescribing and administration system (WHEPMA).

Legal and Compliance

The Pharmacy & Medicines Management annual report 2019-20 describes progress with compliance with the legislative framework since the 2018-20 report was submitted to the BCUHB Board.

Impact Assessment

None

Board and Committee Report Template V1.0 December 2019.docx

Pharmacy & Medicines Management Annual Report 2019-20

1.0 Executive Summary

The three Area pharmacy teams continued to focus their efforts to ensure that patients received safe and correct therapeutic treatments through the procurement, distribution, manufacturing, prescribing, administration and disposal of medicines. Upholding the principles of prudent healthcare, pharmacists and pharmacy technicians have worked across interfaces to add value and improve outcomes, including stopping medicines no longer indicated. New community pharmacy enhanced services to improve access for patients for minor illness have successfully been tried and are being rolled out across North Wales.

An over-riding theme for pharmacy for 2019 was almost certainly medicines shortages, affecting some 200 per month. Despite this, the procurement team worked with clinicians and colleagues to ensure that where necessary stock was recalled, and safe alternatives sourced and substituted, so patients were not harmed. They have also supported community pharmacy with information and advice.

The impact of these shortages and drug price changes (Category M, No Cheaper Stock Obtainable (NCSO)) to meet the funding needed for the community pharmacy contract, has resulted in significant price volatility and higher prescribing costs. There were no windfall savings from expired patents in 2019 and together with rumours of stockpiling by patients, BCUHB experienced growth in both items and cost in excess of the savings schemes. However it is worth reflecting from the graph below how far BCUHB has moved when comparing the six counties of north Wales with the rest of Wales and England.

The appointment of a third assistant director for the central area, thereby separating the role of Chief Pharmacist, has enabled significant progress to be made with both governance and strategic direction, the latter being progressed through the Medicines Management Improvement Group (MMIG), chaired by the Executive Medical Director. The focus for the MMIG going forward will be prudent prescribing and clinical pathways which will require investment to deliver improved patient outcomes, and better value. The business cases will be taken through the BCUHB project management office (PMO) process.

Key Achievements
- Savings from the cost effective use of medicines and from de-prescribing are forecast to be in excess of £6.6m by the end of March 2020.
- Significant progress has been made to address the recommendations from the Welsh Audit Office report of 2015, which are being monitored by the Audit Committee. However, the lack of a clear timescale and funding plan for the implementation of electronic prescribing remains outstanding.
- An external review, commissioned by the Executive Director for Primary and Community Care has been published. Upwards of 70 staff from BCUHB at varying levels, including the Chief Executive were interviewed. The document will provide the strategic direction on where to focus the workforce to deliver medicines optimisation for patients.community transformation board will monitor
- The workload continued to grow, but at a lower rate than 2018 with 1.61 million items dispensed or supplied from the four hospitals (including Llandudno), more

than 90,000 doses of sterile medicines prepared and the equivalent of 37,000 clinical safety interventions.

- A Medicines and Healthcare Regulatory Authority (MHRA) inspection of the Wrexham Maelor pharmacy department took place in December in lieu of an application for a Wholesale Distribution Authorisation. The subsequent letter from the MHRA confirmed that with some minor improvements and assurances the standards had been met and so the supply of medicines to third parties e.g. hospices, Air Ambulance, WAST can legally take place from Wrexham on behalf of the Health Board.
- Runner up in the Pharmacy Technician Association UK Pre-registration of the Year award;
- 2 BCUHB Achievement Award nominations; 1 winner;
- Poster winner for the pre-registration pharmacist category at the UK Clinical Pharmacy Association (UKCPA);
- Co-producer of the revised, rewritten and expanded Handbook of Perioperative Medicines on behalf of the UK Clinical Pharmacy Association (UKCPA), endorsed by the Preoperative Association and the Royal College of Physicians and Surgeons of Glasgow;
- 2 Pharmacists shortlisted for awards at the 1st Advancing Healthcare Awards, one in the Pharmacist of the Year category and the other for the award for Improving Public Health Outcomes;
- BCUHB was one of 19 non-profit making organisations internationally to receive a grant from Gilead Sciences for the routine rapid testing and treatment of hepatitis C among the homeless population in Wrexham by specialist pharmacists and supported by the harm reduction team.
- BCUHB is at the forefront of exploring new ways of working and extending roles for community pharmacists to support the unscheduled care agenda and take pressure off GP practices, Out of Hours services and Emergency Departments.
- Ysbyty Gwynedd took part in a UK multicentre trial, the ARK Study (Antibiotic review toolkit), which is a stewardship tool for secondary care. It uses behavioural change science to improve prescribing. The antibiotic prescription review rate at Bangor increased from the baseline of 23% to 92% and the antibiotics stopped rose from 22% to 34% by the end of the trial.
- Several members of the pharmacy team are working as part of a Wales-wide collaboration led by Welsh Government, the Transforming Access to Medicines Supply (TrAMS). Several work streams are looking at technical services including sterile manufacturing, logistics, procurement and Homecare which will have an impact on how these services are delivered across Wales in the future.

Governance, Leadership and Accountability

In 2019 a third assistant director for pharmacy and medicines management was appointed for the central area, thereby enabling the Chief Pharmacist to focus on his role in ensuring that policies, processes and systems are in place for the safe, secure and cost-effective handling of medicines within BCUHB and medicines optimisation is clearly defined.

The Chief Pharmacist accountability sits now with the Executive Medical Director, who also chairs the Medicines Management Improvement Group, which as well as considering finance and savings, will set the strategic direction for medicines optimisation.

Wholesaler Distribution Authorisation (WDA)

In 2012, the Medicines and Healthcare Regulatory Authority (MHRA) put more stringent regulations in place for the supply of medicines by hospitals to third party organisations, including hospices, Welsh Ambulance, Air Ambulance, Mountain Rescue etc. Their objective was to ensure the safety of medicines, including unlicensed medicines, the recall of defective products and to prevent diversion or the introduction of falsified medicines.

A series of events prevented all three acute hospitals from achieving their aim to each hold a licence: the redevelopment of the Glan Clwyd pharmacy and the installation of the new robot at Bangor. The Wrexham Maelor Hospital agreed to be the first to apply. It was a significant piece of work to comply with the Good Distribution Practice of Medicinal Products for Human Use (GDP) and involved re-writing procedures covering all aspects of medicines procurement, receipt, supply, recall and disposal, staff training and embedding new practice which has taken two years to complete.

The Medicines and Healthcare Regulatory Authority (MHRA) visited the Wrexham Maelor Hospital in December 2019 for the preliminary inspection. The post-inspection letter, in January 2020 highlighted a number of minor deficiencies that required a response within 28 days, including an action plan and also a decision about the future supply to third parties from two non-compliant hospitals in BCUHB. The minor deficiencies cover quality management systems, personnel, premises and operations. There were no critical or major concerns. It has been decided that Wrexham will supply all third parties in North Wales until such time that the other two hospitals are ready to apply for a licence.

Staying Healthy

1.1. Health promotion Protection & Improvement

Choose Pharmacy

A national Choose Pharmacy IT platform supports community pharmacy delivered services, which include the following enhanced services commissioned by BCUHB:

- The Common Ailments Scheme
- Sore Throat Test and Treat
- Discharge Medication Review
- Flu vaccination
- Emergency Medicines Supply
- Emergency Contraception

Common Ailments Scheme and Sore Throat test and treat

The Common Ailments Scheme (CAS) offers free access to advice and treatment for 26 common conditions in 150 of the 153 of community pharmacies in BCUHB. Of these, 63 also offered the sore throat test and treat service, an extension to the CAS. Both have had a significant impact on the use of unscheduled care services. Patient feedback indicates that over 75% would otherwise have made an appointment to see their GP, so saving almost 11,000 GP appointments over an eleven-month period.

Action patients would take if CAS/Sore throat test and treat was unavailable	Frequency (%)
Made an appointment with a GP	10,833 (77.6%)
Bought medication from the pharmacy	2,170 (15.5%)
Done nothing	354 (2.5%)
Made an appointment to attend the out of hours service	282 (2.0%)
Made an appointment with other (e.g. dentist or optometrist)	149 (1.1%)
Made an appointment with a nurse or health visitor	126 (0.9%)
Attended the accident and emergency department at hospital	35 (0.3%)
Called NHS Direct for advice	13 (0.1%)

Table 1 - Patient reported planned action if common ailment service had not been available (BCUHB data from December 2018 to October 2019 inclusive)

An electronic CAS summary sent to the patient's GP via the Welsh Clinical Portal was tested by BCUHB to reduce paper, improve information governance and safety. This will now to be extended to the other modules within the Choose Pharmacy Platform.

Sore Throat Test and Treat Service

Patients with a sore throat are assessed using the FeverPAIN or Centor scoring systems and where indicated, a rapid antigen test (RADT) is used to confirm the presence of *streptococcus A* and appropriate antibiotic therapy supplied via a PGD. For negative results, the pharmacist gives reassurance and self-care advice.

3,500 patients were seen in the pilot pharmacies in BCUHB and CTMUHB at the point of the service evaluation in July 2019. Of those seen, 97% reported that they would have consulted their GP or the out of hours (OOH) GP. A follow-up questionnaire indicated a 99% satisfaction rating and intention to re-use the service.

- During the pilot phase, two cases of epiglottitis were correctly identified and referred for urgent care.
- A review of quinsy presentations in local hospitals (the most likely complication from under treatment of sore throat with antibiotics) showed no rise in cases, suggesting that the service is being safely provided.
- Consultations at two GP surgeries local to the service were monitored and reported the lowest number of consultations for sore throat in the past 5 years.
- A lower rate of antibiotic use (1 in 5) was seen compared to the typical rate for general practice (around 3 in 5), which led to NWIS winning the Innovation and Technology category of the National Antibiotic Guardian awards.

The positive impact of this pilot in early 2019 means that the service will be extended from 63 to 110 pharmacies in 2020.

Independent prescribing in acute conditions

Further extending their role, the Health Board sponsored a number of community pharmacists to become independent prescribers; initially three were commissioned to see, assess and treat or refer patients as appropriate. In the last quarter of 2019, 793 patients were seen for a range of conditions, the most common being respiratory disorders, including COPD and asthma exacerbation, suspected upper respiratory tract infections, sore throats, and sinusitis.

Number of consultations provided under the IP in Acute Conditions service by group of presenting complaint (September to December 2019)
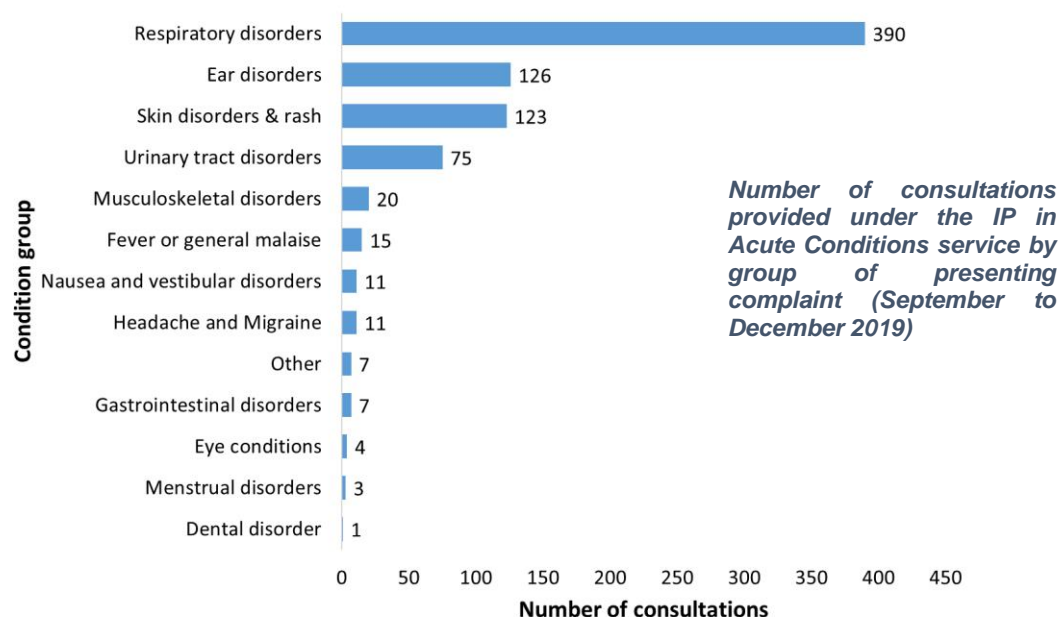
Consultations requiring an urgent referral included:
- NEWS score 7, suspected sepsis;
- Cough with blood, smoker;
- Fall with loss of consciousness;
- Lump on throat, with numerous red flags - haemoptysis, weight loss, smoker, swallowing difficulties, smoker
- Asked to attend a pub across the road as patient had collapsed and having asthma attack. 999 already called
- Breathlessness and faint
- Oxygen Saturation 91%, dropping to 88%

Again, the feedback was extremely positive with 94% citing that their alternative course of action would be to attend their GP or the OOH service.

GP practices referred approximately two fifths of patients (42%) with the remainder self-referring. Approximately 7% were temporary residents in the area. A further 6 pharmacies will begin the service in early 2020.

Flu vaccination service

Now an established service, the number of people vaccinated through community pharmacy has grown substantially to 13,010 in the 2019/20 winter season (Nov 19). Prioritising individuals of working age with one or more risk factors, pharmacists were given discretion to vaccinate patients over 65 if they do not consider the patient will attend their GP practice. In addition, the service was extended to include staff from adult care homes and domiciliary care workers.

Emergency Medicines Service

For local residents when their surgery is closed and for temporary residents at any time, the Emergency Medicines Service (EMS) allows pharmacists to assist patients who have run out/lost their medicines, by confirming the details of those regular medicines needed via the Choose Pharmacy platform and provide a supply. The OOH GP service benefits greatly from this service, which in the 2018/19 year saw 8,645 patients accessing an emergency supply of medicines.

Emergency Contraception

Although emergency contraception is available for purchase over the counter, 140 pharmacies also provide advice and free supplies via this enhanced service. Ease of access is particularly important because of the critical timing to ensure effectiveness and also helps tackle inequalities for women unable to pay. Around 8,000 consultations take place each year and in a minority of cases there may be a need to refer patients to other services for further advice or treatment.

Continuity of Services

Continuity of services has been a problem because of difficulties with recruitment and retention leading to a reliance on locum staff, who may not be accredited to provide the BCUHB services. To improve the reliability of the common ailment scheme, a continuity incentive was introduced in October 2019. Initially rewarding pharmacies able to offer the service for over 60% of the days that they are open, the minimum requirement rose to 70% in January and on the 1st April 2020 this will rise again to 80%. In December 2019 115 (77%) met the threshold.

Pharmaceutical Needs Assessment

BCUHB will be required to publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2021 following new Pharmaceutical Regulations coming into force on 1st April 2020. The PNA will include:

- Evaluation of the need for pharmaceutical services across North Wales, including enhanced services.
- Matching the identified needs to existing service provision.
- Identification of any gaps in services, which must be articulated in the report.

New contracts may then be applied for on the basis where there is an unmet need for a pharmaceutical service, allowing the Health Board to guide the development of new contracts in a way that is not possible under the existing regulations. A Steering Group, chaired by The Executive Director for Primary and Community Care was convened in January, and has commissioned an external agency, Primary Care Commissioning, to prepare the PNA document.

Safe Care

2.1 Managing Risk and Promoting Health & Safety

Medicines Storage – PSN015 & PSN030

The medicines management nurses and the safety lead pharmacists have repeated the medicines storage audit to assess compliance with the Patient Safety Notice. Some improvements have been seen since 2018 with further compliance improvement notices in place (see table on page 7). Some points to note on the standards:

Standard	Monitoring/Notes
Medicines Storage cupboards/Fluid storage cupboards are locked	Matron's walkabouts, medicines management collaborative; annual audit
Medicines Fridges are locked	
Fridge monitoring	
Room temperature monitoring	
Secure access utility room	Some wards will have to wait for refurbishment/ redevelopment to achieve.
Patient POD lockers are locked	

Table to demonstrate BCUHB compliance with PSN015 and PSN 030

	East Area			West Area			Central Area		
	WMH including ED	Mental Health	Community Hospitals	YG including ED	Mental Health & LD	Community Hospitals	YGC including ED	Mental Health	Community Hospitals
Medicines storage cupboards	⇔	⇔	⇔	⇔	⇧	⇔	⇔	⇔	⇔
CD cupboards	⇔	⇔	⇔	⇔	⇧	⇔	⇔	⇔	⇔
Medicines fridges	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇧
Patients own POD lockers	⇔	⇔	N/A	⇩	N/A	⇔	⇔	N/A	⇔
Secure access- Utility room	⇔	⇔	⇔	⇩	⇔	⇔	⇔	⇔	⇧
Fluid storage	⇔	N/A	⇔	⇔	N/A	⇔	⇔	N/A	⇧
Room Temperature Monitoring	⇧	⇧	⇧	⇔	⇔	⇩	⇔	⇔	⇧
Fridge Temperature Monitoring	⇩	⇔	⇔	⇔	⇧	⇧	⇧	⇔	⇧

Medicine Procurement and Business continuity

National shortages and supply disruptions of medicines continue with around 200 medicines affected per month. This has impacted on a wide range of clinical specialities, across all care settings and created additional demands on pharmacy staff to maintain supplies to patients. Each medicine will have different requirements and so requires an individual management plan. In community pharmacy, there are also complex supply chains and, in some cases, quotas and limits on the quantities that can be ordered, further adding to the challenge and workload.

The BCUHB medicines procurement lead pharmacists work closely with an advisory group that was set up by Welsh Government to coordinate intelligence and provide advice on shortages and a Health Board-wide pharmacy communication cascade has been established for primary and secondary care, extended to include a surveillance process for community pharmacists to report local issues.

Successful medicines shortage management relies on collaborative working with clinicians. Following initial assessment of where stock is held and its usage, plans are developed which may include centralisation of stock, re-distribution between sites, or procurement of licensed or unlicensed alternatives, which have to be risk-assessed for safety and approved by the Drugs and Therapeutics Group. Ring-fencing supplies in secondary care for access by primary care patients proved effective in the recent case of an antidepressant, phenelzine.

Critical Medicines shortages in 2019/20	
Bupivacaine 4% injection (epidural)	Digoxin injection (atrial fibrillation)
Epirubicin and mitomycin injection (chemotherapy)	Ranitidine (widely used for reflux oesophagitis)
Procyclidine injection (acute dystonia)	Dinoprostone pessaries (induction of labour).
Diamorphine (analgesia)	Phenytoin (epilepsy)

In December 2019, Welsh Government passed legislation, the Serious Shortage Protocol (SSP), permitting community pharmacists to endorse a change, such as a formulation or quantity on a WP10 prescription, without prescriber consultation.

Planning for a No-deal EU exit in 2019, the procurement lead pharmacists were active members of the BCUHB working group, leading on the business continuity plans for managing concerns and maintaining supplies of medicines for patients in North Wales.

Because medicine contracts are negotiated nationally, there are few advantages to centralising all procurement, but there are exceptions e.g. ordering the 2019/20 annual influenza vaccine for occupational health and the 15 managed GP practices, with 38,000 vaccines ordered and successfully distributed.

Homecare (Care closer to home)

The new Pharmacy Medicines Homecare team manages the governance procedures for all homecare prescriptions generated across the Health Board from one site. As well as processing prescriptions, it provides a single contact point for dealing with queries and concerns. Actively involved in a national collaborative, they are developing "Once for Wales" service level agreements for new medicines approved for homecare supply.

Fifteen different specialities within the Health Board now use this route to supply these medicines and the number of patients has risen by 14% up to 2739. Despite this growth, the total expenditure in 2019 remained static at £10.1 million. This was due to a successful switch programme (recognised as the most successful in Wales) for the biosimilar adalimumab implemented across dermatology, gastroenterology and rheumatology saving £1.8 million, so offsetting the growth from other newly approved high cost medicines.

Some of the new medicines supplied via homecare will have a significant impact on spend, such as a £500k increase for cancer and respiratory; £400k for the management of atopic eczema and £230k for oral dosing formulations of biologic medicines for rheumatoid arthritis. Despite this, the VAT exemption on these prescriptions has saved the Health Board approximately £2m.

Interventions

The interventions collected by pharmacists on twelve days in 2019-20 across secondary care within BCUHB totalled 1790, of which 52 were classed as potentially lethal. The cost avoidance of those actually reported was £560,000* or £48,000 per day from harm reduction, admission avoidance and reduced length of stay.

* based on the Equipp study

Row Labels	Interventions Count	Cost avoidance/ Intervention	Cost avoidance
Minor	305	£ 3.00	£ 915.00
Not Applicable	48		£ -
Potentially lethal	52	£ 1,500.00	£ 78,000.00
Serious	383	£ 1,000.00	£ 383,000.00
Significant	1002	£ 100.00	£ 100,200.00
Grand Total	1790		£ 562,115.00

Case: Patient presented to ED with constipation, confusion and slurred speech. Recognised on drug history that diltiazem had recently been started ~3 weeks ago, and patient on carbamazepine. Diltiazem can increase concentration of carbamazepine. Highlighted to medical team that patient may be showing signs of carbamazepine toxicity and level should be checked; medical team had not considered as potential diagnosis and were treating patient for constipation. Level= 24mg/L (more than twice therapeutic) and patient was admitted based on this and managed for carbamazepine toxicity.

Intervention by Type

Interventions Count

9
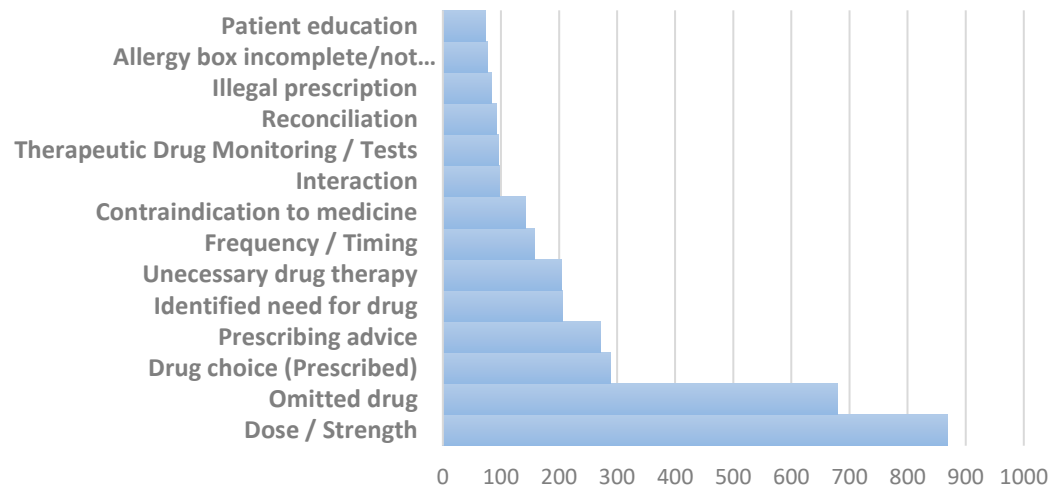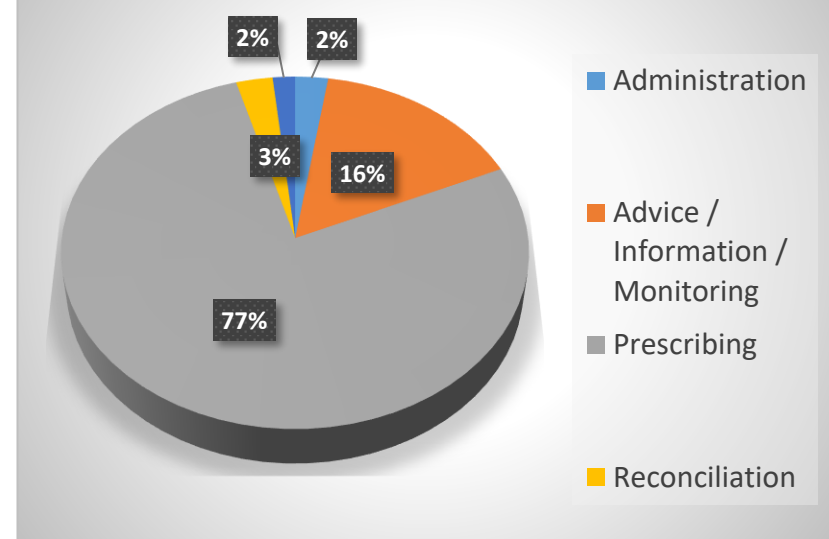
2.4 Infection Prevention and Control (IPC) and Decontamination

Antimicrobial stewardship

Primary Care

The widespread and often excessive use of antimicrobials has been identified as one of the main causes of the increasing emergence of antimicrobial resistance.

BCUHB (the green line ranked 3rd best in Wales) contiunes to demonstrate a steady decline in prescribing volume of antibiotic items with an overall reduction of 8.03% exceeding the Wales target of 5%. All 14 BCU cluster areas achieved the target.

Figure 12. Trend in antibacterial prescribing items per 1,000 STAR-PUs
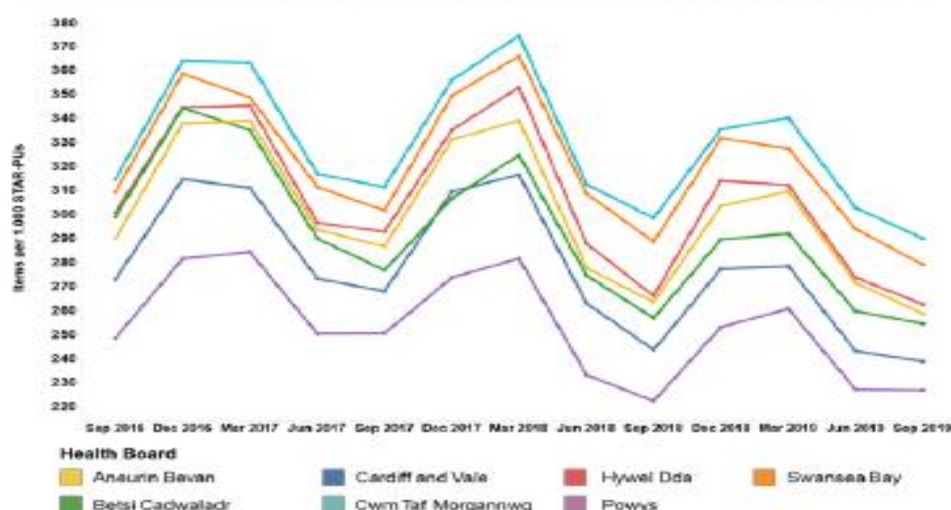
In primary care the pharmacy teams have continued to build on the successful projects of last year including:

- The primary care Urinary Tract Infection (UTI) treatment guidelines were updated in 2019. Working collaboratively with the practice development nurses, care home training included how to take mid-stream urine samples; stopping urine dipstick testing (as per NICE guidelines), with the aim of supporting care staff to make decisions on when it is appropriate to seek medical advice for suspected UTI
- Focussed support on the outlier high prescribing practices and clusters including Dwyfor who achieved a significant prescribing reduction.
- Visits to primary schools by the antimicrobial pharmacists as part of a health promotion project, eBug, to educate the next generation on the importance of antimicrobial resistance. Train the teacher events have started in Conwy to reach more schools in the future. An e-Bug collaboration with Techniquest Wrexham is currently being scoped to enable education and awareness across all schools in North Wales.

OPAT (Outpatient Parenteral Antimicrobial Therapy)

Limited progress has been made with OPAT, a service to enable patients who would normally require a hospital bed to receive their antibiotic treatment in another setting e.g. IV suite, community hospital. This is still a far from an equitable service across North Wales but BCUHB hosted a national conference at Glyndwr University, which highlighted areas where OPAT is working and facilitated some strategic planning. An overarching policy is now in place and a patient management system has been purchased to allow virtual ward rounds and regular review of patients to ensure patient safety and antimicrobial stewardship through regular multidisciplinary team review.

This will address many governance concerns and allow further development of services across BCUHB.

Secondary Care

Ysbyty Glan Clwyd was the only one of the 3 acute sites to achieve the WG target for total antibiotic reduction, and one of only 4 hospitals in Wales.

TOTAL ANTIMICROBIAL VOLUME DATA

Total antimicrobial volume improvement goal
Update 12-month target period ending March 2019

HOSPITAL CODE	UHL	WBH	RGL	YGB	WMH	PCH	MOR	PPH	UHW	YGC	GGH	NHH	POW	BGH	RGW	SIN
Period ending 03/2019	6796	5954	5823	5591	5269	5218	5199	5065	4864	4603	4195	3908	3799	3591	3439	3430
5% reduction target	6141	5480	6167	4756	4906	5003	4676	4897	4755	4674	4413	3873	4050	3568	3205	3155

Key: BGH – Bronglais; GGH – Glangwili, MOR – Morriston, NNH – Nevill Hall, PCH – Prince Charles, POW – Princess of Wales, PPH – Prince Philip, RGL – Royal Glamorgan, RGW – Royal Gwent, SIN – Singleton, UHL – University Hospital Llandough, UHW – University Hospital of Wales, WBH – Withybush, WMH – Wrexham Maelor, YGB – Ysbyty Gwynedd, YGC – Ysbyty Glan Clwyd

Further improvements to limit the broad spectrum antibiotics to reduce the risk of Health Care Associated Infections and resistance via a restriction policy are in progress. Wrexham Maelor hospital achieved the target of 55% or more antibiotics being from the "access aware", or narrow spectrum category, set by the World Health Organisation and both YG and YGC saw improvements.

PROPORTION OF ACCESS ANTIMICROBIALS DATA

Proportion of access antimicrobials improvement goal
Update 12-month target period ending March 2019

HOSPITAL CODE	PCH	RGL	MOR	POW	UHW	WMH	UHL	NHH	SIN	YGB	YGC	RGW	GGH	PPH	BGH	WBH
Period ending 03/2019	68.4	67.4	62.6	61.4	58.4	58.3	55.3	54.8	53.4	52.3	52.2	48.9	41.0	37.3	36.9	33.8
Baseline (2016 data)	67.5	66.4	44.5	46.8	57.0	46.4	54.6	53.6	41.1	49.4	51.1	44.3	43.4	36.5	36.0	38.7
55% access target	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0

Figure 5: Proportion of access antimicrobial usage by acute hospital - 31/03/19

Ysbyty Gwynedd took part in a UK multicentre trial, the ARK Study (Antibiotic review toolkit), which is a stewardship tool for secondary care. It uses behavioural change science to improve prescribing. An eLearning package explains the principles, which include an initial prescription of antimicrobial treatment for 72 hours and then a hard stop. This ensures that patients get an early decision for the need for ongoing treatment. A finalised prescription is written by the prescriber if antibiotics are still indicated based on diagnosis and sensitivity, switching to oral therapy where possible.

Fully implemented in Bangor and Wrexham, a further roll out of the ARK to Ysbyty Glan Clwyd is planned when staffing allows. The antibiotic prescription review rate at Bangor increased from the baseline of 23% to 92% and the antibiotics stopped rose from 22% to 34% by the end of the trial. Recent data shows these rates are being sustained.

The Ysbyty Gwynedd and Swansea Bay sites presented their results at the Wales Antimicrobial Resistance Delivery Board following which a recommendation for a national rollout was made to the Chief Medical Officer for Wales.

2.5 Nutrition and Hydration

Home Parenteral Nutrition (HPN)

In August 2019 Calea, the supplier of Home Parenteral Nutrition (HPN) to BCUHB patients, suffered severe disruption to supply following a suspension notice by the MHRA. This caused significant distress to patients dependent on HPN.

With no spare capacity at other commercial suppliers, the Wrexham Pharmacy Sterile Production Unit stepped in to manufacture bags. 70 of these labour intensive formulations compounded from scratch were manufactured in the first two months and staff worked additional hours and at weekends in order to achieve this. During this period, Calea's communication on the formulation for patients was frequently incorrect, requiring daily communication between pharmacy, the nutrition team and patients. This also meant that planning work in advance was impossible, and frequently bags had to be made at short notice.

Calea's capacity stabilised in September at a reduced level and another supplier was able to take on some patients, so Wrexham now supplies for a single HPN patient.

Dietetic Food Supplements

Medicines management dietitians have now been employed by each area to review patients and provide support to the pharmacy team and GP practices to ensure that repeat prescriptions are appropriate and guidelines for initiation of dietetic products and formulary choice are being followed. They are also delivering training to nursing homes to encourage 'food first' practice and reduce the use of supplements.

2.6 Medicines Management

Medicines Storage

BCUHB has the greatest number of automated medicines cabinets installed in the UK, with 75 in situ across the three sites. They offer better safety by reducing errors from incorrect selection of medicines and enhanced security, because access is via fingerprint and ID badge. A forthcoming article soon to be published in the Clinical Services Journal also highlights that in a study in Wrexham Theatre B sustained savings were demonstrated when compared to Theatre A.

However, a significant problem has been highlighted, that will need resolution in early 2020-21 in that many of the automated cabinets are being operated with computers that are running on Windows 7, that soon will be unsupported by Microsoft or are too old for an upgrade to Windows 10. Touchpoint Supplies, the pharmacy department and BCUHB IT departments are working closely to prioritise and make the necessary changes. With the ever increasing numbers of these cabinets, there is a need for additional pharmacy expertise to be able to support nurses with training and address issues at ward level to maximise the functionality of the electronic systems. A business case will be prepared in 2020.

Controlled Drugs

The Accountable Officer's responsibility is to oversee that arrangements are in place for the safe use of controlled drugs (CDs) of all schedules across North Wales (post Shipman). Vigilance on pregabalin and gabapentin increased this year following their re-classification to Schedule 3, due to their potential for diversion and misuse.

Renamed the North Wales CDLIN to reflect the network's wide-ranging functions from within the Health Board, external agencies and independent bodies across the region, it is chaired by the Chief Pharmacist as the BCUHB Accountable Officer.

Nationally this group has led work to:
- Address variation in the procedures for the private supply of CDs to Ministry of Defence personnel;
- Introduce a management procedure for the circulation of controlled drug alerts;
- Adopt the English NHS CD incident reporting tool;
- Form a collaboration between the Dan247 all Wales Drug and alcohol helpline and the England based Drug Watch scheme;

A locally developed (BCUHB) electronic-based CD monitoring tool was recognised nationally by a Health Inspectorate Wales report.

An area of high risk remains around the ability to scrutinise individual doctors' prescribing practice particularly in GP practices reliant on locums. However, this problem is not unique to BCUHB, and is awaiting a national solution e.g. the introduction of a personal prescriber PIN.

Medicines Information

More than 1000 queries from healthcare professionals were dealt with by the BCUHB Medicines Information Service, whose function is to support the safe, effective, economical and rational use of medicines both in the hospitals and the community, with a strong emphasis on promoting quality care and ensuring safety. These queries concerned individual patient care that could impact on safety, experience and treatment effectiveness and outcomes. Split across three acute sites in BCU the MI team work together to ensure access to information is available five days a week. Pharmacists providing on-call services are trained by the MI team to be able to provide quality advice on request. Some recent examples of queries include:

Request	Response
Genitourinary Medicine; female, 24 weeks gestation, concern of pre-term labour. If a tocolytic is needed, what could be used with the antiretrovirals being taken?	Nifedipine may be used if needed but caution that the antiretrovirals can increase concentrations of the calcium channel blocker. Advice provided regarding dosing and monitoring.

Tertiary neurology centre requested a switch from pregabalin to oxcarbazepine to aid pain control. How should the swap be managed? Also on other antiepileptic medicines.	Comprehensive literature search and pharmacological knowledge used to produce regimen for titration. Advice also given on how to manage phenytoin doses during, and following the swap due to drug-drug interactions.
Patient having difficulty in swallowing their medicines (including antiepileptic). Can we offer any advice on changes to support her?	Supply of alternative formulations arranged where possible (e.g. granules or liquids). Advice regarding crushing tablets and taking with apple sauce provided for rivaroxaban.

Single Patient

- Presented at 24 weeks gestation with provisional diagnosis of diffuse large B cell lymphoma. We provided advice regarding the chemotherapy regimen and supportive medicines in pregnancy with information on the potential risks to the foetus and any monitoring that may be required postnatal. Clinicians were encouraged to register the drug exposures in pregnancy with the UK Teratology Information Service to add to the evidence base for the use of these medicines in pregnancy.
- At 26 weeks gestation we were asked to give advice on appropriate pain relief.
- At 27 weeks gestation we advised on alternative administration sites/routes of rituximab to avoid subcutaneous injection into the abdomen.
- Also at 27 weeks we risk assessed each of the options for pneumocystis carinii pneumonia (PCP) prophylaxis and made a recommendation which to use, whilst also providing additional information on post-natal monitoring.
- Postnatal; contacted by the GP to advise regarding the infection risk of using the Mirena coil.
- Postnatal; asked to advise regarding the risks of using live vaccinations in child given in utero exposure to chemotherapy.

Community Hospitals

Pharmacy support for community hospitals is limited to a once weekly visit by a pharmacist and pharmacy technician. Whilst this may have been appropriate in days gone by, now when acute hospitals are often in escalation, higher acuity patients are being transferred to community beds, to make way for patients with greater needs. As a consequence, patients may not have their medicines reviewed by a pharmacist for up to seven days. This does not meet the NICE guidelines and may mean that patients continue on unnecessary, or have unmet treatment needs for longer than necessary. A business case will be prepared in 2020 to address the community hospital gap in service.

Llandudno Hospital

Pharmacy worked with nurse leads at Llandudno Hospital to develop an action plan following a number of administration omission errors. As a result, two new pharmacy technicians and the medicines management nurse supported nurses on two wards by:

- Delivering Back to Basics administration training for identified nursing staff
- Adopting the Parkinson's UK 'Get it on time' campaign and resources.
- Re-configuring ward stock lists and storage to make it easier to find medications.
- Adopting a formal handover of the medication chart by nurses at shift changes

- Attendance at morning handovers, support on the morning medication round which helped identify medicines and obtain supplies not available on the ward. This and the advice to promote good medicines management resulted in fewer interruptions and less time spent on the medication round.

However, due to a lack of funding these pharmacy technicians have had to be re-deployed to other duties.

These charts show the omission rate on two wards, one supported by a pharmacy technician and the other not.

	Jan	Feb	March	April	May	June	July	August	Sept
Total	33	15	28	35	2	3	7	9	6
Critical Meds	12	10	13	4	0	1	3	1	0

	January	February	March	April	May	June	July	August	Sept
Total	14	18	23	48	37	43	42	26	39
Critical Meds	2	3	3	18	8	9	10	2	7
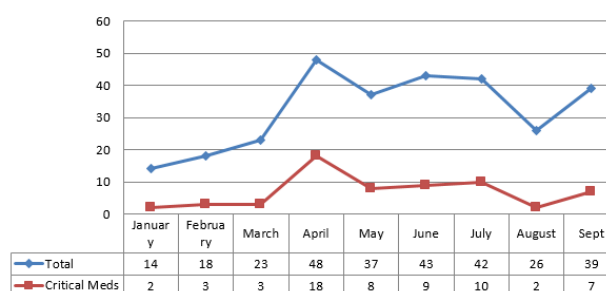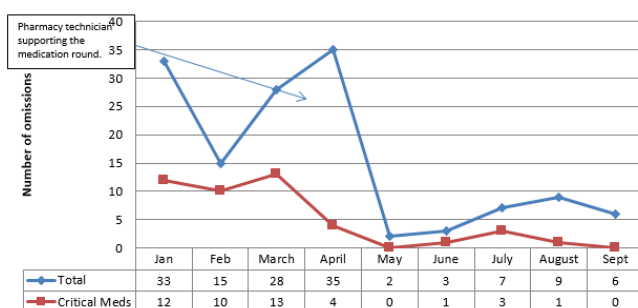
Manufacturing

Independent Audit of the YG, YGC and WMH Sterile Production Units (SPU)
An external audit of the four BCU Sterile Production Units was undertaken in September and October 2019 by the National Quality Assurance Lead for Wales. Although internal audit takes place against Medicines and Healthcare Regulation Authority (MHRA) standards, this independent assessment is particularly important, as the licensed sites (YGC & YMW) are due inspections by the MHRA. As NHS licensed manufacturing units are treated the same as commercial organisations, any deviations from the Good Manufacturing Standards need to be addressed urgently.

The MHRA tightened its standards around Pharmaceutical Quality Systems (PQS) as a result of contaminated neonatal TPN supplied by a pharmaceutical company which resulted in the deaths of 3 neonates in Hampshire during 2014 and more recently a commercial supplier of parenteral nutrition for homecare had to significantly reduce production due to MHRA standards not being met. PQS covers everything from maintenance of facilities, document version control, training and competence and deviations investigation. An example of a deviation might be environmental, where bacterial growth from routine monitoring is detected. The expectation is that approximately 25% of time is devoted to PQS. Data shows that the SPU are running at 90-104% capacity, which does not leave enough time for PQS. All three sites will need to consider how they can build capacity for this essential function.

Each audit report is accompanied by an action plan and each site provided its response within the required timescale. Progress with the action plans monitored by the pharmacy senior management team meeting. The summary comments for each site are outlined thus:

Comment	WMH	YGC	YG
Progress since last audit	✓	✓	✓
Resource for Pharmaceutical Quality System	✗	✗	✗
Facilities	Cosmetic issues	Poor (see below)	✓

Replacement programme for isolators required	✓	✓	✓
Review of level & type of investigation into microbiological contamination	✓	✓	✓
Documentation control improvements needed	✓	✗	✓

Site Specific Comments supplementary to the above:

Ysbyty Maelor Wrecsam

Improvements are needed to address the variation in staff technique for the transfer process with regard to contamination control identified.

Ysbyty Glan Clwyd

The Cancer Centre is of poor design and fabrication and the Sterile Production Unit is past its recommended working life and the Air Handling Unit (AHU) is condemned. There is considerable vulnerability around the AHU at the SPU site which has stopped the merging of the Cancer Centre into the SPU. However this option is currently being considered by the Health Board Capital and Estates prioritisation process for 2020-21 while longer term solutions are being planned and coordinated as part of a wider Welsh Government capital replacement programme called Transforming Access to Medicines (TRAMs).

Ysbyty Gwynedd:

The existing resource of Authorised Pharmacist (AP) and Accountable Pharmacist (AcP) is at present vulnerable. Another AP is required for contingency and must have regular sessions in order to release time for the existing AcP and AP to carry out Pharmaceutical Quality System activities.

Prescribing

Independent prescribing

Registered on the BCUHB database are 694 non-medical prescribers, which includes both independent and supplementary prescribers. The breakdown by profession is as follows:

Nurse prescribers	Pharmacists	Allied healthcare
563	78	53

Continuous Professional Development is arranged and supported by the medicines management nurses through the Non-Medical Prescribers Forum, covering therapeutic topics throughout the year and encouraging the sharing of good practice.

One of the key objectives for 2020/21 will be to update the Health Board's Non-medical prescribing policy to ensure our guidance both safeguards and empowers all prescribers to meet the need of our patients and to consider the future role of Physicians Associates within the policy.

Junior Doctors

Each of the acute hospitals has a pharmacist, funded by the NHS Wales Service Incremental Fund for Teaching (SIFT) to tutor undergraduate doctors on prescribing. In addition to learning how to use the Wales Medicines Administration Chart, they have sessions covering the prescribing of high risk medications such as insulin, anticoagulants and opioids, interactions and drug interactions. In future programmes there are plans to cover more of the human factors that can lead to errors.

The additional sessions that they undertake with the newly qualified doctors is currently unfunded, which is particularly important for those who did not train in Wales. Topics covered include: Recent prescribing errors, common themes; key information to be aware of; 'Hot prescribing topics' as requested by the F1 doctors.

In primary care, there has been a focus on tackling medicines waste and polypharmacy. This has been both transactional, but also involved high quality face to face medication reviews. The diagram below summarised the activity they have been undertaking.

6 Care Medicines Management in 2019-20

33,000 Level 1 Medicine Reviews
Technical review of the list of a patient's medicines to address any issues relating to the prescription or a medicine

15,820 Level 2 Medicine Reviews
Treatment review of medicines with the full patient notes

7,400 Level 3 Medicine Reviews
Clinical review of medicines with the patient and carer in discussion making decisions about their medicines and addressing any difficulties

360 Medicine Reviews in the patient's home
A level 3 medicine review particularly valuable if there are concerns that the patient may not be taking their medicines

41,500 Ad Hoc Medicines Enquiries

6,383 Medicines Stopped

The diagram below summarises the works taking place in the Medicines Management Collaborative to support the Med

FACTS

Established in November 2018 to focus on:

- Safe storage of medicines
- Education standards
- Clinical standards

Safe Storage of Medicines

Working to improve compliance with controlled drugs checks, fridge temperature monitoring and ensuring that medicines storage cupboards are locked using PDSA cycles and tests of change for improvement. Support is given by the medicines management specialist nurses. Where compliance is sustained, the Matrons undertake the monitoring as part of their monthly Leadership Walkabouts

Participation

⇒ Several wards including the emergency department at Ysbyty Glan Clwyd.
⇒ All acute wards in Ysbyty Gwynedd and Ysbyty Wrecsam Maelor
⇒ East Area community hospital wards
⇒ Mental Health wards
⇒ Womens Division

Problems:

A common theme is inconsistent reporting

Educational Standards

- Medicines Management competence workbook for nursing has been reviewed and updated
- Medicines Policy Chapter 8 and the standards have been completed, covering the education and governance arrangements for health care support workers to allow them to assist or administer medicines delegated by a Registered Nurse. A training package is to be

Clinical Standards

The care for patients receiving medication on discharge was identified as an area that required improvement. This followed a thematic review of incidents which highlighted that patients may go home without their medicines, without any counselling on their take home medicines, or occasionally with another patient's. A discharge checklist was in place but not being used.

Participation

▷ Discharge lounge and pilot wards, Ysbyty Gwynedd
▷ Central area community hospitals
▷ Discharge lounge, Ysbyty Wrecsam Maelor

Automated Medicines Storage Cabinet

New Developments:

The medication section of the Harms Dashboard has been refreshed, to include administration incidents. A new field to capture 2nd independent check incidents has been added to Datix.

Medicines Management Nurses

Support safe medicines administration through training at undergraduate level and for registered nurses at all levels, with group training and individual mentoring if errors have occurred.

delivered by Llandrillo College.

Administration of Intravenous Morphine by Nursing Staff for adults with acute severe pain ➜ A new BCUHB Guideline is near completion and a competency & assessor's document for all appropriate nurses in designated areas has been prepared together with an implementation plan for competency assessment. Oxygen Cylinder Competence ➜ An improvement plan was put in place for the safe transfer of patients on oxygen between departments and wards. This includes the use of a checklist and knowledge of cylinder use for ensure nurses and healthcare support workers. Registered nurse compliance in secondary care is 85%.

2nd Independent Check ➜ From April 2018 to April 2019 there were 97 reported incidents due to inappropriate or absent second independent check by another healthcare professional. Ysbyty Gwynedd has done a significant amount training all newly registered nurses and following reported incidents. IV Pump training has been delivered in key areas in YG following an audit that identified issues with the use of libraries and pump locks, revisiting competencies. Medicines management back to basics training across the Health Board includes the importance of separating pumps (not stacking) outside critical care wards to minimise associated errors.

MEDICINES MANAGEMENT COLLABORATIVE

Incidents

There were 4 major medication incidents in BCUHB in 2019-20, down from 10 in the previous year. Three related to medication-related admissions and the fourth to a delayed administration of an antibiotic to a septic patient, with a recorded allergy to penicillin (1st choice treatment of sepsis), while an alternative was sought.

Pharmacy Incidents

SAFETY	West	Centre	East
Total number of incidents reported last year	62	86	38
Number of incidents overdue	5	4	11
Number of WG reportable incidents last year	0	0	0
Number of serious incidents reported last year	0	0	0

Adverse Drug Reactions and Medicine Related Adverse Incidents

Surveillance on adverse drug reactions via Yellow Card reporting is key for patient safety. Even for well-established medicines, new themes, such as drug-drug interactions can be picked up, which may result in changes to treatment recommendations. For GPs there is a set minimum target for Yellow Card reports included in the enhanced service for medicines management.

Number of Yellow Cards submitted by Health Boards per 100,000 Health Board population

Number of Yellow Cards submitted by secondary care – Quarter ending September 2019 vs quarter ending September 2018
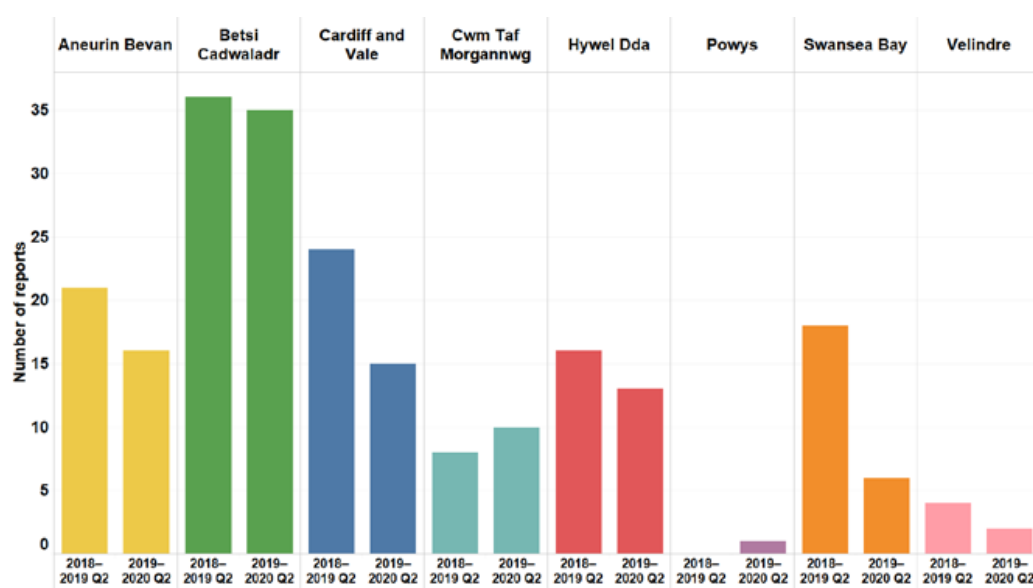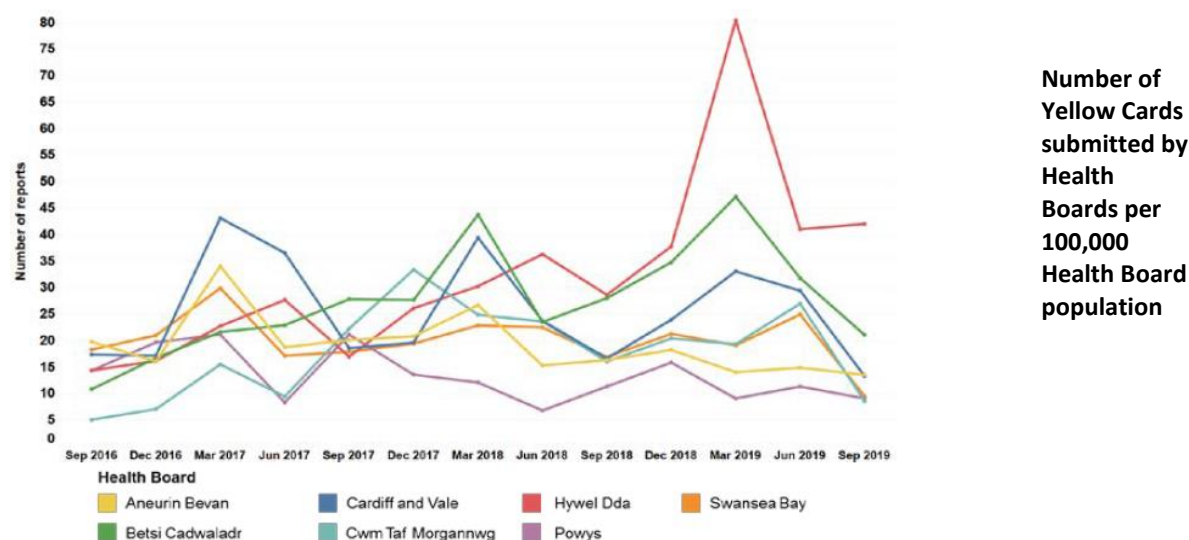
Collection of medication-related admission data by pharmacists has highlighted that acute kidney injury (AKI) is a significant burden of preventable harm for BCUHB and is associated with a poor prognosis for patients. Thirteen of the 14 clusters in North Wales have agreed to focus their quality improvement interventions on reducing the harm from medicines that can cause AKI in acute illness for their Mandatory Patient Safety Programme of the Quality Assurance and Improvement Framework (QAIF). This quality improvement programme in BCUHB will be supported by Improvement Cymru.

Policies & Procedures, PGDs

The extensive work to ensure robust governance underpins the safe use of medicines across the Health Board continued in 2019, resulting in the publication of the revised Medicines Policy together with the launch of new Injectable Medicines and Unlicensed Medicines Policies respectively. The medicines management nurses have worked towards a more streamlined authorisation process to improve the governance arrangements for Patient Group Directions (PGD) and will be in place in 2020. There will be PGD education sessions for staff running alongside this process to ensure PGD use is aligned to best practice recommendations.

The Medicines Polices Procedures PGD Subgroup (MPPP) of the BCU Drug and Therapeutics Group (DTG) met 11 times and reviewed 124 documents, 11 of which were deferred and at year end were awaiting resubmission. The 113 approved documents were:
- 63 Written Control Documents (i.e. guidelines, SOPs, prescription charts)
- 6 Policies
- 44 PGDs

The Group remains without medical representation as required by its terms of reference, so clinical queries are escalated to DTG for further discussion and subsequent approval. In addition a replacement senior nurse with corporate responsibility for medicines management is being sought.

2.9 Medical Devices, Equipment and Diagnostic Systems

The Medicines and Healthcare Regulatory Authority (MHRA) has introduced new standards for dose calculators. As a result, pharmacy and medicines management is improving the governance on those used across BCUHB. Those already in use have been registered with the Medical Devices Oversight Group (MDOG) and a standard operating procedure is being produced for the introduction of any new dose calculators to include validation, and logging and monitoring of any incidents associated with their use before introduction. The review of any reported incidents will be undertaken as part of the Pharmacy Patient Safety Lead Network meetings to identify and remedy any related issues.

Effective Care

3.1 Safe & Clinically Effective Care

DTG

The BCUHB Drug and Therapeutics Group (DTG) met eleven times in 2019. It has 40 members from across BCUHB, including primary and secondary care doctors and pharmacists, nurses (medicines management), midwives, dentist, physiotherapist independent prescriber, patient, finance and Association of the British Pharmaceutical Industry (APBI) representative respectively.

DTG actions	Approved	Declined
New medicines for formulary inclusion	21	2
Applications for individual patients (non-formulary)	134	22

The Wound and Dressing sub-group revised and launched its formulary in 2019. Now available on the MicroGuide app, it enables access to invaluable information is at hand for assessment of wounds and appropriate dressing choice.

The development of prescribing guidelines to support the BCUHB clinical pathway strategy will be a key priority for 2020 to ensure that patients' medicines are optimised to ensure both safe and clinically effective prescribing. Capacity to support this is limited and will require some additional investment.

NICE & AWMSG Impact Assessment Group

BCUHB remains fully compliant with the formulary inclusion of NICE/AWMSG approved drugs within the 60 day timeframe. However 2019/20 has proven to be a challenging year within the cancer service due to the volume of new NICE drugs approved that are now fulfilling a previously unmet need. These require not only access to new services for treatments but also the need for ongoing care for surveillance thereafter.

In 2019, treatment pathways had to be considered for 48 new NICE/AWMSG approved drugs. The cost per patient per course/annum for these treatments ranged from £6 to £90k. The net full year impact of the drugs assessed was estimated to be £3.77m in year 1 taking into account the cost of the drugs displaced. Two novel Cystic Fibrosis treatments were approved by Welsh Government in November 2019 and will be provided by tertiary centres through WHSSC contracts, which alone have an additional impact of £2.96m for BCUHB.

Of the 46 new drugs, 41 are for specialist secondary care prescribing only.

Speciality	Number of drugs	Speciality	Number of drugs
Cancer	17	Cardiology	1
Dermatology	2	SMS	1
Pain	1	Infection	3
Gastroenterology	2	Respiratory	1
Neurology	11	Diabetes	3
Surgical	1		

HMP Berwyn

The pharmacy department at HMP Berwyn continues to play a major role in medicines optimisation and safer prescribing with pharmacy technicians and pharmacists reconciling medicines and supporting administration. Newly developed face to face medication review clinics identify and support any difficulties with adherence.

The introduction of the remand population took place in December 19. Sent directly from courts to HMP Berwyn, there are significant difficulties obtaining an accurate medical history, which has challenged the pharmacy technicians to ensure continuity of care as they may be under that care of both their GP and the substance misuse service. In addition because the men often arrive from court out of normal working hours, there are some difficulties with access to the men's summary NHS record to allow the GPs to prescribe safely to prevent sudden alcohol or drug detoxification.

Education and training has been delivered to other members of the health care team on medication used for detoxification and withdrawal.

The pharmacy robot is operational two years after installation allowing improved scrutiny of prison stock levels and improved data for analysis by finance and for discussion at the monthly Medicines Management Group. There has also been a reduction in near misses and errors from incorrect drug selection.

A lack of sufficient prison officer support to allow safe and effective clinics, room checks and administration of medicines is a common issue which has been raised at multiple forums, including the Medicines Management Group, the Local Health Delivery Group and the Quality, Service and Performance meeting.

Mental Health & Learning Disabilities

Pharmacists and pharmacy technicians provide an outstanding clinical service to the inpatient wards, supporting staff, answering queries and dispensing specialist psychotropic drugs. They also support the Medicines Management group (MHMMSG) and medicines governance for the MHLD Division. This year:

- Several policies /protocols have been reviewed and updated.
- New policies and guidelines have been developed and approved.
- Mediwell automated medicines cabinets for the adult and older persons mental health (OPMH) acute wards have been purchased and planning is in progress for their installation.
- A pilot is underway to support two community MH teams and an OPMH community team to demonstrate benefits to support a previously unsuccessful bid for pharmacist support.
- A successful bid has secured funding for EMIS (electronic prescribing) for community mental health teams, to address safety issues raise by GPs.
- Purchase of MicroGuide app for easy access to prescribing policies and pathways, although progress with uploading documentation has been slow because of pharmacist and clinician capacity.

All this, delivered with insufficient resource which impacts on staff morale and other support functions, including savings. For example the technicians spend the majority of their time dispensing when they could be providing ward-based patient care and there is insufficient capacity for pharmacists to attend ward rounds or counsel patients prior to discharge or in even provide basic pharmacy input on some acute mental health wards. No further resources have yet been made available and a letter following the visit by the WG Chief Pharmaceutical Officer is seeking assurance by the Health Board to invest in MHLD pharmacy resources.

Cancer Services

In 2019 it was recognised that the increased patient numbers and quantities of systemic anti-cancer treatments (SACT) being managed by the pharmacy teams across BCUHB was creating a strain on service provision which could impact upon safety and was affecting the welfare of staff. A review of staffing levels using the British Oncology Pharmacy Association (BOPA) standards identified a shortfall in YG and YWM. Following a successful invest to save bid, two additional team members were recruited to make the service more robust.

The latest version of Chemocare, the cancer electronic prescribing system, has been tested and will be rolled out across BCUHB in 2020. The priority is to upload the haematology protocols to mitigate the risk of the failing OPMAS system used in the

North Wales Cancer Treatment Centre. Chemotherapy production on the YGC site has been consolidated into the sterile production unit to facilitate the efficient use of staff although the air handling unit is recognised as being fragile as mention on page 16. A capital business case is being prepared to renovate and ensure the viability of this unit over the next 5-10 years.

AWMSG Prescribing Indicators

1. Safety indicators:

1. Proton Pump Inhibitors (PPI) – DDDs per 1000 Pus

PPIs have been a key element of BCUHB's prudent prescribing Local Enhanced Service for 3 years now. The pharmacy team has worked collaboratively across primary and secondary care to ensure best practice in the prescribing of PPIs. Education initiatives have been developed for both health care professionals and the public, and include step down guidance. Posters & banners were produced for patient and public events e.g. Eisteddfod. In addition, the AWMSG PPI patient leaflet was printed professionally for distribution from GP surgeries and community pharmacies. **The graph below demonstrates the trend over the last few years. BCUHB has shown the sharpest decline in prescribing in Wales since 2015. The upward trend in late 2019 is as a result of a national shortage of ranitidine.**
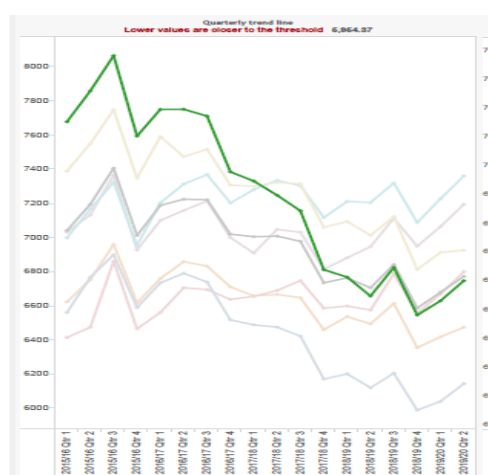
Trend in PPI prescribing DDDs per 1,000 PUs
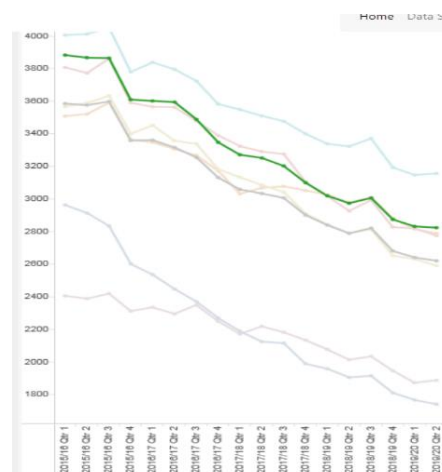
Trend in hypnotic & anxiolytic prescribing ADQs per 1,000 STAR-PUs

2. Hypnotics and Anxiolytics – ADQs per 1000 STAR-PU

Of note are independent prescribing pharmacists who with technicians support patients to slowly reduce their hypnotics or anxiolytics. BCUHB also hosts a 'Prescribed Support Medication Service' to reduce patients' use of benzodiazepine, opiate, antidepressant etc. Patients can be referred into this nurse-led service for managed withdrawal and intervention, including signposting to other local services, alternative strategies for pain management and holistic care discussion. Whilst capacity is relatively low, it is another avenue for patient intervention and GPs find these resources useful, as reducing these medicines requires patience and time over weeks if not months. The positive downward trend has been maintained.

2. Efficiency indicators

The biosimilar switch programme, to move patients from a reference biological medicine to its biosimilar equivalent, led by specialist pharmacists working with their clinical teams in rheumatology, dermatology, gastroenterology and cancer services continued in 2019. BCUHB now has the highest proportion of biosimilar use in Wales.

Figure 21. Biological reference and biosimilar as a proportion of total reference plus biosimilar prescribed – Quarter ending September 2019
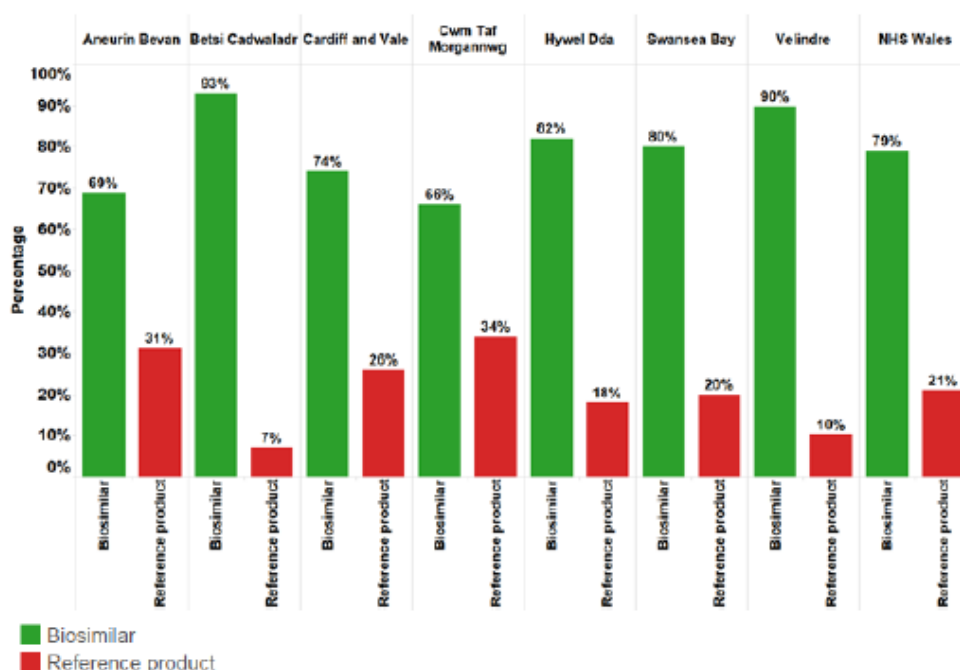
Blood Born Virus Infections (Hepatitis C and Human Immunodeficiency Virus)

The new direct-acting antivirals (DAAs) for hepatitis C, introduced in 2015, have revolutionised treatment, particularly with the greatly improved cure rate, lower incidence of side-effects, and a shorter treatment duration than older alternatives.

In 2019, 136 patients were treated bringing the total number of patients in BCUHB treated since 2015 to 547 patients. With a success rate of 95% this equates to over 500 being cured of the disease in north Wakes, thereby reducing the incidence of liver disease, liver cancer and deaths related to end-stage liver disease. To achieve the World Health Organisation aim to eradicate hepatitis C by 2030, BCUHB needs to treat 194 patients per year. Staff capacity to test and treat some harder to reach groups of patients means that the Health Board has fallen short of the target, but plans are in place (see below).

- 40 patients have been treated at HMP Berwyn since the end of 2018.
- A new pharmacist-led pathway developed in 2019, is being run at the Homeless Hub in Wrexham as a 12 month project with care delivered to patients in the community. Adherence to treatment is supported through weekly medicine collection, provision of mobile phones with reminder alarms and with help from the Harm Reduction Team. This innovative project has received a £53K grant from Gilead (pharmaceutical company) which has enabled the team to rent a point of care test (POCT) machine to enable diagnosis in less than an hour. Thus rapid access to testing and treatment for hepatitis C is available for homeless patients whose only other route would be via secondary care.

A new national HIV antiretroviral prescribing guideline was introduced into BCUHB in 2019 and three new part-time specialist HIV pharmacist posts were appointed in each of the acute hospitals this year. Working as part of the multidisciplinary team, they offer specialist pharmacist support on all 3 sites for clinical verification of prescriptions, drug history taking, advice on HIV medicines and adherence ensuring the most suitable and cost effective choice of agents.

3.2 Communicating Effectively

This year has seen considerable activity in promoting the use of Welsh at Glan Clwyd Hospital where they have been successful in recruiting a number of Welsh speakers. Ten members of staff from reception, dispensary and the administration team are enjoying role specific Welsh lessons. Three attended a residential course which they found to be very intense but useful. Our Welsh learners were nominated for a BCUHB Achievement Award.

3.3 Quality Improvement, Research and Innovation

North Wales Pharmacy Conference

The inaugural North Wales Pharmacy Conference took place at the OpTIC Centre in May 2019. The event offered an opportunity for pharmacy staff to share the wide range of research, service improvement and audit work they undertook through the year. The wider team were joined by guests from Cardiff and Swansea Universities and the Royal Pharmaceutical Society who joined the judging panel for the best presentation. Projects shared at the event included:

- An audit to determine the extent of omitted medicine doses at Ysbyty Glan Clwyd.
- Assessing prescribing in the treatment of renal anaemia for dialysis patients at Ysbyty Gwynedd and Ysbyty Alltwen
- Review of medication transfer and wastage at admissions in Wrexham Maelor's Emergency Department
- Improving patient counselling services in the dispensary setting.
- Direct Oral Anticoagulants: are we counselling patients, providing information leaflets and communicating effectively with primary care?

Pharmacy studies featured at the 2019 Welsh Medicines Research Symposium, organised by Bangor University, Royal Pharmaceutical Society and Health and Care Research Wales, included an evaluation of "*Patient Satisfaction with a pilot sore throat test and treat point of care service provided in community pharmacies in Wales*" and "*Cost utility analysis of fidaxomicin versus vancomycin for the management of Clostridium difficile infection in BCUHB*".

Several members of the pharmacy team have either completed or are in the process of completing Research Masters level Modules and Programmes. Outputs include assessed research and evaluation protocols and completed research projects e.g.

- Evaluation of patient and healthcare providers perceptions of homecare medicines services
- Influences on the decision making process for prescribing antimicrobial agents

Two pharmacists have successfully applied for research funding awards: a HCRW Clinical Research Time Award and BCUHB Pathway to Portfolio Award.

The Health Board are collaborating with the Centre for Health Economics and Medicines Evaluation at Bangor University to develop an evidence base for the delivery of Value-Based healthcare. The initial focus will be on usage of Direct Oral

Anticoagulant Agents (DOACs) and Intravitreal Biologic Agents, exploring variation in usage of these agents and scoping Patient Reported Outcome Measures.

Pharmacy & Medicines Management continues to host Clinical Trials of Investigational Medicinal Products, ensuring procedures are in place to enable BCUHB compliance with the relevant regulations, guidelines and directives. Work is ongoing to ensure the Health Board has sufficient pharmacy capacity to meet the current opportunities for investigational studies across each site and Division.

Dignified Care

4.1. Dignified Care

Palliative Care

In collaboration with Macmillan UK, a third specialist palliative care pharmacist for East Area was appointed to work collaboratively across north Wales. Providing clinical pharmacy services across primary, secondary care and hospices to support complex symptom management for palliative care patients, they aim to optimise medicines to ensure that patients are pain and symptom-free. In addition, BCUHB are the first Health Board in Wales to appoint a Macmillan Pharmacy Technician to expand medicines management services for palliative patients.

Improving access to palliative medicines both in and out of hours to support end of life care for patients in whichever setting they wish to die has been a priority this year, this includes the governance to prevent diversion and educational strategies to promote the safe prescribing of strong opioids and medicines that can cause dependence.

Continence

Each of the areas has dedicated Medicines Management Continence Nurse in their pharmacy team. Working with patients, families, carers and colleagues they provide advice and education on products, including appropriate ordering quantities and assessment of patients' needs to prevent catheter-related and continence problems, referring to a specialist as appropriate. Whenever possible and when appropriate, patients are encouraged to have a trial without a catheter.

These specialist nurses also support district nurses with the development of pathways and education, work with Dispensing Appliance Contractors to address governance concerns, and visit GP practices to encourage adherence to the continence formulary.

This work has demonstrated better patient care, greater compliance with the formulary, release of savings and a valuable resource for the pharmacy team, GPs, nurses (in all settings) and patients alike. Next steps include Independent Prescribing.

The West have developed this concept further with a community-based stoma nurse. Working with GP practices to identify patients, she invites those no longer under secondary care who may not have been reviewed for some time. Stoma changes can take place over time and for 60% of the 163 patients reviewed, the wrong size appliance was in use and skin problems had developed as a result of leaks. Patient feedback has been very positive. As well as the ongoing emotional and psychological support, there has been less demand for stoma accessories. As a result, a pathway has been developed for the handover of new patients after their first post-surgery review.

Communication with the Dispensing Appliance Contractor and regular contact with GP practices prevents incorrect ostomy supplies being delivered to patients resulting in savings.

4.2. Patient Information

The Medicines Information (MI) and Advice Service provided advice for 56 patients in 2019 via the medicines helpline. The majority of the patient advice calls concerned complementary and alternative medicines and whether they were safe to use in combination with prescribed medicines or if there are other cautions or contra-indications to their use.

Other examples of queries covered:
- Administration of medicines
- Travel
- Vaccines
- shortage concerns; availability in primary care; how to arrange a new prescription

- Suitability of over the counter medicines
- Dental

Plans are underway to promote the medicines helpline more widely in 2020.

Timely Care

5.1. Timely Access

MTeD (Electronic Discharge Advice Letters)

There has been no further rollout of MTeD in 2019/20 and so the average number of discharge advice letters sent out each month remains static and the dashboard development stalled because additional resource is needed. A business case is being developed for a funding decision to further roll out MTeD across Wrexham Maelor Hospital, community hospitals and Mental Health and Learning Disabilities.

Testing of a new version of MTeD is in progress at the hospital admission stage, which can import the patient's drug history from the patient record and allow pharmaceutical care planning to be documented electronically thus enabling access by the wider multi-disciplinary team.
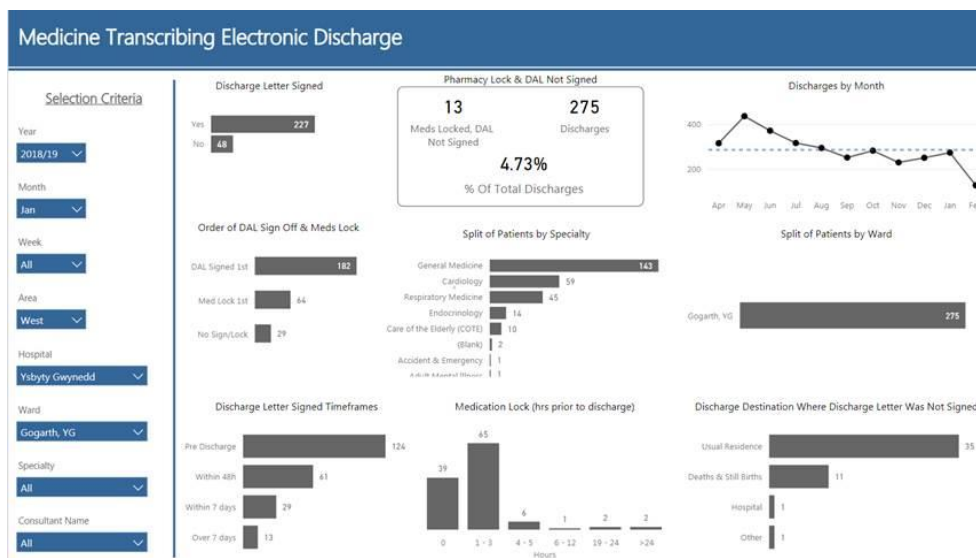
The dashboard tracks the volume of discharge letters, but also identifies areas of concern such as the timeliness of completion and number of unsigned letters, which can increase the likelihood of a patient's re-admission

Pharmacy in Emergency Departments (ED)

Winter pressure money has enabled a pharmacy technician to join a pharmacist working in the emergency departments. When there may be long waits for inpatient beds, it is imperative that patients taking time critical medicines e.g. antiepileptic, insulin, Parkinson's disease, have their charts written up and have access to treatment. Medicines frequently do not get transferred with the patient, which may mean that critical medicines are omitted. The pharmacy technician presence in ED enables the medicines reconciliation and medicines supply to be completed by the most appropriate healthcare professional and frees the pharmacist to focus on the clinical interventions, safety and medicines governance.

In one ED department alone, in addition to savings from improved transfer of patients own drugs, the pharmacist collected interventions to preventing life threatening and serious medicines harm over 4 weeks:

Intervention Grading	Number of Interventions	Cost Avoidance (£)
Serious (£1000)	180	180,000
Life Threatening (£1500)	37	55,500
Total	**217**	**£235,500**

Individual Care

6.3. Listening and Learning from Feedback

1 A diploma pharmacist project asked inpatients whether they wanted all their medicines dispensed when they went home. They said that as long as they have a supply at home they would rather only new medicines or those where the dose has changed are dispensed. This has now been implemented in Wrexham.

2 A concern was raised at Glan Clwyd Hospital that a mum picking up her medicines from the children's ward did not understand the dose change. Mum was collecting from the ward rather than pharmacy as it was more convenient but in doing so did not get to speak to anyone from pharmacy. On reflection the gap in the pharmacy service was recognised and it is believed that a Carers will not be collecting from the pharmacy and they need more information they are now contacted by telephone or other arrangements made. This learning has been shared across the three sites.

3 Nursing staff at Ysbyty Gwynedd requested a satellite dispensary on H block similar to T block which is now being built as part of the pharmacy automation and redevelopment project due for completion by April 2020.

4 The reception area at the main Ysbyty Gwynedd pharmacy dispensary has been separated to improve confidentiality for outpatients.

COMPLAINTS	West	Centre	East
CATEGORY			
On the Spot	2	2	5
AM/MP	5	4	6
Formal Complaint	3	2	2
Formal CHC	1	0	0

7.1 Workforce

Multi Sector Training

BCUHB was the first organisation to train its pre-registration pharmacists in hospital, community and primary care and as a result, the model is being adopted nationally. Now this multi-sector training is to be extended to pre-registration pharmacy technicians and the Foundation Pharmacist training programme. This is in addition to nine hospital based posts which have placements in the primary care team and HMP Berwyn (in the east). These innovative programmes result in well-developed and rounded professionals who are able to work flexibly in any sectors, and help to attract high calibre candidates from across the country for training opportunities.

These programmes are not without difficulties, due to limited desk and clinic space in GP practices and competition with other professional groups for mentorship from non-pharmacy staff.

Advanced Practice

Each year pharmacists and pharmacy technicians are being supported to work at an advanced level through postgraduate courses. For 2019-20 these include:
- Independent prescribing (8 pharmacists) in general practice and specialist areas such as HIV medicine, Respiratory and Paediatrics.
- Advanced clinical practice module (including physical examination/diagnostics and minor illness modules)
- Research Methods module at Cardiff University (4 pharmacists) in preparation for a research project within their areas of work.
- Diploma in therapeutics (2 pharmacists)
- Postgraduate certificate in Psychiatric Therapeutics from Aston University (1 pharmacist)
- Postgraduate Diploma in Diabetes (1 pharmacist)
- Pharmacy Clinical Services Diploma at Bradford (5 pharmacy technicians)

Career and Recruitment Events

Committed to developing a future pharmacy workforce, numerous career and recruitment events were attended in schools, colleges and universities across North Wales and the UK respectively during 2019-20.

A new "Science in Healthcare" career event was organised in conjunction with Cardiff University's School of Pharmacy and Pharmaceutical Sciences at the MSparc Science Park on Anglesey in September 2019. Supported by dentistry, speech and language therapy and psychology, it gave years 12 and 13 students from local secondary schools opportunities to enjoy an interactive day covering the application of science within healthcare as well as advice regarding applying to universities.

Workforce Performance

STAFFING	West	Centre	East
Current Staffing Numbers	126.24	139.17	120.46
Number of vacant posts	20.2	4.84	10.68
% of staff who have had a PADR	67.3%➡	72%⬇	89%⬆
% of staff compliant with mandatory training	91%⬇	86%⬆	93%⬆
Sickness rate	3.99%⬇	2.8%⬆	2.9%⬆

Maternity rate	5.1%➡	1.62%➡	1.36%⬆
Staff turnover rate	3.8%⬇	9.5%⬆	9.1%⬆

Managed GP practices

In the last twelve months, 16 GP practices within North Wales that were previously General Medical Services (GMS) contractors gave notice of their contracts and became the responsibility of BCUHB to manage. These practices provide services for approximately 70,000 patients (10% of the North Wales population). One has now successfully returned to a GMS contract and a further two are planned for 2020.

The Health Board is responsible for ensuring safe and effective governance processes are in place. Because medical provision in managed practices is via salaried GPs and locums, who are either employed on a 37.5 hour week contract, which clearly defines their roles and responsibilities or on a sessional basis and locally negotiate their working day, many do not have the capacity to:

- Undertake home visits or provide on call;
- Prescribe for patients, support chronic disease management, care home reviews, or undertake medication reviews.
- Undertake reauthorisation of regular repeat medication for patients that they have not seen in the surgery, as they have no knowledge of the patient's clinical history or the governance processes in place in the surgery to ensure a safe robust repeat prescription process.

Shortages of both salaried and locum GPs result in difficulties providing safe, effective medicines management processes. Across primary care, each area has a team of pharmacists and technicians working to support these practices with patient safety, education, clinical information and budget management within GP practices.

Community Pharmacy

Changes to funding model – off site dispensing; closures; withdrawal of unfunded services

Recent changes to the funding structure of the national Community Pharmacy Contractual Framework aimed to refocus income towards services and reduce the cost of dispensing prescriptions. This has resulted in steps being taken to restructure staffing in community pharmacies. Larger companies, taking advantage of economies of scale are adopting a 'hub and spoke' dispensing models. These changes will ultimately enable community pharmacy to deliver a better value supply service for their patients. However, during the implementation phase, there have been a number of challenges around communication and the need for other parts of the system to change the way they work to accommodate the new systems (e.g. patients ordering and GP practices issuing prescriptions earlier). As a result a number of complaints and concerns have been raised.

Other repercussions have been difficulties with cash flow, home deliveries and provision of medicines dispensed in monitored dosage systems (MDS). Partly in consequence of this, two pharmacies have given notice on their NHS contract and closed in Q4 of 2019/20 and a number of other pharmacies have changed their opening hours, to close earlier on weekdays and open for less time, or not at all, at weekends. This inevitably impacts on other parts of the health system, particularly unscheduled care, as there are fewer self-care access options available. Restriction on delivery service and MDS will have a disproportionate effect on the most vulnerable in our communities and has the potential to contribute to increased health inequalities.

Recruitment of community pharmacists is proving challenging across North Wales, but is particularly acute in the West area and can also extend to securing locum cover which can result in pharmacies having to close for part, or all, of the day. When available, contractors often have to pay significant fees to secure locums who would normally work in England and so may not have the necessary accreditation for some of the key enhanced services. This affects service continuity and patient experience and creates additional pressures elsewhere in the system.

In the West area, temporary closures peaked in August 2018, with 70 closures for at least some of the day in Gwynedd and Anglesey. Since meeting representatives from Rowlands, the largest pharmacy operator in the area, there has been a significant reduction, although there are still 6-7 closures per month.

Secondary Care

Recruitment of pharmacy staff at Ysbyty Gwynedd is challenging and there are high vacancy rates. The national ORIEL pre-registration pharmacist recruitment system, implemented during 2016 appears to be having a detrimental effect on local recruitment and staff retention.

The Glan Clwyd hospital pharmacy team are taking part in the pioneer Be Proud programme to build and enhance team engagement. Their Be Proud team are driving forward changes which are impacting on staff morale and the efficiency of the department. There is a strong focus on communicating openly and honestly with staff and of keeping the wider team informed and involved at every stage. This is energising colleagues and has a ripple effect outwards.

Mentoring

Junior pharmacists in secondary care now are often appointed to a rotation, with time spent in different specialties. Mentoring is provided by the respective specialist pharmacists and this new rotation is proving to produce well rounded individuals, ready to take on more senior roles.

In primary care a monthly education is facilitated by the clinical lead specialist supported by GPs, which involves role play, case-based discussions, sharing of good practice and NICE guideline updates. These sessions enable the primary care team to hold more in depth, confident and effective medication reviews with complex patients.

Risks

Benchmarking and analysis of prescribing data in both primary and secondary care have identified significant growth and cost pressures for the 2020-21 financial year. These include implementing NICE approved medicines in primary care e.g. direct oral anticoagulant (DOAC), which have new indications and revised thresholds for treatment; treatment and monitoring of diabetes. Blueteq®, shortly to be introduced will give greater assurance on NICE compliance with high cost medicines.

The fact that the prescribing budgets were set without an uplift or due consideration of potential growth, the impact of medicines shortages, or volatility of the market emphasises the need to establish a single planning process for drug budgeting and monitoring in 2021-2. A recent finance report suggested that there is till the potential to save £12m-£21m from the primary care prescribing budget. This was calculated using flawed benchmarking data and has been recalculated using an appropriate selection of health organisations (County & Coastal). The comparative data gives a

figure of £3.4m with potential scope for savings in respiratory, nutrition, skin and stoma. All areas are included in the financial savings scheme planning

RISK (HIGHEST RATED RISKS – TAKEN FROM RISK REGISTER)			
RISK	**SCORE**	**DESCRIPTION**	**MITIGATION/ MONITORING**
Lack of funded pharmacy resource for Mental health at Wrexham	20	There is insufficient pharmacy resource to provide the required dispensing and clinical functions for the MH division. This poses a risk to the patients on Heddfan and increases pressure on the pharmacy dispensary at Wrexham. There are currently 0.8 pharmacist and 2 technicians in total and no annual leave or sickness cover. 3000 items are being dispensed per month over and above what is funded. National workforce recommendations for the unit size recommend 5 Pharmacists and 8 Pharmacy technicians.	A locum pharmacy technician has been funded to support dispensing. EMIS has been purchased & will be implemented
Failure of dispensing robot resulting in delayed medicines supplies to patients	16	There is a risk to patient safety as the Pharmacy Dispensing Robot is no longer reliable. This is due to the robot being twelve years old and has reached the end of its life expectancy (10 years) with replacement parts becoming more difficult to obtain and there are problems with operating system. The old robot also makes it more difficult to automate the Falsified Medicines Directive (FMD).	East priority for capital (medical device). Monitoring via east area
Pharmacy Support for Community Hospitals & Rehabilitation Wards	16	The current funded pharmacy support for the east area community hospitals and rehabilitation wards (160) beds only allows for a once weekly visit from a pharmacist and technician respectively. This means that patients may wait for up to 7 days for a medicines reconciliation to be undertaken, which does not meet the standard of 24 hours set by NICE. This can lead to significant harm to patients who may have critical medicines omitted from the prescription chart.	Business case in development. Monitoring via area teams
There is a risk of patient harm from a failure of the production unit delaying chemotherapy	16	There is a risk of the failure of operational systems within one or both Pharmacy manufacturing and compounding facilities within the Central Region BCUHB. Following the breakdown of the SPU air handing unit in 2019 Estates advised that the unit could fail catastrophically and would not be repairable. Both facilities are poor, the Cancer Centre is of poor design and fabrication and the SPU is past its recommended working life and the Air Handling Unit (AHU) is condemned. The lay out of the Cancer Centre production unit is not fit for purpose and production has been consolidated in the SPU unit. Merging has enabled the staff could be better utilised and some of the organisational issues addressed but the Cancer centre unit cannot be fully shut down as it remains the contingency provision should SPU fail. Products that would be affected are; Chemotherapy, radiotherapy, total parenteral nutrition for adults and babies, prepared products that reduce risk e.g. insulin and morphine syringes and antibiotic infusions, and over labelled packs for discharge.	Business case to convert band 7 to fixed term band 8a whilst longer term solution is put in place. Monitored via East Area.
Implementation of new pharmacy computer system	15	The current pharmacy computer system EDS is to be replaced on an All Wales basis with WellSky. Contracts have been signed by WG and an implementation plan is required on sites. There is a risk that there is insufficient staff resource to maintain current services whilst implementing a major change. There is also a need for IT support which will require significant resources to assist implementation.	BCUHB have members on each of the WG module working groups and the overarching implementation group. Further ID of personnel to continue support post implementation required.
Risk of breaching legal requirements to store	15	There is a risk that BCUHB will breach legal requirements for storing controlled pharmacy documents. This is because the scanner in the department is no longer working and any future	Paper prescriptions, worksheets etc are being kept,

prescriptions securely		procurement of a replacement is not possible because it is unsupported by BCUHB IT. This could have a financial and information governance impact. The estimated financial impact per year is £10,000. Legally, pharmacy required to store adult prescriptions for 2 years, paediatric prescriptions until they reach 21 years of age; worksheets for a period of 13 years (26 years for paediatrics); purchase invoices for 5 years. The pharmacy previously scanned all the documentation, keeping the hard copies for 1-2 months before destruction.	but lacking storage capacity. Awaiting IT support for solution/ Monitored via area teams
There is a risk of patient harm from a failure of the production unit delaying chemotherapy	15	There is a risk of the failure of operational systems within one or both Pharmacy manufacturing and compounding facilities within the Central Region BCUHB. Following the breakdown of the SPU air handing unit in 2019 Estates advised that the unit could fail catastrophically and would not be repairable. Both facilities are poor, the Cancer Centre is of poor design and fabrication and the SPU is past its recommended working life and the Air Handling Unit (AHU) is condemned. The lay out of the Cancer Centre production unit is not fit for purpose and production has been consolidated in the SPU unit. Merging has enabled the staff could be better utilised and some of the organisational issues addressed but the Cancer centre unit cannot be fully shut down as it remains the contingency provision should SPU fail. Products that would be affected are; Chemotherapy, radiotherapy, total parenteral nutrition for adults and babies, prepared products that reduce risk e.g. insulin and morphine syringes and antibiotic infusions, and over labelled packs for discharge.	Business case developed. On central area estates capital plan. Monitored via Central Area.
Prescription charts in pharmacy therefore not on ward.	15	There is a risk that patients will not receive critical or emergency medication or consultant review due to prescription charts being sent to pharmacy for a clinical check. This is because Pharmacy needs to undertake the clinical check for all newly prescribed drugs to ensure that there are no interactions with co-prescribed medicines and that the dose, and route are correct. If this coincides with a consultant ward round it could result in the chart not being available for review, so medicines could be continued inappropriately, or new medicines not started. If it coincides with a medicines round it may result in omission of critical medicines e.g. insulin, antiepileptics, Parkinson's drugs. New electronic ordering form has been developed in the east, which will reduce the need to send charts down to pharmacy.	All actions to mitigate have been taken. Awaiting Electronic prescribing.
There is a risk that patients in mental health are harmed by poor prescribing practice as pharmacy support is minimal	15	Lack of pharmacy staff both pharmacists and technicians to support MH interventions and lack of regular medication review and reconciliation, education to doctors and nurses poses a risk to safety of patients. Increasing specialist services being provided in primary care with no dedicated pharmacy support. Ongoing recruitment issues for nursing and doctors increase medicines related risks and dispensing which requires pharmacy support but no extra funding is being considered to support this	Business case has been developed. Pursuing opportunities for further MH funding from WG.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Psychological Therapies update
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Lesley Singleton Interim MHLD Director/Director of Partnerships
Awdur yr Adroddiad Report Author:	Dr Dawn Henderson
Craffu blaenorol: Prior Scrutiny:	Executive Director of Mental Health & Learning Disabilities
Atodiadau Appendices:	1) Psychological Therapies Review in North Wales Report 2) Psychological Therapies Review Programme Board – Terms of Reference

Argymhelliad / Recommendation:

The Quality Safety & Experience committee are asked to receive this information and regular updates on improvement work for scrutiny and assurance.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	☞	Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	

Sefyllfa / Situation:

Within Wales, despite improvement work an increase in demand for psychological therapies, together with low levels of specialist resource and a lack of NHS architecture and infrastructure to support workable stepped care pathways, means people are still waiting too long for treatment. There are areas of North Wales where waits are reasonable and compliant with Welsh Government Targets. However, there remain areas of concern such as Wrexham which continue to skew regional reporting due to a backlog of legacy waits.

The BCUHB MHLD external review has now concluded, and within the MHLD Division a workshop in February 2020 and a new programme board developed to take 5 specific improvement workstreams forward. The lines of accountability will be update reports and any issues/concerns will be escalated to the Health Board QSE.

Cefndir / Background:

National Welsh NHS guidance and standards have been developed over the last 5 years to guide evidence based service improvements and provision across Wales. The All Wales Psychological Therapies Committee (NPTMC) together with Public Health Wales developed the National Psychological Therapies Plan 2018 and Matrics Cymru 2017, which recommend a stepped care model for Wales across multidisciplinary services. System wide challenges to improvement in access across Wales are identified in the All Wales 2019 survey, and for North Wales also reflected in the 2019 BCUHB MHLD commissioned external review of Psychological Therapies.

In North Wales there remain considerable challenges to increasing access across multidisciplinary stepped care services, and in the wider aim of psychologically informed care across all health care. In many areas there is an over reliance on specialist staff, with lower step and earlier access to other parts of the system not readily available. Where particularly prevalent, this has led to longer legacy secondary care specialist waiting lists (eg. Wrexham Adult Mental Health).

To encourage improvements in access across Wales, Welsh Government piloted national 26 week Psychological Therapy Targets for Secondary Care Specialist Mental Health Services in 2018 and in April 2019 these became statutory reportable Targets across Wales. This has increased the visibility of secondary care specialist waits.

Asesiad / Assessment & Analysis

Waiting Times

The current most visible area is the 26 week specialist secondary adult mental health (AMH) Welsh Government Target data. There are no separate psychological therapy secondary care specialist AMH services in North Wales. All specialist clinicians work within multidisciplinary CMHTs across North Wales. Currently, there remains a total low 13 WTE specialist resource to cover all the North Wales CMHTs, with an additional 5.0 WTE current vacancies due to staff turnover/vacancies/maternity leave. Informatics systems in North Wales do not support systematic data collection across mental health services. For the 26 week secondary care specialist data submission to Welsh Government, manual extrapolation and collation from each individual CMHT area across North Wales is required.

BCUHB SECONDARY CARE SPECIALIST CMHT LEVEL - WAITING LIST STATS - FEBRUARY 2020

AREA	No waiting	Longest wait (months)	DAYS >84 / WEEKS >11 / MONTHS 0-2	85-126 / 12-17 / 3-4	127-182 / 18-25 / 5-6	183-252 / 26-35 / 7-8	253-364 / 36-51 / 9-11	365+ / 52+ / 12+
Gwynedd (including CBT)								
ARFON / 1.0 WTE Specialist Staff	9	5	5	2	2	0	0	0
DWYFOR / 0.6 WTE Specialist Staff	8	0.5	8	0	0	0	0	0
MEIRIONNYDD - NORTH / 0.4 WTE Specialist Staff	7	7	1	6	0	0	0	0
MEIRIONNYDD - SOUTH / 0.8 WTE Specialist Staff	4	4	2	2	0	0	0	0
Ynys Môn (including CBT) / 1.3 WTE Specialist Staff / 0.8 WTE vacancy	27	11	8	8	5	3	3	0
Conwy								
Conwy Psychol / 2.6 WTE Specialist Staff / 1.0WTE CBT vacancy	12	29	0	3	0	0	0	9
Conwy ASD	2	19	0	0	0	0	0	2
Denbighshire								
Hafod Psychology / 1.0 WTE Specialist Staff	2	1.5	2	0	0	0	0	0
TDC Psychology / Vacant post Nov 18-Apr 19 / (0.4 WTE covering from Conwy)	6	27	0	0	0	0	2	4
Denbighshire CBT / 0.6WTE vacancy	14	13	2	2	1	4	5	2
Denbighshire CBT / 0.4 WTE Specialisit Staff	4	4	3	1	0	0	0	0
Flintshire								
Mold / 1.8 WTE Specialist Staff	14	29	2	4	2	0	1	5
Flint / 1.0 WTE Specialist Staff	8	36	1	0	0	0	0	7
Deeside / 1.4 WTE Specialist Staff	5	5	1	1	3	0	0	0
Wrexham								
RURAL Sec Care from Aug 18	26	18	1	5	1	2	5	12
CENTRAL Sec Care from Aug 18	13	18	1	1	0	0	1	11
2.8 WTE Specialist Staff / 1.0 WTE MAT LEAVE / 1.0 VACANCY	0.6 WTE covering from Arfon advert out							
LEGACY LIST - Rural	120	55	0	0	0	0	0	120
LEGACY LIST - Central	91	55	0	0	0	0	0	91
			37	35	14	9	17	52

TOTAL WAITING (not incl legacy list) 161
LONGEST WAIT (months) 36
Summary totals (not incl legacy list)

WREXHAM LEGACY W/LIST - TOTAL NO WAITING 211
WREXHAM LEGACY W/LIST - LONGEST WAIT 55m

A detailed breakdown of data indicates that in most CMHTs the waits for specialist psychological input at secondary care are comparable with South Wales. Current input throughout all Gwynedd CMHTs, Deeside CMHT, and Rhyl CMHT, are compliant with the 26 week Target. Where there are variances or longer waits, they are linked to staff vacancies/absence. There is a mismatch between capacity/demand which affects all areas, meaning some waits are inevitable but open consultation in teams means there is a prioritisation of people at risk.

The Wrexham area continues to be an area of concern despite significant improvement work. This is due to legacy lists, built up before Psychology took over management. A detailed analysis of the legacy waits in Wrexham indicates around half the people waiting have been assessed as primary care mental health level of need, rather than specialist secondary level. As Target compliance is reported regionally as a collated figure, the legacy waits in Wrexham continue to negatively skew regional figures for BCUHB.

The work to address longest waits:

- Take over management of the legacy lists in Wrexham, and completed reviews and risk assessment of people waiting.
- Active management of waiting lists and pathways across North Wales CMHTs, people with clinical risk seen up front and not placed on lists.
- Flexible utilisation of a small increase in specialist resource (WG investment bids)
- Rolling out of equitable delivery of advice, training, and supervision to MDTs across North Wales, aimed to better support MDT colleagues across primary and secondary care mental health services to provide psychological interventions thus reducing need to step up to specialist staff
- Rolling out of training and materials for staff to run groups in both primary and secondary mental health, eg. Coping Skills Groups, ACT Groups, Dialectical Therapy Groups.
- Increased availability of psychological expertise at front door clinical decision making and clinical leadership via SPOAA to MDT services, team joint working, team formulation.
- Take over management of the legacy lists in Wrexham, and completed reviews and risk assessment of people waiting.
- Active management of waiting lists and pathways across North Wales CMHTs, people with clinical risk seen up front and not placed on lists.
- Recruitment of North Wales Stepped Care Clinical Psychologist lead (started January 2020) and 6 Assistant Psychologists to support stepped care clinical and strategic developments across North Wales.
- Tender developed for outside agency help to target Wrexham hotspot legacy waiting lists, currently shewing North Wales regional figures to WG. Tender process underway - out currently for second time (no suitable tenders in February 2020).
- Psychological Therapies Training Programme Training Team to support training needs in all age service development across Health Board. Team now fully recruited January 2020, but as a smaller resource has delivered CBT training programmes to staff from Child & Young People's Services, SMS, Mental Health Services, and wider.

Results
An analysis of data April 2018-January 2020 indicates that the number of people now waiting for secondary care specialist input has shown a general downward trend across all North Wales counties. Conwy and Flintshire stand out in the early data as having comparatively large waiting lists, but both have shown a steady and marked decline to date. Gwynedd, Ynys Mon, and Denbighshire have all shown fluctuations in waiting list numbers but with a general downward trend. Gwynedd's rising trend at the end of 2018 correlates with staff absences in Meirionnydd North and South. Likewise Ynys Mon shows a rising trend in mid-late 2019 when there was a vacant post. The downward trend in these areas is most notable since early 2019 and some fluctuation is to be expected given all three areas have experienced vacancies.

Work needed to fully resolve
The complexity of the stepped care challenges across the whole system is considerable, and adult secondary care waits for specialist input should not be considered in isolation. Sustainable improvements require

system wide solutions and support, and will take time to show sustainable effects.   The strategic work to take this forward will be focused on the recommendations from the external review.

BCUHB MHLD commissioned external Review of Psychological Therapies 2019

The review made 6 recommendations for improvements:

1. Focus first on engaging staff
2. Co-create a vision for psychologically-informed approaches
3. Design and equip pathways of care that are fit for purpose
    a. addressing the legacy waits in East Adult Mental Health
    b. making stepped care a reality
    c. tacking inequality of access
    d. looking at out of county repatriation potential
4. Devise a strategic workforce plan and phase its implementation, with clear resource commitments at each stage
5. Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.
6. Pay attention to enablers of change.
    a. take urgent action to tackle the gaping intelligence deficits
    b. strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee
    c. make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid "big bangs" and initiative overload.

The reviewers conclude the Health Board should see the ambition for psychologically informed care as an organisation-wide responsibility, and that it is not realistic to look to the specialist resource to meet all need. They also conclude that it is not possible to improve access to high quality psychological interventions by ring fencing improvement work in the specialist services and everyone should play their part.

Psychological Therapies Programme Board
Going forward, the work detailed above will continue. Further system wide and MDT engagement is planned around the BCUHB's Review's recommendations. This will be supported by a programme board responsible for the implementation, monitoring, and providing assurance of the delivery of the key recommendations within the Psychological Therapies Review. This Board will report and escalate any issues/concerns to the Health Board's QSE.

The Board work plan:

1. Initial Scoping Workshop 4 February 2020
2. Programme Board meeting 25 February 2020
3. Draft Terms of Reference
4. Agreement on 5 initial workstreams
   a. Working Differently
   b. Psychological Safety in the Workplace
   c. Families Across the Lifespan
   d. Pathways – Co-occurring
   e. Pathways – Adults
5. Agreement on Leads for each workstream. Individual TORs and workgroups membership for each workstream in development, workgroups to develop individual workstream priorities and action plans.
6. Leads due to meet to identity cross cutting themes, and ensure connectivity
7. Two year programme timescale agreed with year 1 and 2 priorities
8. Project support requested via business case to WG
9. QI training, and joint initiatives and opportunities re: university links utilised.
10. Governance & reporting agreed
11. Stakeholder approach agreed

SUMMARY ACTION PLAN

Actions	Outcomes	Timeline
1. Improvement work including review of waiting lists and clinical review of people waiting; prioritisation of people at risk. Flexible utilisation of low resource staff across MDTs, targeting of hotspots including Wrexham outside help out for tender.	Analysis of data over the last 2 years indicates the number of people waiting has reduced, with a steady reduction and a marked decline to date. Variances outside of Wrexham due to vacancies.	Ongoing Tender process due for completion March 2020, dependent on successful tender
2. Psychological therapies teaching, supervision, advice and consultation to MDT staff, to ensure wider provision for service users from MDT primary and secondary services so reducing need to step up to specialist.	Multiple CBT & DBT training programmes delivered in the last 2 years. Set up of Psychological Therapies Training Team for systematic provision – fully recruited to Jan 2020. Supported by North Wales PTMC, and national curriculum work.	Review and full programme plan for 2020 - deliver April 2020
3. Recruitment of Stepped Care Psychologist, CBT Therapist and 6 Assistant Psychologists.	Mapping of individual and group interventions across Tier 0, Tier 1, Tier 2, Tier 3, engage staff - developing roadmap, tools, and groups for equity provision across the 6 counties.	Recruited January 2020 Mapping//first phase engagement on ground completed March 2020
4. BCUHB MHLD commissioned external review of psychological therapies 2019.	Six key recommendations given to support improvement work. Recommends WG national stepped care model Matrics Cymru (2018).	BCUHB Report released 24.12.19 BCUHB Workshop 4.2.20 BCUHB Programme Board 24.2.20
5. Five Programme Board workstreams.	TOR, working groups, and leads agreed.	30.5.20 first phase, 24 months delivery plan

PSYCHOLOGICAL THERAPIES REVIEW IN NORTH WALES

Facilitated by *TogetherBetter* Collaborative Consultancy

February - August 2019

Reviewers & Report Authors

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Acknowledgements

The authors would like to thank all those who participated in and supported the review process. It would not have been possible to gather as rich an understanding of current services, strengths, challenges and opportunities as we have been able to do, without your commitment and honesty. We hope we have been able to do justice to your contribution through the narrative of this report and its recommendations.

Contents

Psychological Therapies Review in North Wales

Foreword

Andy Roach
**Executive Director for Mental Health
and Learning Disabilities**

In 2017, we embedded a commitment to psychologically-informed care in our all-age strategy, *Together for Mental Health in North Wales*. Today, that commitment remains at the heart of our ambition for modern mental health and learning disabilities care for the people and communities we serve. So I am delighted to receive this review of our existing psychological therapies provision. It is the product of many different conversations with a wide range of stakeholders, and it has generated lots of ideas for the future. It is an important milestone in the implementation of our strategy and vision. It showcases the hard work and creativity of our frontline teams and partners, as well as the vital role we play in national developments in policy, service development, research and teaching. I am proud to celebrate these achievements with you.

Importantly, the report also raises some challenging issues that we must tackle together. Many of these challenges are common to services across Wales and the UK; others are specific to us in North Wales. My team and I are listening to what you have said, we welcome the passion you have expressed, and we ask you to work with us to co-create the improvements we all want to see. At the heart of our response to this review will be an engagement approach which goes beyond what we have attempted before. We want to shape this with you, and will make it our first priority in response to the review.

As I have reflected on the messages in this report, what strikes me most is that psychologically-informed care is a responsibility for each of us. Whether we provide clinical care as part of a multidisciplinary team, have an operational management role across a network of services, or design and deliver strategic developments to impact across the whole system, we each have a part to play in building on our successes and improving outcomes for local people *and* our workforce. If this is something we have not yet fully embraced, then this has to change. My hope is that we can work together to do this, and hold each other to account to live the values that I see in action every day in our services.

Thank you to all of you who have given your time to contribute to this process. I hope it is just the start of a constructive and impactful collaboration, through which we will continue to improve access to high quality, evidence-based therapeutic interventions for everyone.

Executive Summary

Betsi Cadwaladr University Health Board's Mental Health and Learning Disabilities Division commissioned this review in order to:

- clarify the way in which its psychological therapies services currently work
- explore the extent to which psychological mindedness is embedded in the culture and practice of its wider mental health services
- test its readiness to increase access to, as well as quality of, psychological therapies
- outline a roadmap towards improvement, in line with its overarching strategy.

As a team of reviewers, we did this by:

- holding conversations with over fifty stakeholders in one-to-one or small group settings, as well as attending relevant meetings
- reviewing documentation and data about psychological therapies and the wider multidisciplinary services
- seeking out user experiences of care
- undertaking an electronic resource mapping exercise
- facilitating three area-based workshops with frontline staff and service user representatives

We found many examples of positive and innovative practice being pursued at team and specialty levels, as well as opportunities being seized for additional investment from Welsh Government. However, we also found persistent and entrenched structural, systemic and cultural obstacles to fulfilling the ambition for psychologically-informed care across the organisation. For example:

- a lack of shared vision about what you are seeking to achieve through psychologically-informed care and what it means in practice – confusion as to the core offer
- significant unwarranted variation in provision, access, team working practices and culture amongst the multidisciplinary workforce at all levels
- unacceptably long waits in some areas, in part associated with pathway design which is under-resourced and not fit for purpose
- a lack of strategic clarity and oversight at Health Board and Divisional levels; a piecemeal and fragmented approach to pathway development rather than full implementation of stepped care
- a lack of strategic and integrated workforce development
- an enormous data deficit, leaving intelligence-driven decision-making wanting

- a sense of despondency and, in some places, learned helplessness as to how the organisation might work itself into a better place

In short, it is our view that neither the system of care nor the culture is yet equipped to deliver psychologically-informed care as the norm, so change is inevitable. We encountered both enthusiasm and scepticism about this prospect.

The core message we hope you will take from this report is that improving access to psychological therapies, and embedding psychologically-informed approaches, requires **whole system change**. Achieving this goal requires commitment and contribution at strategic and operational levels from clinicians, managers, partners, regulators, and from people who access services. It is as much about mindset as it is about practical solutions. If the potential contribution of psychological approaches can be actualised, the benefits for both service users and staff in North Wales are enormous.

Our Recommendations

1. **Focus first on engaging staff.**

2. **Co-create a vision for psychologically-informed approaches.**

3. **Design and equip pathways of care that are fit for purpose by:**

   a. **addressing the legacy waits in East Adult Mental Health**
   b. **making stepped care a reality**
   c. **tackling inequality of access**
   d. **looking at out of county repatriation potential.**

4. **Devise a strategic workforce plan to build capacity and capability, and phase its implementation, with clear resource commitments at each stage.**

5. **Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.**

6. **Pay attention to the enablers of change:**
   a. **take urgent action to tackle the gaping intelligence deficits in services**
   b. **strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee**
   c. **make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid 'big bangs' and initiative overload.**

Introduction

1. Definitions

We want to start with clarifying the use of terminology in this report. Language is important, and it is also a potential source for confusion and misunderstanding.

Psychological therapies have been defined as

'treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. They are delivered in a structured way over a number of sessions by a suitably qualified practitioner.'

(Matrics Cymru Guidance for Delivering Evidence-Based Psychological Therapy in Wales, 2017)

Practitioners include Clinical Psychologists, accredited therapists who have a core profession such as mental health nursing or occupational therapy, and accredited counsellors.

Psychologically-minded (or psychologically-informed) services are

'those in which – at all stages of assessment and intervention – the psychological needs of service users are considered and addressed through the use of evidence-based interventions. Furthermore, a psychologically-minded service focuses upon the quality of relationships between practitioners and service users in the delivery of all treatment and interventions. These relationships provide the foundation for service delivery.'

(Psychological Therapies in Wales Policy Implementation Guidance, 2012)

Low intensity **psychological interventions**, shown to be highly effective when applied in the right circumstances, can be offered by any clinician equipped with some core skills and appropriate supervision. They cover a very wide range of interactions with service users, and underpin an ethos which values and believes in the prospect of living a 'life beyond illness' (recovery). When psychological approaches run through every aspect of care, there is a coherence between multidisciplinary clinicians which enables the service user to develop their own skills from the outset, rather than wait to work with a specialist practitioner.

2. The Role of Psychological Therapies in the Wider Mental Health Service

The value of psychological therapies is well-established as a core element of modern mental health care, consistently reflected in policy, strategy and

evidence-based practice (including NICE guidance). In Wales, there is a solid strategic context for and policy commitment to psychological therapies, which includes:

- Psychological Therapies in Wales Policy Implementation Guidance 2012
- Matrics Cymru Guidance for Delivering Evidence-Based Psychological Therapy in Wales 2016 (which covers adults, older adults, and people with a learning disability)
- Together for Mental Health Strategy 2012 (and North Wales' strategy of the same name in 2017)
- Access targets for psychological therapies in Wales, which are becoming increasingly rigorous
- The Mental Health (Wales) Measure 2010, which includes statutory responsibilities to ensure a range of psychological therapies is available within both primary and specialist settings
- Matrics Cymru for Children's Services is expected later this year

Yet many areas across the UK continue to face challenges in improving access to high quality, evidence-based, condition-specific therapeutic interventions for the diverse communities they serve. According to the *Equality and Human Rights Commission*, the number of people waiting for mental health treatment has doubled in the last six years in Wales, despite increases in funding (*Is Wales Fairer?* 2018). North Wales is one of these areas, and the East area is an outlier across Wales for its waiting times for psychological therapies. In its local strategy, Together for Mental Health in North Wales, Betsi Cadwaladr University Health Board (BCUHB) has made a clear commitment to:

- improve the availability of a range of psychological therapies, including online therapeutic interventions
- ensure psychologically informed (community) services are at the heart of what they do, focussing on:
    - making sure psychological intervention/therapy is evidence-based and effective
    - ensuring a timely and multidisciplinary approach
    - making sure the intervention happens as quickly as possible
    - choosing the most appropriate and effective intervention/therapy based on a collaborative and individualised formation of the person's difficulties
    - encouraging all services to be trauma-informed

Delivery of this strategy since 2017 has focussed on prevention and early intervention, and improvements in the acute care pathway, working together with service users, carers and the third sector to build an identity around the 'iCAN' ethos – *independent, contributing, active and networked*. This review is an

important step towards a renewed focus on psychological mindedness across all services, including better access to high quality psychological therapies.

3. The Stepped Care Model

THE STEPPED CARE MODEL

Tier Four
Highly specialist, high secure services

Tier Three (MHM Part 2)
Specialist inpatient services, e.g. low & medium secure care, specialist community teams

Tier Two (MHM Part 2)
CMHTs incl. CRHT, AO & EIP functions, acute inpatient care, supported accommodation

Tier One (MHM Part 1)
Primary healthcare team, LPCMHS & related services. 3rd sector services, mainstream accommodation, leisure, education, recreational services

Foundation Tier (Tier Zero)
Open access courses

The model of provision for whole system mental health services that is advocated widely in NICE guidance, and adopted by Matrics Cymru, aligned with Mental Health Measure requirements, is called 'stepped care'. The goal is to match evidence-based interventions with needs in the most resource-effective way, including emphasising the value of self management and wellbeing in communities. According to NICE guideline *Common Mental Health Problems – identification and pathways to care* (2011), local pathways based on stepped care should:

- provide the least intrusive, most effective intervention first

- have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway

- not use single criteria such as symptom severity to determine movement between steps

- monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.

While this lends itself to pathways for anxiety and depression, it is less helpful for other needs. Complex co-morbidities mean it is important to remain patient-

oriented when planning individual care and support, so this need for flexibility is important to preserve within the design and delivery of stepped care.

On a related note, it is important to highlight that the Matrics takes a **non-diagnostic approach**. It assumes, rightly, that most people accessing secondary care services are likely to have co-morbid presentations. This requires assessment, formulation, and care planning to be integrated, transdiagnostic and multidisciplinary. In order for those things to be possible, the system across the tiers must be designed, delivered, evaluated and improved accordingly. It is worth bearing this in mind throughout the reading of this report.

4. The Scope of the Review

BCUHB's Mental Health and Learning Disabilities Division commissioned this review in order to bring clarity to the way in which its psychological therapies services currently work, the extent to which psychological mindedness is embedded in the culture and practice of its wider mental health services, to test its readiness to increase access as well as quality, and to outline a roadmap towards improvement, in line with its overarching strategy.

The review was tasked with looking at psychological therapies in:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Mental Health Services (AMH)
- Older People's Mental Health Services (OPMH)
- Substance Misuse Services (SMS)
- Forensic and Rehabilitation Services
- Learning Disabilities Services (LD)
- across primary and secondary care, including third sector provision

with specific reference to the Matrics Cymru Gap Analysis, and the Together for Mental Health in North Wales strategy (but noting that Matrics does not cover CAMHS, and the strategy does not cover SMS or LD).

The review was not tasked with looking at:

- Liaison and health psychology
- Eating disorders
- Perinatal mental health

At the mid point of the review, and based on interim findings, an agreement was reached with the sponsor to focus the remaining review period on the services where the need appeared greatest – namely AMH. This means that the review was more detailed in AMH than in the other specialities. However, we are confident that the findings we have reported across each specialty are reliable. The review has been an ideal opportunity to showcase good practice and

Psychological Therapies Review in North Wales

recognise the hard work and dedication of so many people working in the field. It has also faced a number of constraints and challenges:

- A fundamental lack of routine accessible information, and/or data quality concerns – clinical, demand and capacity, staffing, training, finance, population needs. This has prevented completion of the Matrics Gap Analysis in full.
- Capacity for potential contributors to participate, as a result of competing priorities (time), and some scepticism as to the motivations for an independent review and its perceived impact (inclination).
- Scale and breadth of diversity of the services in scope – from primary care CAMHS to medium secure care to memory assessment; NHS and third sector; urban and rural; multi-professional; acute and community
- A risk that AMH will overshadow other services which face equally pressing problems from the perspective of their client group.

5. A Systemic Understanding

Many of the challenges that manifest themselves in BCUHB's psychological therapies (e.g. waiting times; demand and capacity pressures; lack of role clarity) are a function of the wider system within which they operate. Every person accessing services will have some degree of psychological need, but that doesn't mean that every person needs to see a Clinical Psychologist or Psychological Therapist. The extent to which this basic principle is embedded – the capacity and capability within the wider system to respond to these needs in the right place and at the right time – is fundamental to the achievements of any specialist service. This means it is essential to look at this wider system, in order to gain a deep understanding of what is happening and what might work better in future.

This is equally true in seeking to make sense of the 'softer' aspects of organisational working, such as understanding interprofessional relationships and behaviours. This systemic perspective is the one we have taken throughout this process, and we invite readers to do the same. It is our view that any attempt to ringfence the specialist psychological therapies for scrutiny in isolation of the wider system is flawed, and will dramatically reduce the prospects of finding solutions that will work.

What We Did

1. Ethos

As a team of reviewers, we set out to do three things through this process:

- Respect the local context, and nurture the passion and expertise of local people to address the challenges they face together;
- Take a strengths-based approach, looking for opportunities to celebrate and build upon positive practice in BCUHB;
- Be honest about what we found, and facilitate constructive and collaborative dialogue towards systemic improvement.

We leave others to judge whether we were successful.

2. Methodology & Constraints

WHAT WE DID
NORTH WALES PSYCHOLOGICAL THERAPIES REVIEW

SCOPE & PLAN — Review commissioned, scope finalised, plan agreed.

USER EXPERIENCE — Gathered with support from Caniad, Parabl, PTMC SU rep & BU People's Panel

TEAM WORKING — A headline review of the evidence for interdisciplinary team working

RESOURCE MAPPING — To collate team level detail about PT staffing, therapies, development

CONVERSATIONS — >50 stakeholder conversations via face-to-face & 'phone interviews & meetings

DOCUMENTATION REVIEW — Polices, audit, service performance, information development bids

WORKSHOPS — 3 area workshops to bring together people at the frontline interested in the review

We used a variety of methods, both qualitative and quantitative, to gather intelligence to inform the review and its recommendations. The blend of methods evolved between initial design and mobilisation, when it became clear that there is very limited relevant information that is routinely and systematically collated and considered about psychological therapies across BCUHB. So it was necessary to generate much more primary research than was originally envisaged. Some readers may feel this means the review evidence is overly

subjective. We attempted to address this in two ways. Wherever possible, we sought to triangulate subjective narrative account with objective information in order to reach conclusions. We also ensured we spoke with a broad range of stakeholders to get a balance of views. However, the paucity of data has restricted our scope to triangulate as thoroughly as we would have wished. It has also prevented completion of the Matrics Gap Analysis to the level of granularity indicated.   Where subjectivity is a particular challenge, we have endeavoured to highlight this within the report. The difficulties we encountered as reviewers are, of course, mirrored for those responsible for running the services.

The methods were:

- *Desktop research* – we reviewed a range of documents provided by BCUHB, covering strategy, funding, service models, operational resources, policies and procedures, service evaluations and audit, performance data, development proposals, and contractual information. We comment later on the adequacy of some of this information for its intended purposes. We also looked at national policy and strategy in relation to psychological therapies. Finally, we undertook a high level review of the literature around interdisciplinary and team-based working.
- *Field research* – we held over fifty conversations, in person or by 'phone, with individuals or small groups, all of whom have an interest in improving access to psychological therapies. We also attended meetings with third sector partners to discuss their views and ideas. We travelled to a broad range of clinical sites across the region. The number of interviewees by speciality varied according to the degree of focus agreed with the sponsor.
- *User voice* – we asked Caniad to facilitate a feedback exercise amongst local communities. We received helpful input from Bangor University's People's Panel, enabled by the Service User Representative on the Psychological Therapies Management Committee. We read case studies from third sector providers, reviewed a Learning Disabilities client satisfaction audit, and we looked at summary data about compliments and complaints to BCUHB.
- *Resource mapping* – we undertook a digital exercise to capture key information at a team level about psychological therapies staffing, range of therapies, training, and barriers to progress (in the absence of reliable data available centrally). We received thirty six responses.
- *Area-based workshops* – we facilitated three workshops across West, Central and East areas, to which around fifty five frontline (mainly psychological therapies) staff from BCUHB and the third sector came, along with service user representatives from Caniad and the BCUHB Psychological Therapies Management Committee. The workshops focussed on mapping existing processes for the delivery of care, and using

this information to generate change ideas, which we have synthesised within this report's recommendations.

In terms of governance, the review was overseen by its sponsor, the Director of Partnerships for Mental Health and Learning Disabilities, to whom a monthly progress report was provided. It reported into the Strategy and Service Redesign Group, and the Together for Mental Health Partnership Board.

We recognise that we could have continued the review process for many more months, examining individual pathways or services in greater depth, and broadening our conversations even more. Some services have received greater focus than others, according to the scale of need and urgency of attention. It is a constraint of which we are very mindful. *We encourage those who can add greater richness to this narrative to do so*, as the organisation determines the next steps it will take towards improving the psychological mindedness of its services, and access to high quality psychological therapies.

What We Found

1. Overview & Links

This chapter is structured by specialty, and is framed around the key components of the Policy Implementation Guide and Matrics Cymru. Our findings are based on the intelligence generated or collated through the methodology we used (as described in Chapter 2). What you read in this chapter is what you told us and showed us. Sometimes there are differences of view between contributors. We have endeavoured to represent those differences fairly.

At the outset, we recognise that the Matrics doesn't cover Children's Services. We also acknowledge the views expressed by many that it is heavily focused on services for adults of working age. However, in seeking a consistent means of structuring our feedback, we have taken the view that there is sufficient commonality of issues to warrant a single format.

We wish to highlight that many of our findings are consistent with those referenced in the Together for Mental Health North Wales strategy in 2017, and the more recent HIW/CIW Joint Thematic Review of Community Mental Health Teams (2019). We strongly urge the organisation to consider its response to this review in this context, and, in planning action, make the connections that are clearly evident across the whole system.

We recognise that some of the messages in this report are challenging, and want to highlight some important points to bear in mind:

- The challenges for psychological therapies services in North Wales are mirrored throughout the country and across the UK. Mental health needs and expectations of psychological treatments continue to grow, but service and financial pressures hinder innovation and strategic development. North Wales is not alone in grappling with these issues.
- The desire to standardise approaches through stepped care is not without its limitations. The scale of complexity that all mental health services are facing presents clinical and service challenges that cannot always be answered by recourse to an evidence base or standardisation. There is much untapped opportunity, but there is no magic answer.
- The Divisional leadership team made a commitment to commission this review because a psychologically-minded offer is at the heart of its strategy. The team recognises the need and importance of prioritising this area of provision for improvement. This commitment was consistently and genuinely expressed to us.

- To our knowledge, BCUHB is the only Health Board in Wales to have invited independent scrutiny of its psychological therapies services. This signals courage and commitment to open learning and improvement that should be properly acknowledged by all.

2. Overarching Factors

The Matrics highlights several overarching factors which impact on psychological therapies, in recognition of the broader organisational context within which individual specialties work. We look at those here, and have added some related points.

In line with Welsh Government expectations, there is a BCUHB-wide **Psychological Therapies Management Committee** (PTMC) in place, chaired by the Interim Head of Psychological Therapies. It has a strategic remit for services beyond the scope of this review, and scrutiny of its functioning has not been within our brief. However, it has arisen in various conversations. There seems to be broad agreement that its authority, role and relationship to the Divisions and their priorities are unclear – in other words, *who does what and when*? Board level PTMC membership and sponsorship are similarly unclear. An organisational strategy for evidence-based psychological therapies is not in place, although individual specialty strategies make reference to them. We have not seen evidence of organisation-wide strategic workforce and improvement planning in relation to need – for example, a consistent approach to managing capacity and addressing waits, or a plan that builds capacity and capability across the entire clinical workforce.

The Chair describes a strong relationship with the national PTMC, close working on national developments, and there is some cross membership of both committees.

At a Mental Health and Learning Disabilities Divisional level, the **governance** of psychological therapies does not appear to be wholly integrated. On paper, there is a Divisional infrastructure which is organised around area and specialty Quality, Safety and Experience groups (QSEEL), into which psychological therapies feed. Examples of a small number of individual project evaluations were shared with us (e.g. DBT-informed coping skills group), as was a referrals audit from one Community Mental Health Team. However, we didn't hear or see compelling evidence that the needs, risks, priorities and potential value of psychological therapies were fully considered in these arrangements, particularly at Divisional level. There is a Medical and Psychology Workforce Group, but there appear to be differences of view between members as to the purpose, focus and value of this group. Psychology representation has not been present for some time. This appears to be an area in which the separation of the management of psychological therapies from the wider services is an obstacle.

In Children's Health, we observed a more embedded Divisional approach to the leadership and delivery of psychological therapies within the core services, at strategic and operational levels, which is then reflected in its governance arrangements. However, the questions about the relationship between the Division and the PTMC are equally relevant for Children's Health as they are (adult) Mental Health and Learning Disabilities.

Equal access is another overarching factor. Systematic data on population need, access and availability of psychological therapies are not collected and triangulated, so it is difficult to be specific as to where priority should be targeted. We were able to identify some of the issues via the resource mapping exercise, as well as interviews and service user feedback. The anecdotal evidence suggests that:

- When the overriding service challenge and priority is to improve access by cutting waiting times, access *to what* and *by whom* become secondary considerations. Can I access help through the medium of Welsh? Can I access help within a reasonable travel distance? Can my specific communication needs be met? Have reasonable adjustments been made? Is the therapy most suited to my needs available locally? Can I move easily between services according to my needs? Does the offer maximise my chances of building a therapeutic alliance with my therapist? In short, is the offer patient-centred? Responding effectively to these questions adds further challenge to already-overwhelmed services.
- For some, this means that the offer is entirely inaccessible to them – e.g. for people with a learning disability or a substance misuse need trying to access core services (e.g. AMH). Those people are then reliant upon some compensatory response in the wider system – e.g. by LD or SMS services developing their own resources to respond to need. Or for people who may fall into a group considered to be 'hard to reach' for whom health inequalities are most damaging.
- For others, it may mean accessing help that is sub-optimal for their needs or out of line with national guidance – e.g. for people whose first language is not English, or for people who would benefit from DBT but can only access CBT.
- Unmet need is an inevitable consequence, and this generates more demand upon services over time. It is safe to conclude that this disproportionately affects people who are already marginalised. There is a process for capturing unmet need at team level, but interviewees were honest in saying that this is often not prioritised as meaningful responses do not transpire. It might also be interpreted as indicative of the sense of learned helplessness that prevails.

3. Children's Services

'Patients before profession'

1. In Brief

Based on the intelligence we gathered for Children's Services, we saw consistent evidence of a whole system approach to the planning, development, delivery and evaluation of psychological therapies. Multidisciplinary integrated working is well-established. This has a positive impact on the Division's capacity to work in psychologically-minded ways across its mental health workforce. Leadership of the partnership, strategic and operational agendas is clear and well-established, and there has been consistent success in securing investment for developments in line with an overall plan for psychological therapies. Processes for evaluating quality and outcomes are in place. When asked what had made this progress possible, one clinical leader said it was a case of 'patients before profession'.

There are challenges relating to growing access times, and recruitment and retention, which are being addressed innovatively. However, the anticipated increases in future demand for CAMHS across the UK, and the significance of early access to lifelong health and wellbeing, require a long view in terms of strategic workforce requirements for psychological therapies. There is opportunity to further strengthen the use of psychological skills within the workforce, as well as improve the interface with AMH.

Note that the tiers within CAMHS are labelled differently to the Matrics for adults. The Matrics for CAMHS is expected later this year.

2. Psychological Therapies Model

Child and Adolescent Mental Health Services (CAMHS) are managed within the Children's Health Division, and deliver Tiers 3 and 4 of services. There is an area-based structure, aligned to Local Authority boundaries, and underpinned by a Regional Advisory Group for Psychological Therapies. This helps to ensure a consistent approach to service delivery and development, still flexible to local needs.

The Psychological Therapies workforce is fully integrated into the multidisciplinary team, its management and budget, and works to a single operational policy. Clinical lead roles are often undertaken by Clinical Psychologists, including at Tier 4 (acute).

Non-specialist universal support at Tiers 1 and 2 is provided across the third sector, as well as BCUHB's primary care mental health service for children and young people. The latter has recently been reviewed by the Delivery Unit.

The integration of services across primary and secondary care enables management of demand and capacity across the whole system, using the well-established Choice and Partnership Approach (CAPA). Waiting times have grown for both assessment and intervention since 2017/18, with target compliance for the latter being significantly lower than the former. Waits for neurodevelopmental assessment are much longer (over a year in East). Clinicians flagged a concern that patients are allocated to clinicians at the Choice appointment according to who is available, which may or may not coincide with who is most appropriate to address their needs.

There is a set of Regional Priorities for 2018-21 in place, although an overarching Children's Plan is still developing. CAMHS is included within the *Together for Mental Health North Wales* strategy. There is a desire to see a stronger strategic influence and impact from the Psychological Therapies Management Committee.

3. Psychological Therapies

Evidence from the resource mapping exercise indicated a good range of therapy options, reasonably balanced across teams but still with some local variation. There is good evidence of the use of psychological interventions by all clinicians, which enables specialists to focus on the more complex work, as well as providing support to the wider team. However, there are some gaps around EMDR, IPT, family therapy and low intensity interventions (sometimes related to lack of access to supervision). According to resource mapping data, typical treatment length for most patients is seven to twelve sessions in the community.

There is a commitment to improve access for marginalised groups, such as children with a learning disability.

4. Psychological Therapists

The even balance of the psychological therapies skill mix across bands is a noticeable feature of the workforce in comparison with other specialties, from consultant grade to newly qualified, as well as the numbers (33.9wte in post), suggesting that there is a critical mass in the establishment to sustain services. Vacancies as at 31 May 2019 ran around 14% (5.3wte), with recruitment and retention challenges described as being longstanding. New roles at Band 8A are being introduced, allowing postholders opportunities to consolidate their learning and development at that level in their first year in post.

Job planning is undertaken in collaboration with team leads, which helps to ensure that capacity is fully integrated into the wider multidisciplinary team (MDT) – this is a relatively new development.

5. Training

There is a wide range of training opportunities in evidence-based therapies, aligned to strategic workforce needs across the Division, including IPT, DBT (rolling programme) and family therapy. A trainer post has been established with Bangor University to train CAMHS staff initially in CBT. This capacity is growing, in collaboration with AMH. CAMHS would welcome more shared training opportunities with the Mental Health and Learning Disabilities Division.

Mentalisation-based therapy requires development, and there is an enthusiasm for it in Tier 4 services.

Some clinicians are trained in the use of dyadic developmental psychology for attachment disorder, but do not practise due to a lack of clarity about its use in North Wales. This would entail cross-agency working, and include children and young people in the care system.

6. Supervision

Supervision is appropriately maintained for therapies in use, but some IPT expertise is not put to use as supervision is not available. The position is different in different areas. This is being addressed through training. Investment has been sought to ensure better availability of senior psychologist time to facilitate supervision of specialist clinicians, as well as ensure access for the wider MDT to psychological expertise and case formulation.

7. Audit and Data Collection

Relevant outcome measures are in use across the board (e.g. C-GAS, GBOS, ESQ), and other measures (e.g. MFQ) are used in some teams. These are recorded at an individual level only.

Performance data using metrics such as waiting times and Mental Health Measure compliance is analysed and reported routinely by area.

The team is currently working on establishing clear and measurable quality standards for psychological therapies, to be supported by a workable data management process.

Overall, there is a sense of strategic and well co-ordinated delivery and development of fully integrated psychological therapies in CAMHS. Challenges are well understood and proactively addressed, using collaborative approaches. Tactical use of opportunities for investment are being made, aligned to a clear set of priorities. Nevertheless, there are growing difficulties around timely access linked to increases in demand and pressures caused by vacancies. The publication of the Children's Matrics later in the year will be key to informing future developments.

Key Questions Specific to CAMHS

- Are the plans in place sufficient to address the growing demand upon services and ensure access is maintained and improved?
- How will CAMHS and AMH work together strategically? What is needed for that to happen?
- What opportunities can be created to improve shared learning between specialties, including showcasing what integrated working can look like in multidisciplinary settings?
- What, if any, aspects of Children's Health psychological therapies services have not been considered to the extent that the leadership team would wish, and how might that be addressed?

4. Adult Mental Health Services

'We need to make the most of what we have.'

1. In Brief

Providing a single narrative to describe Adult Mental Health services is challenging, as the variation between areas and teams, in terms of population, history, identity, experiences, service configuration and availability, culture, ways of working, and more, is significant. So this chapter attempts to draw out common factors that emerged through the review, but every factor may not resonate with every team.

More detailed findings about the nature and extent of interdisciplinary working are covered in Chapter Four.

We found many examples of targeted work to address waiting times and access to psychological therapies by psychological therapies staff across the tiers of stepped care. For example, through the development of new posts, redesigned processes, service innovation, as well as efforts to change team practice and thinking. However, this appears to be happening without the benefit of a North Wales system-wide approach or engagement in psychologically-minded care. Both horizontally and vertically, there are untapped opportunities to work smarter across boundaries. The system as it is currently designed and resourced, and the culture that underpins it, are not equipped to deliver the ambition for psychologically-minded care as envisaged in local and national strategies.

It is important to bear in mind that not all therapy works. It is not for everyone. We noticed a sense and expectation across the service as a whole of 'needing to offer something', rather than providing an outcome-oriented approach for people who are most likely to benefit. Helping both clinical colleagues and service users to understand both the potential and limitations of therapy in different circumstances is key.

2. Primary Care – Tiers 0 and 1

Much of the Division's strategic work in the last two years has focussed on increasing access to opportunities outside specialist mental health services, working closely with partners (e.g. education; community groups). While these are not specifically related to psychological therapies, they are about building awareness, community resilience and psychological skills to cope during difficult life circumstances. These developments have the potential to improve universal access at Tier 0.

The first opportunity to offer a psychologically-informed service response is at the first point of contact, usually in primary care. Yet experience is often very different. The Joint Thematic Review of CMHTs (2019) identified the importance

of making marked improvements in assessment at primary care level, so that there is a consistent and capacity-oriented approach to step up into specialist multidisciplinary services in secondary care. This requires access to specialist psychological therapies expertise within the primary care MDT, so that decisions about care planning are properly informed. This is not the norm in the services we reviewed. Without this, long waits accumulate for access to a specialist opinion, which may ultimately determine that psychological intervention is not indicated.

Services for psychological therapies at Tier 1 level are comprised of two core elements across the region.

i.   Parabl

Parabl is a partnership **model** of third sector providers, co-ordinated by CAIS and delivered, with CAIS, by local branches of MIND as well as two other small charities. The pathway provides low level psychological interventions. It is based around initial telephone assessment, undertaken on the day of referral by the CAIS team, using PHQ9 and CORE10 instruments to assess suitability. Most people self refer. If suitable, the intervention options are cCBT, group work or one-to-one counselling, all of which are short term (usually less than six sessions). The pathway does not include direct access to Tier 2 services, so referrals, including crisis, go back via the GP. This negates the notion of step up and step down access. Drop out rates between each step of the pathway (referral to assessment to treatment to planned outcome) run at around 50%.

Call assessors are counselling-trained **therapists** (1.33wte). There are 2.4wte accredited counsellors and 0.8wte qualified counsellor. They are supported by 2.5wte administrators and 1wte Service Manager, who provides clinical and management **supervision**. There is a small amount of volunteer and student input. There is no interaction with Tier 2 colleagues, for example for consultation, supervision or capacity management across the tiers. This staffing includes coverage for the Substance Misuse counselling provision.

Therapies offered include CBT, cCBT, psychodynamic psychotherapy, MBCT, self help, bereavement counselling and supportive counselling.

Service **data** for Parabl is the most extensive available across the reviewed services. It is collected and submitted as part of the contract monitoring process on a quarterly basis. Data includes demographic information by area, number and type of assessments and interventions, waits, DNAs, outcomes (including the IAPT Recovery Rate metric), and service user feedback. In Quarter 3 of 2018/19, over 90% of people rated their experience as 'beneficial' or 'very beneficial'.

Waiting times for assessment reach the target on average 99% of the time, and at that stage people receive relevant self help material and signposting to other

community resources. However, the wait for treatment (i.e. to start counselling or access a Parabl group) is just 26% (Q3 2018/19 data). This is as a result of capacity/funding shortfalls for groups, which vary between areas. Parabl activity is not reported under Part 1 of the Measure.

The funding of the contract by BCUHB (c.£300k per annum) has remained unchanged since inception six years ago, despite significant 'overheating' of contractual activity levels. CAIS reported that it subsidises a financial loss on the contract every year.

The Parabl model is described by its partners as working well for a number of reasons:

- While CAIS holds the contract with BCUHB, there is no single dominant partner in the working relationship
- Each partner knows their community very well
- There is a central point of access, and the pathway within Parabl works smoothly
- Each partner brings added value through the other services they provide and can signpost into (e.g. peer support)
- The service is community-based and accessible (not seen as part of the NHS)
- There is a menu of options for support
- The service is self-directed, not prescribed
- It delivers good outcomes for people, often beyond the service itself (e.g. by opening up other community-based opportunities that the provider offers)
- The partnership is clearly governed, and partners meet regularly

The richness of community connection was particularly striking within Parabl. Knowledge about what exists in the wider community to support people in their health and wellbeing, and how it can be accessed, were notably stronger in our discussions with third sector partners than it was with the NHS. Building wellbeing capacity across the system requires knowledge of what is out there, something that the NHS is not traditionally skilled at or has valued. There is considerable potential for specialist services to learn from and collaborate closely with the third sector to build this capacity.

Limitations of the Parabl service are evident in the design of the wider system, in that the enablers of stepped care are not evident. We heard accounts that there is a gap between the upper end of what GPs are able to 'hold' in general practice and the lower end of what Parabl will accept, which has precipitated the establishment of the Active Monitoring service in some areas (see later). We heard an equivalent gap between thresholds from Parabl into secondary care

services. The impact of the service on wider demand in the system has not been analysed.

ii.   Local Primary Mental Health Teams (LPMHTs)

The LPMHTs are accessed via the Single Point of Access (SPOA) for BCUHB's specialist mental health services, with which they are co-located. They are oriented around meeting Part 1 of the Mental Health Measure, which requires assessment within 28 days of a routine referral, and 48 hours for urgent referrals. We were told consistently that primary care practitioners' capacity is absorbed by this assessment requirement (which includes administrative tasks as well as direct patient contact), and time isn't protected to deliver low intensity interventions as intended. In many conversations, we heard the LPMHT function described as 'assess and signpost', because it has insufficient time to offer meaningful intervention. The Mental Health Measure monthly statistics for quarter one of 2019/20 show that:

- There are around 1200 referrals received each month
- Around 65% are assessed within 28 days
- Around 950 people (c80%) are discharged from services every month. This stands out for further exploration and potential for better pathway management 'upstream'.
- Around 80 people are referred into secondary care
- Of those who do receive a therapeutic intervention (c150 per month), around 70% will start that intervention within 28 days
- The number of people waiting for intervention that has not yet started are not included within the Welsh Government data set. This is an important but unknown piece of the jigsaw

Caseloads were described by some clinicians as unmanageable, with numbers of over 100 cases per clinician mentioned by one respondent to the resource mapping. Reasons given for high caseloads include:

- Gaps in thresholds between services (Parabl to LPMHT to CMHT)
- An expectation that all referrals are accepted for assessment by LPMHT
- An inability to make timely referrals into CMHTs due to bottlenecks
- An inability to refer directly to specialist psychological therapies services (referrals have to come via the CMHT)

These could be summarised as 'failure demand' generated as a result of system design and capacity as well as silo working, rather than clinical need *per se,* the consequence of which is that people are unable to access the right care at the right time.

From the two resource mapping responses, we were told that the LPMHTs are staffed by Band 6 RMNs who are trained to provide assessment of needs, but

who may not be trained in low level psychological interventions. Some have a Support, Time and Recovery worker. Clinical supervision arrangements were unclear.

iii.   Other Primary Care Psychological Therapies Services

In addition to the North Wales-wide provision, some areas have services at Tier 0 or 1 either as a legacy or as a new initiative in response to a pathway deficit.

The **Primary Care Counsellors** team in the West area has been established since 2002, and has previously covered every GP practice, receiving direct GP referrals for brief interventions. Now, it operates on a much smaller scale with a handful of long-serving staff who are attached to the LPMHTs, with referrals coming through SPOA. Their role and fit within the set of services that has subsequently been created do not appear to have been considered strategically.

MIND Active Monitoring is a 12-month pilot service, based on national MIND's model, which started in Denbighshire and is now operating across several areas. It is commissioned and funded through GP Cluster funds. Through an eight week course of one-to-one sessions based in GP practices, it provides self-directed psychoeducational support using CBT approaches. The intention here is to plug a gap in support for people who do not meet the criteria and/or have to wait a long time for other services, and who present regularly to their GP seeking help. It is reported to be popular amongst GPs. As a new service, the data available is not yet fully analysed.

Healthy Prestatyn is a great example of a biopsychosocial model in action. While not exclusively aimed at people with mental health problems, it works alongside GPs to help people with chronic conditions to self manage, using a strengths-based approach with individuals and communities. A team of four Occupational Therapists, with backgrounds in mental health and palliative care, work largely with psychosocial issues, and are able to respond in crisis situations for people with greater levels of need than can be addressed in other parts of the primary care system. They help people to build the skills to use community resources, such as managing anxiety and building self confidence. They encourage people to make their own management plans, looking at the person's whole context (work, home, social) to do so.

They provide one-to-one work up to six sessions, and facilitate a five session course based around the Five Ways To Wellbeing. Other courses include a CBT group for chronic back pain, and a bereavement group. They are building links with the ICAN centres.

Audit data shows a positive impact upon GP attendance levels (75% reduction), while anecdotal data for impact upon secondary care is also positive.

As one of the OTs reflected, 'it is vital to support self management skills from day one. Otherwise you build expectations of miracle solutions, and thus deskill and disempower people, which leads to increased use of services.' The early intervention approach, which builds on strengths, is key to its success.

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3. Secondary Care – Tiers 2 and 3

3.1 Psychological Therapies Model

Community Mental Health Teams provide all non-acute community-based functions in AMH, including psychological therapies. While the organising principles for these services are not explicitly spelt out, the core offer seems to be organised around compliance with the Mental Health Measure. The unintended consequence is that quality in evidence-based care planning and delivery is at risk of being overshadowed, in pursuit of initial access and maintenance. This is consistent with the findings of the all Wales Joint Thematic Review of CMHTs (2019). Strategy and service redesign work is currently oriented around attachment theory, strongly advocated by the Medical Director, but this is in its early days and not yet evident in day-to-day working.

Psychological therapies staff are variously aligned – some clinicians describing themselves as fully integrated with the MDT, others describing an MDT resistance for that to happen, and other professionals suggesting that there is a deliberate intent for Psychological Therapists to work in detached ways. Line management arrangements are separate. Referral arrangements vary, but most, if not all, appear to require CMHT referral 'into' psychological therapies. While the intention behind this is about responsible use of a very scarce resource, it sets up the conditions for waiting lists (and therefore risks) to build, as there is no shared ownership or responsibility for the total capacity of the system. There is no direct access from primary care to secondary care psychological therapies, so referrals must come via SPOA, meet the (non-standardised) criteria for secondary care, and then be allocated for care co-ordination, regardless of the need for multidisciplinary input. This is often handled by holding service users on the caseload of a Consultant Psychiatrist, pending psychological assessment and possible intervention. Roles and responsibilities between multidisciplinary team members are left for individual teams to work out, and thus inevitably vary.

In **acute care**, the model for psychological therapies operates across all wards (i.e. cross specialty) at each inpatient unit. Specialist staffing capacity is designed on the assumption that psychological working is practised across the ward team – i.e. a stepped care approach. In reality, competing demands and lack of protected time mean that nursing staff have limited opportunity to engage in the delivery of psychological interventions, or to develop their skills through training and supervision. Twelve hour shift patterns were mentioned as an exacerbating factor. However, Clinical Psychologists do work closely with nursing staff to support their understanding of a biopsychosocial approach. They make use of existing mechanisms such as ward rounds, clinical meetings and informal discussion to offer this guidance and support. Team formulation meetings tend to occur on an ad hoc basis. Clinical Psychologists also provide an important role in

supporting inpatient staff to explore the psychological impact of the work they do upon themselves, although this tends to be ad hoc rather than formalised, again due to time constraints. They support community staff around the point of discharge (e.g. positive ways to manage attachment issues and continuity) but they do not follow service users into home treatment. This impacts on the sustainability of work that could otherwise be started during admission.

More fundamentally, there may be a case to rethink acute models of care so that they are designed around evidence-based responses to crisis, rather than admission *per se*. Current acute provision for people with a diagnosis of personality disorder is not consistent with the guidelines for psychologically-informed and structured support.

3.2   Psychological Therapies

In **Community Mental Health Teams**, the therapies available are predominately CBT-based. DBT skills have developed widely, but the resource mapping feedback showed that the majority of teams have been unable to make full use of DBT skills amongst team members due to a lack of critical mass to run programmes, and/or a lack of supervision access. It is not clear why neighbouring teams have not come together to create that critical mass (despite some attempts to make this happen), but this is clearly an untapped opportunity for a more co-ordinated pathway for personality disorder.

Another barrier to using psychological skills is that teams report spending their time firefighting demand, managing caseloads and Measure compliance, and so don't have an opportunity to use or develop therapeutic skills. This is unlikely to change within the current service design.

Specific therapies include CBT, EMDR, web-based psychoeducation, DBT, psychodynamic psychotherapy, narrative therapy, TF-CBT, progressive relaxation, relapse prevention, group CBT, ERP, and applied relaxation (although clearly not every therapy in every team, and the variation appears random).

Typical treatment lengths seem to vary, with no standardisation or guide as to what is expected, but most reported over fifteen sessions as typical. Interventions are delivered on group and individual bases. We did not find a standard approach to managing referrals, capacity or waits across CMHTs.

For people experiencing psychosis, psychological therapies provision is patchy. For first episode psychosis, there is a proactive but small early intervention team, with different access arrangements across the three areas. It engages fully with the National Clinical Audit for Psychosis (NCAP) and has also been peer reviewed via the Royal College of Psychiatrists in 2018/19, both of which contain detailed information about current provision, strengths and challenges. The team has been successful in securing new investment, but we were told that this will not be

sufficient to address the needs of the 'at risk mental state' population. As this group does not meet eligibility thresholds for other service such as CAMHS and CMHTs, nor readily self-presents in a timely way, this leaves significant unmet need in the community. The gap in provision means the system is generating its own future demand, as the opportunity for early intervention passes and more entrenched health and care needs materialise over time as needs go untreated.

For those with enduring psychotic illness such as schizophrenia, NICE-recommended therapies are CBTp and family intervention. Benchmarking from the NCAP shows that in BCUHB 29% are offered CBTp and 13% are offered family intervention (sample size n=95). This is around the UK average. In the resource mapping responses, eight AMH community mental health teams responded. One team reported offering CBTp, and another reported family intervention. The remaining six offered neither, meaning that NICE-recommended therapies are unavailable to the majority of communities across North Wales. The EIP team is able to provide training in both of these areas, but dedicated psychosocial interventions posts are not a core part of the workforce. We were shown a BCUHB action plan in response to the NCAP audit which included actions in relation to expanding capacity for psychological therapies, but we understand there has not been material progress and so the situation remains unchanged.

Access to psychological therapies was, without any question, the single biggest issue raised by everyone we spoke to, including, of course, people who use services. Waiting times for assessment range from one month (in Rhyl) to over a year (in Wrexham). Welsh Government is in the process of embedding a 26 week target for high intensity psychological therapies treatment. National data indicates that every Health Board is breaching this new target, and there are many complications in capturing data across Wales for valid comparison. BCUHB's AMH position varies very widely between the six counties, so a regional average is not meaningful. A snapshot of 26 week breaches at 31 May 2019:

Ynys Mon	17
Gwynedd	20
Conwy	51
Denbighshire	14
Flintshire	45
Wrexham	249 (the highest in Wales by a significant margin)

These figures represent a marked improvement in Central, and a steady picture in West. The East area has a particular legacy problem with very long waits, which are generally attributed to a previous model of service more than population need. One clinician described having just cleared the waiting list from 2014, and had found that a large number of people were not suitable for

treatment. While the East position is a major outlier, we were reassured that current practice has reduced the volume of referrals to specialist psychological therapies, thanks to significant work undertaken with team colleagues to change practice as well as some increase in staffing.

Tackling Waiting Times in Hafod CMHT

Two years ago, a new Clinical Psychologist took up post in Rhyl, and inherited a long waiting list, in which psychological input was being used as an 'end of the road' option when other interventions had failed. Working alongside the CBT Therapist in the team, she has reduced the waiting time for assessment and treatment to just one month.

She highlighted the following as key to the achievement:
- Provide information to the MDT about what clinical psychology is and what it can do. It's not a magic answer and won't be suitable for all
- Engage the referrer in making a purposeful referral – discuss it with the service user, find out what they are seeking from it, establish some motivational tasks with the service user to test out willingness to engage
- Support the referrer in making a purposeful referral – be available for consultation, be 'on hand' to the team
- Offer a two hour assessment appointment to establish if psychological intervention can help and if the person is motivated
- Offer a specific number of sessions, which often includes DBT
- Work very closely with the MDT – share notes, be transparent, manage capacity together, be a resource to the team, scrutinise the value of what we are doing relentlessly
- Don't expect every referral to proceed to treatment – only around 50% move onto treatment after assessment

There is a caveat though – the scale of the impact is largely down to the discretionary effort of the psychologist herself, who regularly works above and beyond to get the job done. So while the model of working is replicable, the volume is not, and this should be taken into account in future modelling.

In **acute care**, the range of therapeutic interventions declared through resource mapping was the most extensive of any service – around twenty different options are offered. The Clinical Psychologists emphasised the importance of person-centred transdiagnostic working, based around assessment, formulation and intervention which typically draw on motivational interviewing, DBT, CBT, compassion focussed, and acceptance and commitment approaches. The focus is on understanding the contributing factors that brought people to a point of crisis, identifying skills for prevention of further crises, and stabilisation.

Acute Clinical Psychologists have also been proactive in developing group interventions, including a four week programme comprising three

psychoeducational groups per week (currently being evaluated). Sustaining group work can be challenging as it generally relies on an individual practitioner. There is an aim to build up MDT capability to co-facilitate groups, but this is challenging due to lack of protected time for training, supervision, and delivery.

There is no doubt that a huge amount of work is being pursued to tackle access problems, with good effect, amongst the psychological therapies staff on the ground. Many individuals go above and beyond to make a difference. However, we noticed that the sphere of influence for change is too constrained to impact significantly upon the system of which it is a part. In some instances, it may exert greater pressure on the system (e.g. by closing down direct access from primary care to specialist psychological therapies). That system directly impacts upon the work that flows in and out of the specialist function. While there are good examples of wider team impact at individual team level, this is not the norm and it is not part of a bigger plan to make it happen. This means that the full potential of the system as a whole to orientate towards psychologically-informed care is not being realised. This cannot be achieved by specialists alone – it requires an organisational response and commitment.

3.3   Psychological Therapists

At **CMHT** level, most Clinical Psychologists work as single practitioners, sometimes alongside Psychological Therapists. This leaves the service vulnerable to absence (sickness; vacancy; parental leave) as cross-cover is problematic. Staffing by area is reported as follows:

West   3.3wte Clinical Psychologists

              1.0wte CBT Therapist

Central   2.4wte Clinical Psychologist plus 0.8wte vacancy

              2.0wte CBT Therapists plus 1.0wte vacancy

East   5.8wte Clinical Psychologists

              2.0wte CBT Therapists

Numbers in the East have been able to increase to this level as a result of accessing Welsh Government funding opportunities. The skill mix is consistent across the region, in that almost all clinical psychology posts are at Band 8A, with a small number at Band 8C. This has obvious implications for career pathways at both entry and progression stages. There are indications that this is starting to change at entry level, with Band 7 posts being included in funding bids. Psychological Therapist posts are more often at Band 7. Recruitment and retention data were not made available so we cannot comment on specific impacts.

Benchmarking data in Wales is not currently collected so we are unable to set out how BCUHB's staffing compares with its peers. However, the Joint Thematic CMHT Review (2019) was clear in its conclusion that improved access to psychological therapies across Wales requires 'not only increased recruitment in these disciplines, but looking at more innovative ways of meeting this need. Health Boards and Local Authorities must consider identified unmet needs to inform future commissioning and operational plans.' While it is clear that BCUHB's specialist resource is inadequate to meet the needs of the population, it is important to say that the solution to this is not only to increase specialist staffing numbers. The whole system needs to increase its psychological mindedness, capacity and capability in order to address the scale of need. That requires multi-faceted change across all services and the entire mental health workforce as well as primary care, not least in terms of role design, culture, behaviours and interdisciplinary collaboration.

The rurality of the region is a significant draw on scarce capacity, and sparse populations also pose difficulties in terms of critical mass to offer specialist services. It is not realistic to expect every team to provide every therapy, but this does not appear to have been addressed (e.g. by cross team working). Therefore access to therapies depends on the particular skill set of the local team practitioner/s – hence the postcode lottery.

The professional and line management functions for psychological therapies are combined, so while clinicians are based alongside their MDT colleagues, the team managers do not have oversight of their capacity. This parallel management arrangement continues at area and Divisional levels. There is no representation within the triumvirate structure. There are mixed views as to the value of this infrastructure. There are clear signs of fragmentation in working relationships in places, which may in part be attributable to structure, but structure alone is unlikely to be the answer. Creating the conditions for excellent team-based working is more likely to reap the results that are needed (see Chapter 4).

In **acute care**, there are 1.8wte Band 8A posts in West and Central, with a further post recruited to for East, a Band 7 in West, and an Assistant Psychologist in Central. There are 2wte Band 7 vacancies subject to recruitment (as at 31 May 2019). Offering trainee placements allows the team to run groups and increase capacity for individual assessment and intervention, with appropriate supervision. Clinical Psychologists work alongside ward team colleagues but described a culture of 'referring into' psychology, rather than integrated psychological working across the MDT. A handful of nursing staff are DBT-trained but are unable to offer consistent input due to time constraints.

3.4   Training

We understand there is longstanding effective joint working with Bangor University, through the DClinPsych programme, other teaching and research. This is an important and valued relationship. For example, the Older Persons' ward on Anglesey has hosted Applied Behavioural Analysis graduates who have contributed to behavioural assessments and interventions, and enhanced person-centred care as a result.

There is training activity in the Division, with around half the teams reporting imminent training in DBT and to a lesser extent, EMDR. It was encouraging to hear that one of the inpatient Clinical Psychologists, in collaboration with the area Head of Nursing, is co-ordinating a staff survey to establish training gaps and needs at grassroots level. However, while these training priorities are in line with the commitment to trauma-informed care, we were not able to locate a single multi-professional training strategy for psychological therapies across the Division or into primary care. It is not clear how the training needs of the workforce, in relation to the demands placed upon the service and the overarching strategy for attachment-based care, are being planned for and addressed. We understand there was a historical training group across the Division, and that this function has recently been absorbed within the area QSEEL structure. There were consistent comments about lack of training opportunities and funding, including one clinician who is self-funding and taking annual leave in order to study. A *systematic* workforce development approach to enable the delivery of psychologically-informed care by all clinicians was not evident.

3.5   Supervision

There are undated Clinical Psychology Clinical Supervision Guidelines. There is brief caseload review guidance. A supervision audit was not available. It is unclear whether caseload review is a regular part of management supervision, or what happens as a result. We have learnt recently that the supervision guidelines are currently being reviewed and an audit is being planned.

We were reassured that clinical supervision is a core part of clinical practice, and it is job planned for Clinical Psychologists and Psychological Therapists managed under the same structure. Supervision of low intensity psychological interventions delivered by the wider MDT is offered through team Clinical Psychologists, but take-up is mixed, and it is not clear in policy.

Lack of access to supervision in some specific therapies was cited as an obstacle to practice. In acute care, the relatively short time since inpatient posts were introduced was cited as a reason for access to experienced supervision to be limited.

3.6   Audit and Data Collection

It was not possible for us to be provided with any psychological therapies data drawn from BCUHB's patient administration systems, either because it did not exist, or because of significant concerns about data quality. There is no single electronic system across the tiers to enable information sharing or systematic data intelligence, for activity or clinical record keeping. The three BCUHB areas use different systems, none of which are reported to be user-friendly or clinically meaningful. Clinicians reported that they have insufficient admin support to cover demands, and recording Measure information (e.g. care and treatment plans) is prioritised over activity data entry. Activity in secondary care is largely unaccounted for and/or specialist work is 'lost' within overall team activity. There doesn't appear to be a standard protocol as to what should be recorded and where. We were told that the only record of some practitioners' activity is their individual paper diary entries.

An Excel spreadsheet is used to manually capture the waiting time data set required by Welsh Government. A spreadsheet is also used in the East to capture individual clinician activity, but it was not possible to draw any clear conclusions from the data. We understand BCUHB is waiting for an all-Wales digital solution called WCISS.

There is no reliable reported data for needs, unmet needs, caseload, case mix, recovery rates, or outcomes. Outcome measures are used but not recorded anywhere other than the service user's paper record. Examples include BAI/BDI II, BSL 23, PHQ – 9, GAD – 7. Again, there is significant variation in use. Systemic outcome measures in acute settings, which reflect the systemic nature of an inpatient experience, are being explored.

The Interim Head of Psychological Therapies told us that a typical caseload for a clinical psychologist or psychological therapist working full time in an AMH CMHT is around 25 active complex one-to-one cases, with a range of 15-35+. This number will depend on the case mix and complexity of the caseload, and other job-planned commitments such as training and supervision, team consultation and formulation, team meetings and so on. This number does not include those people who are seen for group interventions delivered by Clinical Psychologists or Psychological Therapists, in addition to their one-to-one caseload.

The consequences of this data deficit are wide-ranging. They present significant operational, quality, safety and financial risks, leaving managers and clinical leaders to make under-informed decisions about how best to allocate very scarce resources and mitigate risks. We are not entirely confident that there is sufficient insight into these risks and consequences, or the part they play in the narrative that surrounds psychological therapies. While we were told that conversations have been happening for some time internally as well as

nationally, including an all Wales Informatics Workshop in June 2019, we observed little conclusive remedial work within any part of the organisation as yet.

4. Common Challenges in AMH Psychological Therapies

Across all tiers, there are consistent challenges about the design and delivery of the model:

- Services across the stepped care model exist, but they are fragmented and do not come together as a coherent whole. There is no standard operating procedure or integrated care pathway. This vastly undermines the scope of stepped care to deliver its potential gains, including 'right care, right place, right time'. It means capacity is not managed across the whole system, and so bottlenecks between services become inevitable.
- Minimum service delivery expectations, in line with stepped care, are not defined. Individual services make rules unanimously, in an attempt to maximise the impact of the resource they control, as a coping mechanism in an under-resourced system which is incentivised to deliver quantitative results. The consequences for service users include the postcode lottery, and that they are subjected to a 'game of snakes and ladders', as one provider put it.
- Relationships between tiers are similarly fragmented, particularly where different providers are involved. Staff do not work across tiers – e.g. to provide supervision and support. There appears to be very limited contact between psychological therapies at tier 1 and tier 2.
- Relationships between MDT members are sometimes negatively affected by structures and processes that deter joint working.
- Services have been developed in piecemeal ways, often in response to specific failure demand somewhere in the wider system. Strategic commissioning is not evident. There is no clear fit or flow across a single integrated pathway. Additional services have been bolted on to Tier 1 rather than integrated. The map of provision looks different in different places.
- While the third sector is fully engaged in direct service provision, its assets and potential seem largely unrecognised and untapped in the wider system. Reaching out from specialist services to build community capacity and capability for psychological resilience is an opportunity waiting to be grasped. This is in line with Welsh Government expectations set out in *A Healthier Wales* (2018).
- This lack of coherence is evident at every interface, each one becoming a bottleneck for people to wait. There are significant gaps between thresholds for services, and lack of clear criteria as to what needs should be met where and by whom. There is significant duplication of work at

different tiers, through lack of joint working (e.g. separate assessment processes; separate clinical notes). Tier 1 reports holding onto people for longer than it is designed to do 'because there is nothing else'.

- A lack of psychological mindedness across the workforce is generating additional need in the population, and additional demand upon specialist staff. Low level interventions, delivered by a wide range of mental health professionals, are not embedded within the core mental health offer. This is attributed variously to lack of focus, time, skills, and awareness of what is possible. In short, the system is not geared for therapeutic intervention.
- Standardised data to understand what is happening in services is not routinely available, and data to understand the whole picture is not integrated or collated. This leaves objective and well-informed decision-making wanting. Data used for contract monitoring appears to be provider-driven, and misses opportunities to 'join the dots' with the bigger picture.
- Considerations about equality of access for specific groups are overshadowed by the many other access challenges.

Key Questions Specific to AMH
- What is our core offer? Are our AMH resources aligned in such a way to deliver that core offer?
- How can we realise the full potential of the stepped care model across all services and tiers?
- What measures do we need to take to 'right size' our demand and capacity, including tackling the legacy waits?
- What can we do to improve our culture and capabilities around intelligence-driven decision making, while we wait for WCCIS?
- How will we devise a strategic approach to building capacity and capability in our multidisciplinary workforce across the region, making full use of opportunities to work better across all services and specialties, in order to offer psychologically-informed care to all?

5. Older People's Mental Health Services

'There is more we can do to influence the broader system by working together.'

1. In Brief

In Older People's Mental Health services, there is a specialist model for psychological therapies, with limited low intensity interventions delivered by other clinicians. This is attributed to a lack of infrastructure (training, supervision etc.) as well as capacity. Clinical Psychologists are highly valued by their MDT colleagues. There is a workforce of less than 7wte for an over 65s population of nearly 158,000 (c.23% of the total population), which is widely dispersed geographically. Services lack the critical mass required to sustain core functions, resulting in specialists being spread very thinly across areas and responding as best they can to need as it arises. For example, the Memory Service in the East area reported being without a psychologist for two years. Waiting times vary widely between areas, from two to fifteen months. There is a desire to move towards a more strategic approach to planning and delivery of care. Despite significant service pressures, Clinical Psychologists contribute extensively to professional and service developments locally and nationally, and to training, in close collaboration with Bangor University.

2. Psychological Therapies Model

Primary Care

Primary care services were consistently described to us as extremely limited and significantly under-resourced for the level of need. There was just one response to the resource mapping exercise from an OPMH Primary Care Team (Wrexham), which consists of one RMN.

Secondary Care

The OPMH community service model in secondary care varies across area, with an organic (dementia) service in the West, an over 65s mixed functional and organic service in the East, and a blend of the two in Central. This is a legacy that pre-dates the creation of BCUHB. We understand this is subject to review currently via the relevant Quality and Workforce Group. Practice between areas is also reported to be variable, and a desire to see a clearer strategic approach across the region was expressed. Views were expressed that over 65s with functional needs were not well met as they often don't meet the thresholds for input, alongside younger adults. There is no dedicated input for young onset dementia, so provision is ad hoc and reactive.

All Clinical Psychologists within the services work within the CMHTs and/or Memory Clinics. Some work across areas to provide cover. Capacity is described as extremely stretched, and varies between areas. Inpatient psychology roles are

shared with AMH. Services are provided from a wide range of inpatient and community settings, as well as the person's home or care home.

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Integrated Team Working in Wrexham and Flintshire

Motivated by the desire to spread the impact of a psychological approach beyond individual therapy, the Clinical Psychologist for the East area came into post understanding the importance of working with the wider team, to develop mutual expectations of the value she could add. She has pursued this goal of collaborative working in several ways:

- attending team meetings for MDT discussions, enabling psychological perspectives to inform care planning even where no direct referral has been made
- working alongside CPNs, OTs, and Consultant Psychiatrists in case discussions and joint appointments
- being co-located with other team members, which enables easy liaison and relationship-building
- organising teaching sessions, offering supervision and facilitating a monthly complex case discussion group. The latter provides space for clinical discussion and team formulation, as well as important reflection about the emotional impact of work upon clinicians

All of these things contribute to building the psychological mindedness and capabilities of the team as a whole, something which is especially important when the Clinical Psychology input is spread thinly between two teams.

Key to this success has been the freedom to develop the role in this way, as well as fantastic support from team managers.

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3. Psychological Therapies

Primary Care

The Wrexham primary care nurse reported that she offers web-based psychoeducation, self help, supportive counselling and watchful waiting. Most people are seen within six sessions.

Secondary Care

Clinical Psychologists in secondary care provide clinical, neuropsychological and behavioural assessments, generate clinical formulations and carry out interventions with the person and their family or carer network. The range of therapies available includes CBT, EMDR, mindfulness-based therapy, acceptance and commitment therapy, relapse prevention and systemic interventions, but this varies according to team. Work is individual- and group-based, as well as consultative with the wider team. Through the resource mapping exercise, staff

reported that some skills are under-utilised due to service pressures and ways of working.

Access to therapies varies widely across the region, largely according to resource availability. Waiting times for psychological interventions vary from two to fifteen months, for both organic and functional needs. Memory assessment waits are shorter, at around one to three months, due to the time-limited nature of the service.

The breadth of people, professionals and services involved in supporting people with dementia brings a unique complexity and nuance to work with this client group. While memory clinic assessments may be the most tangible currency for modern service delivery, it is vital to appreciate the intricacy of the multi-disciplinary work required to support someone from pre-diagnosis onwards, and the role of psychological interventions in ensuring a high quality and evidence-based approach.

4. Psychological Therapists

There are 6.9wte members of qualified staff to serve the population and geography of North Wales (headcount n=11). Information from the resource mapping is limited but appears to indicate a flat skill mix, with most posts at Band 8A. All are HCPC-registered, and several hold membership of relevant professional bodies such as the British Psychological Society. As integral team members, Clinical Psychologists play a key role in service developments, for example in securing accreditation and re-accreditation with the Royal College of Psychiatrists Memory Services National Accreditation Programme since 2015. The Head of Service also sits on the MSNAP Advisory Panel, the Public Health Wales Memory Assessment Service Sub Group, and the National Steering Group for MH&LD Dementia Care.

Additional funding from Welsh Government has been secured less often than in AMH, although 3wte inpatient posts shared with AMH have been introduced in recent years, and three more are in the pipeline.

5. Training

Training is provided to those who are involved with supporting the person, whether they are family members or formal care givers, within and beyond the NHS.

There are strong links with Bangor University, supported by a joint appointment between BCUHB and the North Wales Clinical Psychology Programme. Around ten clinical trainee placements are offered every year. Staff provide training and supervision to the trainees, and several teach on the programme as well as undertake other academic duties.

Links are also being developed with Bangor around Applied Behavioural Analysis, including a successful bid from the Integrated Care Fund for an ABA practitioner.

Clinical Psychologists also provide training to their MDT colleagues.

6. Supervision

Clinical Psychologists provide supervision to MDT colleagues, and are also available for consultation. They supervise trainee Clinical Psychologists.

The same undated Clinical Psychology Clinical Supervision Guidelines are in place as for AMH. A supervision audit was not available to review, but supervision was reported to be in place and job planned.

7. Audit and Data Collection

The primary care nurse in Wrexham uses PHQ9 and GAD7 outcome measures, which are routinely recorded in clinical notes.

From the two secondary care OPMH responses to the resource mapping, we established that:

- One team reported the typical number of sessions as thirteen or more in most cases, whereas the other reported a greater range from seven to more than fifteen.
- One team reported use of CORE, BDI, HADS, GDS, and BAI outcome measures, while the other reported that none were in use.

The position in terms of electronic data management is as inadequate as it is in AMH.

Clinical Psychologists are well-engaged with the University's research programme.

We were told that audit feeds into the QSEEL governance processes.

Overall, OPMH psychological therapies appear to work effectively and proactively alongside the multidisciplinary team, and are fully engaged with Bangor University. However, there is scope for greater integration of psychological work across the clinical workforce, if the infrastructure and capacity allowed. The limited resource mapping data suggests there is variation in working practices as well as access to therapies. The most significant concern is the very small specialist capacity, which hampers direct and indirect clinical service delivery and developments, as well as career opportunities.

Key Questions Specific to OPMH

- Resources for psychological interventions at general and specialist levels are inadequate for the local population and its nature. Can we do anything more to maximise the impact of what we have, and how should we best target any new investment?
- How can we increase access without sacrificing the quality of what we provide in an often complex clinical picture? What is our understanding of the variation in practice across the region?
- What opportunities are there to strengthen joint working with other specialties?

6. Substance Misuse Services

'We started with a blank sheet. There was freedom to do something different.'

1. In Brief

Capacity for specialist psychological therapies in SMS has always been very small, and so when it was established, it cut its cloth accordingly. We heard consistent examples of psychologically-informed working across the MDT, backed up by targeted use of the clinical psychology resource in support of the wider team. There is much learning to share with others, particularly around maximising the impact of resources and growing capacity for psychological interventions. SMS is role-modelling much of what is advocated for AMH and OPMH in terms of improving access, but there have not been opportunities or time to share this learning.

The specialist service is underpinned by third sector provision in primary care.

2. Psychological Therapies Model

Primary Care

CAIS, a local third sector provider, is commissioned by BCUHB to provide a well-established SMS Counselling service at Steps 1 and 2, working with people who are using at a 'hazardous and harmful' level rather than 'dependent'. It receives around 500 referrals per year (2017/18), with around three quarters relating to alcohol and a quarter to drugs. Target times for assessment are met in around 75% of cases, and for treatment around 80%.

In Wrexham & Flintshire only, there is a Therapeutic Intervention service, commissioned outside the NHS by the Area Planning Board (APB) and handling around 600 referrals a year (2017/18). It sits between Steps 2 and 3, providing extended brief interventions for people with mild to moderate mental health and substance misuse needs (up to twelve sessions, but typically three to seven). It works closely with the SMS Counselling Service.

The Psychological Therapist employed by BCUHB runs weekly outpatient clinics for Gwynedd, Anglesey and Conwy, responding to common mental health needs, which very often underlie addiction. This CBT provision is funded by the APB.

This leaves Denbighshire with a counselling service only.

CAIS has a solid data set of performance metrics for the services, and shared some positive case studies that described users' experiences. What is not clear is if/how the provider and commissioners have worked together to use this information to improve pathways and maximise impact across the full spectrum of demand. The current picture appears to be determined more by history than design.

Secondary Care

Psychological therapies in SMS are fully integrated through necessity as well as desire – with just 0.7wte Clinical Psychologist (capacity around six sessions per week for one-to-one work) and 1wte Psychological Therapist (around twelve sessions per week), it has never been feasible to offer a traditional model based on one-to-one work. As the first and only Clinical Psychologist, the Lead was able to set these expectations from the outset, rather than having to unravel established practice that had become unsustainable - a key point to appreciate when comparing with other specialties. This approach complemented the service's ambition to move beyond a solely medical approach to substance misuse treatment.

The service is made up of six county-based teams in North Wales, with a total caseload of over 2000 people. The wider team has been keen to work in psychologically-informed ways and the resource has been organised to enable this.

The model consists of a range of group-based structured interventions, facilitated by care co-ordinators, the (temporary) assistant psychologist, or peers. This leaves the Clinical Psychologist to focus on consultancy, supervision and training to the team (alongside a reducing volume of one-to-one work), which ensures quality is maintained across the board.

There is very little joint work undertaken with AMH clinically or strategically, despite service users often accessing both services. A co-occurring pathway as defined in the Welsh Government Service Framework (2007) is not in place. This is seen to be as a result of lack of engagement from AMH, through lack of time and opportunity to come together.

3. Psychological Therapies

In primary care, therapies include motivational interviewing, CBT and relapse prevention therapy.

CBT is used widely for evidence-based treatment of common mental health disorders by the Psychological Therapist. Many people suffer with PTSD and so EMDR is widely practised.

Therapies in secondary care consist of a range of evidence-based psychological interventions and treatment, including CBT, group CBT, EMDR, ACT, relapse prevention and motivational interviewing. Waiting times for the service as a whole are growing, and access to groupwork varies by area, according to the frequency with which each group runs.

Group-based interventions are manualised and include *Nudge*, *Moving On In My Recovery*, and *Pathways To Recovery* (which is ACT-based). *Moving On* has been

developed with peers, and is co-led. It is designed to bridge the gap between complex needs and moving on, so there is a clear pathway out of services which joins up. There is a sound evidence base for the use and validity of peer support in SMS.

4. Psychological Therapists

Primary care capacity for Substance Misuse counselling is integrated with CAIS's Parabl staffing (see p23). Specialist capacity is as described above.

5. Training & Supervision

A gradual programme to train every secondary care clinician in *Moving On* and *Nudge* is underway, to support all staff to use the skills in their daily work. Around half of the clinical workforce (circa 30) have completed their training, which takes four days for Moving On and 1 day for Nudge. They are included in the service's training matrix and made mandatory for completion every three years.

Twelve staff are undertaking training in Acceptance and Commitment Therapy currently.

The Clinical Psychologist provides training and supervision to the wider team. He also has a role with Bangor University. However, he is isolated professionally, and there does not appear to be a forum across the Division to support professional development and peer support.

6. Audit and Data Collection

In primary care, AUDIT is used and recorded on a CAIS database.

In secondary care, Treatment Outcome Profile (TOPS) data is routinely captured and reported. Pre- and post-measures of effectiveness are in place for CBT sessions, group outcomes are recorded in psychology notes (e.g. recovery strengths questionnaire), and there is some audit activity. We understand there is a discussion taking place with the Area Planning Board to support an additional role for governance and training.

Overall, SMS in secondary care models a contemporary approach to the delivery of psychological interventions which maximises the value of the resource across the multi-disciplinary workforce, thus enabling a psychologically-oriented offer for all service users. Nevertheless, the whole system (across all steps) is neither right-sized (demand outstrips capacity) nor equitable across the areas. Thus there is value in looking strategically and operationally at opportunities for closer working between primary and secondary care to manage demand and capacity more effectively. This may reveal the need for pathway/service redesign in Steps 1 and 2.

Key Questions Specific to Substance Misuse Services

- What can we do to tackle pathway inequalities across the region, and strengthen a whole system approach to managing demand and capacity? What is needed to improve our focus on value for money across all steps?
- How can joint working between SMS and AMH be strengthened, in order to improve services for people with co-occurring mental health and substance misuse problems?
- What opportunities can we create to ensure there is accessible professional development and peer support available to smaller speciality clinicians, and to enable sharing of good practice and learning across specialties?
- Is it a priority to invest in reducing waiting times, and if so, what is the scale of the requirement?

7. Forensic & Rehabilitation Services

'There's lots of opportunity to look at the whole system and see psychological interventions at the heart of every person's recovery and rehabilitation.'

1. In Brief

Clinical Psychologists in Forensic and Rehabilitation services work closely with their multidisciplinary colleagues, but this has not translated into the sustained development of psychological capability and capacity across the multidisciplinary workforce. This is attributed to a lack of protected time for nursing staff, working in inpatient settings, to develop and practise the necessary skills, and to receive supervision. There are very significant gaps in the overall pathway of local services, meaning there is no continuity available to service users working with psychologically-based care plans. Specialist staffing resource in rehabilitation is particularly scant, and there are competing pressures to be involved in service developments as well as deliver clinical care. There are many opportunities, and plenty of enthusiasm, to look more strategically at the potential of psychological therapies to enhance pathways and ensure more timely outcomes for service users. Excellent examples of this potential have already been achieved, including the *Life Minus Violence* programme, and the specialist skill mix changes in Forensics to increase access to graded therapeutic interventions. There is also significant potential for psychological therapies to contribute to strategic pathway improvements across Forensic and Rehabilitation services.

2. Psychological Therapies Model

Psychological therapies provision for people on a forensic pathway is provided entirely within the medium secure inpatient setting, Ty Llewelyn. There is no commissioned provision within the community forensic team, so upon discharge from secure care, psychological input stops.

There are no inpatient secure services locally for women, and no low secure care for either men or women. These are very significant gaps in local pathways that hinder repatriation and risk extending lengths of stay in restrictive environments, with knock-on consequences for rehabilitation. This situation appears to be at odds with the equally significant drive to repatriate people from high to medium security. These gaps have implications for the sustainability of psychological work achieved in medium secure care – e.g. because psychological input ceases entirely, or continuity of care is broken and new therapeutic relationships have to be established.

The rehabilitation service comprises four inpatient facilities and two community teams, and is covered by one clinical psychologist. Inevitably, this means that

there is unequal access across the services. It is subject to a separate review process.

3. Psychological Therapies

The team provides specialist clinical psychology input on an individual and group basis to address the complex mental health and offending presentations of the client group. It has developed a highly effective *Life Minus Violence* strengths-based CBT programme, made up of seven modules delivered weekly over 18 months. It is delivered by Clinical Psychologists and nurses working together.

There is a DBT team in place, led by Clinical Psychologists and co-facilitated with DBT-trained nurses. As such, pressures on the wards make it difficult to sustain, as time is hard to protect when the nurses work 'in the numbers'.

Other therapies offered include CBT, CBTp, functional remediation, relapse prevention, trauma-informed therapy and cognitive remediation therapy.

We were told about occasional situations in which specialist psychological therapy is accessed and funded out of area (sometimes necessitating inpatient care), because there is no local capacity available to provide it. It wasn't clear to us how decisions about priority allocation of capacity are made, except that operational managers don't appear to have a role to play in the decision-making.

4. Psychological Therapists

The forensic team comprises 1wte band 8C post and 2wte assistants, while in rehabilitation there is 1wte band 8C. This small team is overseen by 0.8wte band 8D lead post. Inpatient forensic capacity has recently been remodelled through a skill mix review to enhance a graded approach to psychological interventions, particularly ward-based group interventions. This is being trialled on a 12 month basis initially.

In rehabilitation services, the clinical psychologist has focused her attention, out of necessity, on the 'locked rehabilitation' ward, undertaking complex assessments and delivering individual interventions, while also supporting the wider team in a formulation-oriented approach to better understand the needs of the client group. A number of nursing staff have undertaken training to varying levels in DBT and CBT. However, this still leaves significant gaps in psychological assessment and intervention for service users in the other rehabilitation services – an inequality that is designed into the system through lack of adequate staffing to provide direct and indirect care.

Over the last year, a fixed term assistant post has been in place, focussing on service development and pathway review, in the context of significant demographic and risk profile changes amongst this client group. The funding has been extended for a further year.

The Lead is keen to extend opportunities for all clinicians to work in psychologically-minded ways (e.g. to use psychological interventions in group settings for relapse prevention, CBT for anxiety and depression), with Clinical Psychologists providing support and consultation.

5. Training and Supervision

Both forensic and rehabilitation services are keen to see greater multidisciplinary expertise in psychological interventions, supported by appropriate training and supervision from specialist clinicians. While some of this expertise already exists, the main barrier to its use is protected time. Relevant staff do not have job-planned time to deliver this work, and so there is a longstanding problem with competing priorities, with real time ward pressures taking precedence. This means psychological interventions are not offered consistently, or across all teams.

Given the prevalence of trauma experiences within this client group, and the impact of these experiences on recovery, there is also a desire to expand capacity for EMDR.

In forensic services, eleven staff are due to be trained in *Moving On In My Recovery* (ACT and MI based), which has been successfully developed in SMS for use with individuals with a history of substance misuse.

In rehabilitation services, one member of staff is starting an art therapy course.

6. Audit and Data Collection

There are three different electronic data systems in use across the services, but they are described as being of limited use. Audit work requires additional manual review of case notes, and hence is very time consuming for a very small workforce. As a result, audit activity is limited.

In terms of service user feedback, a satisfaction audit was last undertaken in 2015. Feedback is also collected following group interventions, in addition to pre- and post-measures. As numbers of service users are low, the data set is still in development. Also, the assistant psychologists are involved in facilitation of the Together 4 Recovery service user forum.

Overall, the potential value that psychological therapies in Forensic and Rehabilitation services can add is significantly hindered by the lack of continuity between different elements of the pathway, and by the inherent challenges of protecting time for nurse colleagues in inpatient settings. Specialist staffing resource in the Rehabilitation services is inadequate. As a result, psychological approaches do not yet underpin the model of care. There are very positive and proactive developments in place (e.g. *Life Minus Violence* programme), but a

more strategic approach, appropriately resourced, would accelerate improvements in outcomes for both service users and the system as a whole.

Key Questions Specific to Forensic & Rehabilitation Services

- How might pathway improvements to repatriate local people to their local communities be accelerated by strategic investment in psychological therapies (e.g. to influence and support service development; to reduce lengths of stay; to increase independent living skills; to sustain progress upon discharge; to support capacity building in the third sector; to *rehabilitate*)?
- Does the existing review of rehabilitation have sufficient priority within the wider Division?
- How might the wider workforce be enabled to develop skills in psychological interventions, to strengthen further the graded approach and enable best use of specialist skills and capacity?

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8. Learning Disabilities Services

'Get it right for people with a learning disability and you get it right for everyone.'

1. In Brief

The commitment to fair access for all people is explicit in the local Together for Mental Health strategy, while the detail around the future of Learning Disabilities is covered within a separate but aligned strategy. However, services have evolved over time in a context in which reasonable adjustments for the needs of people with a learning disability have not been made. This has meant that LD services have sought to compensate for this, in order to mitigate the consequences of inequitable access to other 'non-adjusted' services. We saw compelling evidence of integrated working, creative responses to meeting the highly individual needs of the client group, service developments both internally and externally, and a keenness to strengthen interface working with other specialties. There is potential to extend the impact of psychological approaches by developing specialist capacity and capability locally, to respond to those with the most complex needs without recourse to out of area provision.

2. Psychological Therapies Model

It is reported to be very difficult for people with a learning disability to access other health services, including AMH. Reasonable adjustments are not made, and there is a widely-held view that the LD label throws up barriers to access, based on stigma. As such, psychological therapies in LD have responded to this lack of access through necessity.

In this context, the notion of a primary/secondary care divide is not particularly meaningful. There is no specific LD provision in primary care, although theoretically there is no reason for people with LD to be excluded from the existing primary care mental health services. In practice, it is likely that someone with an identified LD would be referred to the specialist teams.

Community LD teams at locality level are hosted by the relevant local authority in an integrated health and social care structure. Psychological therapies staff are a central part of each team. There is one inpatient psychologist, covering various units at Bryn Y Neuadd Hospital and the community rehabilitation team.

Clinical Psychologists work as core team members, and the focus is on the team agenda. Referrals are made to and owned by the team – there is no 'referring into' psychology. This scale of integrated working is the result of many years of work to embed Clinical Psychologists within the core team.

Access to suitable space for people with LD is limited and means that staff spend a lot of time travelling across the rural geography of North Wales.

Operational managers work closely with psychologists to manage team capacity. There is a Psychology Lead for the service as a whole, who focusses on complex needs and ASD developments, as well as providing consultation and supervision to the wider team. He described a culture of working together, anchored in shared values that are all about the individual – 'we don't pull rank'. The Lead is a full member of departmental groups such as the Senior Leadership Team meeting, Team Managers meeting, QSEEL, and the wider Psychology Heads of Service meeting.

In the absence of any local provision for the people with most complex needs, a significant number of local people receive high intensity/high cost inpatient care out of area. There is the potential for Clinical Psychologists to make a major contribution to the development of local services capable of responding to forensic and challenging needs, with upfront resource on an 'invest to save' basis. This opportunity doesn't yet appear to have been grasped in the organisation.

3. Psychological Therapies

LD clinicians described the importance of appreciating the evidence base in the context of the very specific and unique circumstances of each of their clients. The complexity of an individual's needs may mean that condition-specific interventions are not indicated. Where assessment and formulation suggest they would help, the literature is of limited use, as evidence has often been developed with other client groups in mind. So the clinical psychologist will adapt the approach according to the individual, while recognising this may impact on the effectiveness of the intervention.

The work includes:

- Dementia assessment, diagnosis and care planning - at local and policy levels
- Diagnostic assessment for eligibility – a new piece of work to formalise an evidence-based process, including support team colleagues in the application and interpretation of assessment for eligibility.
- One-to-one therapeutic work, including care co-ordination and risk assessment, with people with complex needs. Assessment and intervention often systemic in nature, given the support networks that are needed for this client group.
- DBT was developed and adapted for people with a learning disability, and ran for around two to three years. Unfortunately, it was not possible to sustain this development and it has ceased due to resource constraints. It was very challenging, across a dispersed rural region, to assemble a critical mass of people in one place for a DBT skills group.
- Autistic Spectrum Disorder diagnostic assessment.

- Integrated autism service – LD Clinical Psychologists played a key role in the development of this service, and contributed to national developments in this field.
- Offending work, including use of assessment tools such as HCR-20.
- Capacity assessment, including s49 reports.
- Challenging behaviour functional assessment, and support to other team members.

The resource mapping data indicated that therapies include CBT, DBT, CAT, MBCT, schema therapy, family intervention, applied relaxation and relapse prevention. In addition, there are three programmes tailored to client needs – *Soles of Their Feet*, *Beat It*, and *Step Up*. The range available varies between teams. Some respondents indicated that constraints include time and physical space to see clients.

It is generally expected that therapy length will be longer than the general adult population. Responses from the six teams who participated in the resource mapping exercise show this to be broadly the case, but it is interesting to note a marked variation in the typical number of sessions across different but comparable LD teams.

4. Psychological Therapists

The workforce of 7.9wte is made up entirely of Clinical Psychologists, who work as care co-ordinators where it is appropriate to do so. Work to extend psychological intervention skills to the wider team, particularly nurses, is underway. In the inpatient services, four nurses are trained DBT therapists. Community teams include some staff who are trained in specific approaches – e.g. *Soles of Their Feet* programme. There is at least one DBT-trained nurse.

There are limited opportunities for career progression, as all Clinical Psychologist posts (6.9wte) are banded at 8A (except the lead 1wte Band 8D). This has several implications. It leaves a significant retention risk for experienced staff, it prevents delegation of developmental opportunities by the Lead, and it precludes the development of service-wide clinical specialisms which could impact positively on strategic aims (e.g. services for people with complex needs in high cost placements). The rationale for this skill mix is not clear, but it appears to have come about through removal of posts at Band 8B and 8C, either through cost savings or redistribution of resource elsewhere. This leaves particular staffing pressures in the West area.

5. Training

Several respondents to the resource mapping described difficulties in accessing training opportunities (time and funding). Two teams reported training in the pipeline (ACT and Behaviour Science).

Clinical Psychologists are involved in training colleagues in the wider MDT.

They also play a full role in teaching and development of the North Wales Clinical Psychology Programme with Bangor University, and routinely host trainee psychologists on placement.

6. Supervision

All professional and managerial supervision is provided by the Head of LD Clinical Psychology, as a consequence of the flat skill mix. Anecdotal evidence indicates that supervision is accessed around 10 times a year, for an hour and a half each time. This is soon to be audited. Supervision is also available via DBT consult groups and there is an option to meet for peer supervision monthly.

7. Audit and Data Collection

Again, there are wide-ranging examples of involvement in this domain:

- Clinical Effectiveness Groups have been designed and developed to review existing best practice and evidence, and then bring it to life through pathways and processes for service delivery. Clinical Psychologists are closely involved and chair three of the four groups.
- Some teams report the use of outcome measures, including PTOS, where it is meaningful in the client's circumstances, e.g. those who use the service on a long term basis. Feedback is also sought.
- NICE guidelines audits have been undertaken.
- Needs mapping is being undertaken to look at specific needs (e.g. offending behaviour)
- Support provided to nursing colleagues to participate in relevant externally-funded research projects, including the largest therapeutic Randomised Control Trial ever undertaken within LD.

In terms of electronic data management, psychologists use the system of their host Local Authority, so these differ across the region and are not those used in BCUHB.

Monthly referral data by psychologist is collected. There is no infrastructure to collect or analyse data about waiting times. However, we were given reassurance that working practices are such that urgent needs are responded to urgently. The team approach is key to managing capacity in this way.

Similarly, there is no data available about unmet need.

There is a process to seek client feedback about their experiences of Clinical Psychology, where appropriate, at the end of treatment. A recent analysis of feedback forms indicated positive feedback to over 90% of the questions asked, with the most significant negative response relating to understanding letters

written by the psychologist. The analysis also highlighted some difficulties with implementation of the feedback process, which are being addressed.

Overall, psychological therapies in Learning Disabilities services demonstrate effective integration within a multidisciplinary service model, and an innovative approach to making the most of the resources available. There is reported evidence of wide-ranging developments at local and national levels, and with the university. Access to other health services is consistently cited as a longstanding problem, and variation in access and practice between different areas is apparent. Like most specialties, there is a flat skill mix which impacts on career opportunities, retention and specialist capability building. There is an important opportunity to grow local capacity and capability in complex needs management, to help people to stay closer to home and to deliver cost efficiencies to the health economy.

Key Questions Specific to Learning Disabilities Services
- What are the respective roles and responsibilities of mental health and LD services for people with a learning disability? How do they fit together to ensure equality of access?
- What resource is needed to better enable delivery of those roles and responsibilities, and how can we work creatively with other specialties to manage resource constraints?
- How can we shape and resource a piece of transformation work aimed at repatriating people with the most complex needs, with clinical psychology contribution at its heart?
- How can the career pathway for LD Clinical Psychologists be developed, and simultaneously improve the use of existing workforce skills towards the system's biggest challenges?
- How can opportunities for shared learning be improved, particularly around the experiences of developing effective integrated team working?

Working in Teams

'Integrated care is only possible if the divisions created by professional specialisms are transcended' (McClean, 2005).

1. Overview

For many years, the organisation of contemporary mental health services has been formed around the idea that high quality care requires input from a range of disciplines, expertise and theoretical bases, in order to meet the diverse needs and expectations of service users. Examples include community mental health teams, mental health legislation, national policy and best practice (e.g. NICE guidance).

The practice has proven much harder than the rhetoric. One reason for this is that there is not a shared professional narrative for understanding mental distress. Perspectives differ between professions, as do language and emphasis. This gives rise to behaviour and practice intended to preserve professional identity and uniqueness, in response to a sense of threat.

Working together – between professionals, between primary and secondary care, between specialties, between acute and community services, between the NHS and its partners, between the NHS and the people it serves – quickly emerged as one of the most significant themes of this review. Opinions, experiences and narrative were diverse. The desire for better integrated working in the interests of service users and carers was consistent. So this chapter is dedicated solely to the issue of working effectively in interdisciplinary teams. What does the evidence say, and how might it relate to people working in or accessing services in North Wales?

N.B. This chapter draws mainly on three sources – Effective Teamwork *(2012) by Michael West,* Interdisciplinary Working in Mental Health Care *(2012) by Di Bailey, and guidance published by the Division of Clinical Psychology. It is not a full literature review, but it provides a reliable basis for appreciating the evidence base around team-based and interdisciplinary working.*

2. The Basics of Team-Based Working

Professor Michael West's research on **team-based working** and compassionate leadership is well-recognised across the NHS. Many of his findings are consistent with those of Professor Amy Edmondson (Harvard Medical School) around team working and psychological safety.

West describes teams as having no more than twelve members, and three core components, all of which are necessary for effective functioning:

- Shared objectives (we are working towards the same thing; we understand our precise roles and responsibilities)
- Interdependence (we need each other to succeed, because we can't achieve our objectives alone)
- Reflexivity (we meet regularly to consider how we are performing and what we need to do differently)

Conflict emerges in circumstances where:

- Roles are not clear or mutually understood
- There is no clear, shared vision and goals, so tasks are individually determined rather than collectively owned
- Resources are inadequate for the task
- Work is allocated and rewarded on the basis of function (discipline), rather than there being collective responsibility for the 'end product'
- There are inconsistencies in status between team members
- Authority is overlapping
- Team members don't feel able to rely on their colleagues and, as a consequence, their own effectiveness is affected
- Ways of evaluating success are not compatible

It is West's view that the majority of workplace problems that manifest as interpersonal in nature are actually rooted in structure and process. In other words, the system is capable of generating the conditions for conflict within its design and operation, regardless of the current set of individuals involved within it. This systemic understanding of conflict, and its interaction with staff engagement, is often overlooked in organisations.

West's evidence highlights some stark **consequences** of ineffective teamwork upon the quality and safety of services:

- Higher patient mortality rates
- Lower patient satisfaction
- Higher error rates
- Lower job satisfaction
- Higher staff turnover and sickness absence
- Lower staff engagement

For teams to function effectively, they need a number of things from their organisation:

- *Targets*, determined collaboratively, which make explicit what it required of the team, in measurable terms

- *Resources*, sufficient to deliver the agreed targets (e.g. staffing numbers and skill mix, funding, technology, accommodation)
- *Information*, about what the organisation's strategy is and how the team relates to it
- *Education*, relevant to the team's role and task, regularly updated in line with professional requirements
- *Feedback*, which is accurate, timely, and useful to improved performance
- *Technical and process assistance*, to support the team with skills and expertise which are not core to the team but are essential to its effectiveness and development

3. Interdisciplinary Working in Mental Health

McClean (2005) makes a distinction between two forms of practice:

- Multidisciplinary – 'a team of people working together but maintaining their professional autonomy', and
- Interdisciplinary – 'a team of professionals working as a collective'

Multidisciplinary practice is entirely capable of being fragmented. At best it has an additive effect. Interdisciplinary practice relies on collaboration, which strengthens the contribution of individual team members and has a multiplicative effect (the whole is greater the sum of its parts).

Features of interdisciplinary working include (Miller & Freeman, 2003):

- A meaningful and embedded vision of teamworking
- A shared philosophy of care, which facilitates shared responsibility for delivery
- All team members are involved in problem solving and decision making
- Team members have a deep appreciation of each other's roles and underpinnings
- Team members learn new skills from each other in order to contribute to continuity of care
- Joint practices are in place – e.g. assessment, monitoring, evaluation

The difference between interprofessional and interdisciplinary working is the extent to which service users are regarded to be part of the team, actively participating in their own care. The interdisciplinary approach complements the biopsychosocial understanding of distress. It must be the organising principle for recovery-oriented practice, in which it is the individual, not any one professional, who defines what their recovery looks like – their 'life beyond illness'.

Bailey (2012) describes three dimensions of interdisciplinary working in specialist services:

i. *Organisational* – the strategic context will impact upon what is possible to achieve at team and practice levels. In other words, the organisation has a fundamental role in helping or hindering interdisciplinary working. Examples include mission and vision, planning priorities, financial systems, accountability, processes and procedures, and opportunities for service user engagement.

ii. *In teams* – in order to practise in ways which align with organisational priorities, teams need clear lines of communication and agreed referral routes and pathways. Team members should play a part in defining the measures by which their performance will be judged. Examples include consistent ways of working within and across teams, management and supervision arrangements, a psychologically safe team culture, and an appetite to challenge processes which exclude service users.

iii. *Practice (individual)* – clinicians are sufficiently confident in their own professional identity and contribution that they are comfortable with (not threatened by) increasingly flexible boundaries. Integrated care planning processes are clear and consistent. There is a shared understanding of both mental distress and the value of the collaborative approach to service users.

In the primary care context, Bailey *et al.* (2012) stress the importance of embedding primary care within a whole systems approach to mental health care. Across the three dimensions above, this looks like:

i. *Organisational* – policies and practices which enable interdisciplinary working (e.g. communication and information sharing); shared biopsychosocial values; interdisciplinary learning opportunities which include service users

ii. *In teams* – co-location; shared record-keeping; clear roles and responsibilities

iii. *Practice* – the service user is central to care planning across all services; there is easy access to specialist consultation

The challenge for managers of interdisciplinary services entails the operationalisation of the shared vision and mission. **Where team strategy, operational policies and practices are at odds with the vision, fragmentation and professional protectionism are the inevitable consequences**. 'The process of managing change in interdisciplinary working …hinges increasingly upon effective human interaction alongside the successful management of resources and service redesign' (Bailey, 2012).

The Role of the Clinical Psychologist in the Team

The strategic value of 'talking therapies', for health, wellbeing, and therefore employability and social inclusion, has underpinned key mental health strategy and policy in Wales and England for more than ten years. Clinical Psychology is at the heart of that advance.

According to the Division of Clinical Psychology (British Psychological Society, 2014), Clinical Psychologists,

'*provide face-to-face therapy for individuals, families and groups. They also supervise and teach other professionals to provide psychological treatments.… They offer leadership in organisational development, audit, service redesign and development.*'

Distinct features of their clinical practice include:

- Comprehensive psychological **assessment**, which is vital to inform appropriate treatment plans.
- **Formulation**, a core skill of every clinical psychologist to make sense of an individual's often complex situation, using psychological theory, rather than focussing on diagnosis.
- **Intervention and treatment**, which wherever possible is evidence-based. This includes challenging longstanding practice for which the evidence base is no longer strong.

It is also important to understand and appreciate the value that Clinical Psychologists can add to the work of the wider team, and to allocate time for these activities accordingly. *They enable the psychological capability and capacity of the whole system to improve*, and thus offer potential for far wider reach and impact than is possible from the delivery of direct clinical work alone. For example:

- **Consultation** to the team, providing a psychological perspective in complex case work (formulation), and helping to ensure that the service user's care is psychologically informed & appropriate to their needs
- **Supervision** to the wider team, providing expertise and support to ensure the quality of psychological interventions offered by clinical colleagues, and the capacity of the team to process difficult experiences and dilemmas they encounter in their daily work. This may also extend to facilitation of reflective practice across the team
- **Training** in low level psychological interventions to the wider team
- **Service development**, helping to design and test pathways of care that optimise wellness and ensure timely access to cost-effective treatments
- **Research and audit**, ensuring that our understanding of the field continues to progress, and providing vital data for team performance improvement

BPS Guidelines for Clinical Psychology Services (2011) are clear in advocating increasing integration into multidisciplinary teams, while 'retaining the unique identity and contribution that psychologists can offer'.

4. What We Found

One of the most divergent areas of narrative throughout the review was about integrated team working. It was raised in almost every discussion. Perspectives as to the nature, extent and impact of integrated working between psychological therapies and the wider multidisciplinary team, both as a function and as a group of professionals, were diverse, sometimes even within the same team. Descriptions ranged from to 'integrated', 'involved', 'co-located' to 'fragmented', 'isolated', 'separate', 'not transparent', 'protective'. Where there was positivity, people spoke of professional respect, understanding of each other's roles, and shared ways of working. Where there was criticism, this was characterised as being the fault of those working within psychological therapies teams, rather than a consequence of the design, operation, capacity or culture of the system as a whole. Unsurprisingly, then, the subject often provoked emotive responses and appeared to be a barrier to constructive dialogue between different parts of the system. We observed effective interdisciplinary relationships in places, and in others, varying degrees of conflict, frustration and even hopelessness. It is our view that the evidence from the literature outlined above helps to make sense of what is happening and offers a direction about effective next steps.

The **organisational** context for the delivery of psychological therapies presents several challenges to interdisciplinary working, which are present to varying degrees across the specialties we looked at:

- It is not clear how psychological therapies feature in the organisation's vision for its services, despite positive work underway to implement the *Together for Mental Health* strategy through pathway redesign. There doesn't appear to be a common understanding of their definition, scope, potential, value or fit, beyond some very broad statements about a psychologically-oriented offer to service users. **Without a centralising concept for the contribution of psychological therapies to the wider vision, it is difficult for the system to know what it is trying to bring to life through its design and operation.** Smaller specialities have been more successful in carrying on regardless, than has been possible for AMH and OPMH, where Mental Health Measure compliance appears to be the basis for resource allocation.
- Psychological therapies are structured to sit alongside, rather than within, the rest of the multidisciplinary management structure. In most cases, budgets, capacity, workforce, planning, evaluation and training are managed separately, at strategic and operational levels. The rationale for this is not clear, and it is also not clear to what extent different parties want to see this change. We noticed a sense that the profession of clinical psychology feels the need to be organised as a distinct group. Whether this need extends to unidisciplinary management of the function of

psychological therapies is a different question. There are examples of various different operational management approaches across the specialities, some of which are clearly integrated, while others blur accountability and leadership. There is certainly a consistent message about wanting to work in a more integrated way, just not a clarity as to what this means in practice.

- Clinical leadership roles in the MH/LD Division (as distinct from professional lead roles) are occupied exclusively by Consultant Psychiatrists. We did not explore the rationale for this, but in a multidisciplinary mental health context, it is inevitable that other professional groups may find this lack of professional diversity problematic, and see it as a significant factor in the preservation of a culture and narrative which is medically oriented. We note this was identified in the *Together for Mental Health* local strategy, and it was raised consistently with us by people from various professions.

- There is a very significant and unsustainable mismatch between resources and organisational expectations (which themselves are unclear), and an absence of constructive dialogue about what this means and what might be done. Strategic opportunities have not been exploited and developments are piecemeal. On many occasions, we witnessed a chronic feeling of disappointment, frustration, misunderstanding, defensiveness and lack of trust with the organisation, particularly in AMH. This appears to feed a state of learned helplessness. This is particularly demoralising for individuals who work hard on the ground to find workarounds and piece together fragile solutions within their sphere of influence and responsibility. There was a feeling articulated by many people we spoke to that the professions involved in psychological therapies had become the scapegoats for much more fundamental root causes of the problems that manifest daily in services, most notably waiting times.

- Where stepped care is relevant, there is no commissioned integrated pathway for psychological therapies across the tiers (except CAMHS), and so services at different tiers generally work separately, and therefore use resources separately. Information sharing, supervision, training, capacity management were all raised with us as being problematic across and between the tiers, particularly where different providers are involved.

- Psychological safety to speak up was patchy. There was a strong undercurrent from most of the frontline staff we met that the organisation's longstanding status in Special Measures, and the events surrounding it, had gradually eroded its confidence to take positive risks towards innovation and improvement, or to trust its workforce to have the answers. It was perceived to be heavily centrally-driven, and incentivised around quantitative performance measures rather than quality. One

clinician described a flow of fear and threat amongst staff, when what is needed is compassion.

The lack of clarity at an organisational level has a knock-on impact. At **team** and **practice** levels, there is little within the system that enables what is espoused – a psychologically-minded offer – to become real. Staff do not appear to be supported or guided to cope within the resource constraints, and so are left with onerous decisions about how best to manage in a system that is not designed to perform effectively. It appears to be for local leads and managers to work out how they will operate together, and to do so without reliable data. Inevitably this gives rise to different arrangements with different impact and outcomes – some hugely creative and adaptable, others paralysed. Where it succeeds, it does so in spite of, not because of, the organisation. This gives rise to many different ways of working, which impact on access, quality and outcomes, and reinforces the postcode lottery which was mentioned frequently by staff and service users alike. It also nurtures the conditions for conflict (see p56). We saw many examples of teams working to their own set of rules about how psychological therapies should operate (e.g. referral, assessment, waiting list management), often determined without the full involvement of those who are affected by the rules. Those examples are not inherently wrong, and in some cases have delivered improvements, but they illustrate the lack of co-ordination across the system, and the measures that local leads feel they need to take, in the absence of any clearer organisational direction.

In terms of a common understanding of the role and value of clinical psychology to the wider service and team, we found considerable variation here too, at all levels of the organisation. The more the Clinical Psychologists and Psychological Therapists were integrated into daily team working, the more positive the relationships and appreciation of the role. Where they were working more remotely (for whatever reason), there was greater suspicion as to what their time is spent doing, and less inclination to see the benefit of their potential contribution beyond face-to-face direct clinical work. In this latter scenario, we witnessed fractured relationships, inadequate levels of trust, and missed opportunities to share expertise in the interests of service users and staff.

In summary, and while there were some notable exceptions, many of the conditions for effective team-based and interdisciplinary working highlighted in the evidence are absent in the services we reviewed, particularly at an organisational oversight level. The organisational ask is unclear, resources are inadequate, roles and responsibilities are blurred, and the system is not designed or incentivised to function as a coherent whole. The scope for conflict, therefore, is significant, and in many quarters, expressed. The literature would suggest that, in turn, outcomes for service users and staff are poorer.

While some specialities appear to be coping reasonably well in these circumstances, the consistent message from AMH in particular is that something needs to change fundamentally. It is our view that the organisation must play its part in laying the foundations for frontline improvement – supporting clinicians to achieve the very best – if it is serious in its commitment for high quality, psychologically-minded and accountable mental health and learning disabilities services.

What People With Lived Experience Say

In order to get a sense of the experiences of people who have used or tried to access psychological therapies services, particularly in adult services, we:

- asked Caniad to co-ordinate an exercise to gather comments, in which we asked:
    - what are your experiences of psychological therapies in North Wales?
    - what do you value about these therapies?
    - what would you like to see improved?
    - how can we work together to make this happen?
- invited the Service User Representative on BCUHB's Psychological Therapies Management Committee (who holds the same role on the all-Wales Committee) to participate in the area-based workshops. In turn, she facilitated some discussion with Bangor University's People's Panel to ask a similar set of questions;
- reviewed case studies provided by CAIS, which included direct quotes about a range of psychological therapies services provided by CAIS and Parabl;
- requested relevant information from BCUHB's Compliments and Concerns data
- invited Caniad representatives to participate in the area-based workshops
- reviewed an analysis of client and carer feedback about Clinical Psychology provision undertaken recently in Learning Disabilities services

While we were able to gather a range of experiences through this exercise, we recognise that this is just the start of a conversation which needs to become more inclusive and accessible across **all** specialties. This includes making reasonable adjustments to facilitate access, and ensuring Welsh language equity. We would urge BCUHB to strengthen the voice of the service user in response to this review. We make specific reference to this in our recommendations.

Therapy changed my life	I waited too long	The response I got wasn't consistent
• Therapy helped me to manage the triggers better by using coping strategies. It saved my life • These therapies gave me resilience and coping skills and a safe place to practise • Group therapies were good • The service I received has been life saving. It has given me the confidence to do the right thing and move forward • Someone who really listens and doesn't judge was a really big help • It was a chance to tell my story and discuss problems confidentially • I will always be indebted to you. You gave me back to my children and family • You helped me to see that my future didn't have to be ruined by my past • Through the professional, insightful, perceptive way you worked with me, you empowered me to keep moving forward • My CPN is skilled in CBT approaches and I really value that • I was treated with a lot of respect & [psychologist] understood me	• I was treated for 2 years by my psychologist. He became important in getting to where I am today. But I have had no contact since and would like a yearly update • I waited over 2 years for an assessment and was then told that because my psychological distress and depression are related to complex physical health problems, it was outside the CMHT's remit. I am still battling with the same issues today • I waited 2 years and my depression escalated to PTSD after my partner's death • I wish I could have accessed help sooner • I have been on the waiting list for psychological therapies for 4.5 years • It's important to provide information about therapy before it starts • I didn't get any information while I waited • I have been waiting for 9 months for an urgent referral	• I wish I had not experienced stigma from my GP • GPs don't seem to know what is available • My referral went missing for nearly a year • My therapist didn't understand my difficulties • I feel there needs to be provision for a more person-centred approach to therapy • There is too much emphasis on CBT. It's not helpful for trauma • I wasn't offered any choice of therapies • I didn't have a chance to share my experiences of therapy. I wasn't asked if it helped me • I wanted to have therapy in my first language (Welsh) but it wasn't available

Our Observations

What you read in this chapter is our interpretation, as reviewers, about what is happening. Others will have different interpretations. Themes will feel applicable to teams, areas, specialties and individuals to varying degrees. This is inevitable. Our intention is not to provide you with a 'diagnosis', but to offer you a series of observations based on the discussions we have had, and the evidence we have reviewed. While we have broken down the narrative into a series of themes, it is essential to see them as a systemic whole, as the interplay between these different factors provides the real story.

Psychological therapies' strategic development and provision appears to be most advanced and resilient in CAMHS, SMS and LD. Common themes that cut across these specialities include:

- Fully integrated team working, in which both the culture and the processes within teams are designed to facilitate multidisciplinary working around the service user.
- Clarity as to how best to make use of limited specialist psychological resource. Team skills around psychological approaches have been developed proactively over time, so graded work is made possible across the whole workforce. Skills are developed through training, consultation and supervision for the MDT from the Clinical Psychologists/ Psychological Therapists. One-to-one therapeutic work has been reduced to enable this, and overall the capacity of the service for psychologically-informed care has increased.
- Team processes and ways of working are shared – e.g. referral, assessment, intervention, supervision, training.
- Innovative approaches have developed out of necessity – e.g. as a result of lack of access to other options.
- Active research, audit and development activity, including with university partners.

However, there are challenges that remain and it is important that these are not overshadowed by the entrenched difficulties affecting other specialties. These include:

- The wider organisational themes described below. While these specialties may have been more successful in making progress in this context, it is nevertheless the case that they are part of the same organisation in which the value and fit of psychological therapies are unclear, the strategic workforce requirements are not planned, the electronic data systems are

unfit for purpose, and Measure compliance has become the centralising concept. The organisation's reliance on individual performance to offset the systemic weaknesses in provision leaves it exposed. The potential for these specialties to go further faster with the support of the organisation is substantial.

- The limited opportunities to share learning (e.g. integrated team working) and explore collaborations across specialties. This includes better joint working at service interfaces – e.g. co-occurring needs; pathway transitions; mental health care for people with a learning disability.
- Demand outstrips capacity, so the care system is not able to deliver the right care in the right place at the right time. These specialties have made strong progress in finding creative solutions to spread the impact of specialist resources more widely, but still, waiting times for assessment and treatment are considerable and, in some cases, growing.
- Whole system commissioning is not in place, so the efficiency of primary and secondary care capacity across the spectrum of need is compromised.

There is ample evidence of positive practice happening across other specialties – namely AMH, OPMH and Forensic and Rehabilitation Services. Third sector provision is fundamental to community connection and resilience. Frontline staff have delivered local improvements for service users, in very challenging circumstances, adopting and adapting learning from elsewhere. There have also been successes in securing extra funding via specific national investment pots, thanks to the persistence of senior Clinical Psychologists who take every opportunity to make the case. However, these improvements lack strategic oversight and commitment over the longer term, so their impact is not scaled. They proceed without a clear and mutually-agreed overarching plan. They rely too often on individual effort, goodwill and determination to combat the lack of infrastructure and other constraints. This also risks disengagement of staff whose local initiative isn't seen to be matched with more senior commitment. The potential of the effort being made is not fully realised.

The voice of the service user is not proactively or routinely available to or heard within service delivery. There is consistent involvement through Caniad in initiative-based project work with strategic leads, and also in specific peer roles in SMS. Caniad facilitated a valuable exercise to contribute to this review. There is longstanding service user participation in the PTMC. We are not in a position to comment on the effectiveness of these arrangements. However, when looking at the day-to-day operational business of services, we didn't find embedded examples of people with lived experience working as part of the interdisciplinary team. We didn't find a consistent approach to gathering and understanding diverse patient experiences. Staff talked genuinely about the importance of high

quality care for service users, but didn't seem to perceive them as potential partners in service planning and delivery, or more broadly, to recognise the value of lived experience in the development of effective services. When we asked at the workshops if one of the recommendations from this review should relate to advancing co-production in services, just one person agreed. It is our view that this is a key area to build upon and bring into the core of frontline delivery and improvement.

Equality of access is compromised as a result of lack of strategic planning, commissioning and delivery. The map of service provision varies widely. An individual's access to specific therapies is determined by the skills set of the clinician s/he happens to see, which may or may not coincide with his/her needs. There is a reliance on CBT. Opportunities for planning across teams and areas (e.g. to create a critical mass of expertise in DBT) do not appear to have been taken. The same is true for other aspects of access, such as language or other communication needs. There is no standard operating approach across teams of the same nature (e.g. CMHTs). This is the postcode lottery writ large.

The value and contribution of psychological approaches to a coherent core offer are not defined, recognised, resourced or embedded within the Division's culture or vision, despite a commitment to an attachment-informed approach. There is some way to go before the commitment translates into a workable centralising concept for culture, service development and delivery, which is inclusive of diverse professions and perspectives, including those of the service user. Resources are inadequate to make a multidisciplinary psychological offer a reality, and those that are available are not aligned for this outcome. This 'say/do gap' impacts on staff morale and engagement, conflict potential, strategic and operational improvement opportunities, and ultimately, better quality care. Strong views were expressed through our area-based workshops that staff across professions feel detached from their leaders, and lack confidence that the best decisions for improved care will be made. Reference was made to the long term impact of 'Special Measures' status on the willingness of the organisation to take positive risks in order to innovate and move forward. Terms used to describe what is needed to bridge the gap included 'radical acceptance' (used in DBT) and 'truth and reconciliation'. Staff can't be expected to practise in psychologically-informed ways without experiencing the same ethos as employees.

The potential for clinical psychology expertise to contribute to service transformation across the entire organisation is under-utilised. Clinical Psychologists are amongst the most highly trained professionals within the NHS, bringing specific skills and understanding that have the potential to enrich service responses at a strategic level as well as a clinical one. The under-investment in this part of the multidisciplinary workforce means the organisation is missing

opportunities to leverage that expertise towards some of its most 'wicked' problems – such as responding to the most complex, high risk and costly needs within the patient population; building resilience across communities to reduce demand on specialist services; and supporting the workforce as a whole to cope with the emotional demands that their work places upon them. This potential is untapped not because it doesn't exist, but because there is insufficient capacity, and some believe insufficient support, to make it happen. Building a bridge between a strategy for psychological therapies and the overarching strategic objectives of the organisation is fundamental to the stated ambition for psychologically-informed care for all.

The conditions for high quality interdisciplinary working are variable across the services. Some specialties are clear about their shared team goals, the interdependence of their roles, and have opportunity for reflection as a team. There are large parts of services where this is not the case, and it is here that conflict is most apparent. The narrative in Chapter Four draws out the themes in our findings on interdisciplinary working, while the evidence base presented there offers clarity as to a way forward.

The Division is a group of distinct geographical areas and specialties, with different cultures, values, history, ways of working, that has been assembled with organisational needs in mind. Its existence as a single entity is of limited relevance to each of its component parts, whose first loyalty is elsewhere. We met many values-driven individuals, but we did not hear people talk about *shared* values. There is an inherent tension between Divisional and place-based solutions, and one which some areas feel strongly has not been managed sensitively or fairly. There was a powerful pushback in some quarters to the notion of a standardised approach to ways of working, based upon the stepped care model. When we explored this, it became apparent that it was not an aversion to tackling the postcode lottery, reducing unwarranted variation or improving sustainability. Instead, it was a fear that a top-down solution would be imposed, that lacked the sophistication to respond to local circumstances and needs, and would favour some parties or areas over others.

Compliance with the performance metrics of Mental Health Measure (or related targets) is the organising principle for service delivery. The core offer hangs around this requirement. Disjointed system resources are not 'right sized' or joined up, so demand and capacity do not match. This results in waste, waits, and failure demand. This is most evident in AMH. The organisation's primary operational focus is on the ability to meet 'front door' assessment targets. Accessing rapid assessment is an important quality indicator, and so this is not, in itself, a bad thing. However, the consistent account from frontline clinicians is that capacity for intervention is diverted towards assessment. There are several factors at play here:

- Capacity that is located 'upstream' of the single point of access is inadequate to respond to the demand placed upon it, so the volume and type of assessment is greater than the services can manage, without compromising intervention. While the data to back up this conclusion is not captured, it was the overwhelming anecdotal feedback from the wide range of people we spoke with.
- Capacity that is located 'upstream' of the specialist psychological therapies services is not psychologically oriented, and so early opportunities to support self management through low intensity interventions are lost. This leaves psychological needs unaddressed and exacerbated over prolonged periods of time, and risks raising expectations that when specialist treatment is eventually made available, it is some kind of magic answer.
- Capacity across the whole system is managed in silos. This results in the system generating its own demand (known as 'failure demand'). The requirements for timely, effective and high quality stepped care, as specified in the Measure, are not met. Capacity is wasted through duplication, lack of shared information, decision making, care planning, co-ordination and strategic planning.
- Lack of timely access is likely to increase the extent of need (and therefore cost) as people become chronically unwell. This has knock-on consequences across other aspects of life, such as employment, housing, and relationships, which may necessitate the use of other public and community services.
- Staffing levels in psychological therapies are inadequate to respond to the needs in the system as it is currently designed. It is neither realistic nor desirable to simply do more of the same. Those specialties which have focussed on building psychological capability across the professions are better equipped to address this challenge (CAMHS, SMS and LD).
- The lack of direction from the organisation to its services as to how these resource constraints should be managed, coupled with a lack of confidence that the organisation understands the realities of frontline delivery or the specifics of psychological interventions, leaves many staff working unsupported in challenging circumstances, which push them to the edges of their values base. This has a knock-on effect upon staff engagement, and thus quality.
- The scrutiny of national targets for an organisation in Special Measures is particularly rigorous.

In short, the demand being placed upon services is a function of both population need **and** system design. The capacity to respond is inadequate, resulting in long waits for help. In turn, this creates more demand, as people become more unwell. It is a vicious cycle that causes system harm to individuals, staff and the organisation. The introduction of the new 26 week waiting time target for AMH

psychological therapies presents an additional challenge. It is our view that a sustainable solution to delivery will necessitate a significant redesign of the current system. Right sizing the system will require a two-pronged approach in some areas, particularly Wrexham AMH – one to tackle the legacy of excessive waiting times (non-recurrent), and another to design a pathway that can cope with today's work (recurrent). We cannot see a cost neutral solution to this problem, but nor should it be simply investing in more of the same.

Stepped care is reliant on a range of factors to work effectively. The existence of services that map loosely onto each of those steps is not sufficient, as is recognised in the Measure. It requires interaction between steps to match demand to capacity and skills, shared working methods, easy information flow, training and supervision across and between the tiers. It requires specialist staff to build capacity and capability across the system and workforce, rather than focus entirely on the delivery of one-to-one interventions. The design must not include perverse incentives that lead to barriers and bottlenecks at thresholds. Every clinician must be equipped with a toolkit of psychological skills, appropriate to their role. These elements are more apparent in CAMHS, SMS and LD, but in AMH, tiers of stepped care are fragmented and there are large gaps between tiers. There is no single integrated care pathway for psychological therapies. There is a sense of services being and feeling overwhelmed with demand, struggling in a system which is not designed to enable a psychological approach.

Commissioning of non-BCUHB services appears piecemeal and unco-ordinated. This applies to substantive arrangements within Tier 0/1, commissioning of out of area secure care (recognising this is part of an all-Wales arrangement), and ad-hoc individual commissioning for 'overspill' specialist therapy capacity. Contract monitoring arrangements of third sector provision seem transactional, and don't appear to have addressed a wide range of issues flagged by the providers over a long period (e.g. service thresholds; activity levels; mutual untapped opportunities). Additional services have been bolted onto or fitted into gaps in some areas over time (e.g. Active Monitoring), as a reaction to system under-performance rather than a strategic solution to it. This is not to say that individual services are not doing what has been asked of them; rather that the system is not designed, managed or incentivised to work as a whole.

Strategic workforce planning and development for psychological therapies across the Health Board, in service of an overall vision, are not happening. Given the lack of clarity as to population need, existing workforce profile and organisational ask, this is not surprising. Some specialties are achieving some degree of strategic planning, but are limited in their scope of influence, and miss out on opportunities to be part of something bigger. Similarly so where funding bids have been made, they are broadly aligned to areas of need, but not

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specifically aligned to a whole system strategy. Within the non-BCUHB provision, there doesn't appear to be any dialogue as to workforce needs, risks or potential.

Career pathways for Clinical Psychologists in most specialties are hampered by flat skill mixes and small numbers of posts. Band 7 entry level posts are not widely available. For other core professions, there isn't a clear route towards accreditation in psychological therapy. Progress to date appears to be driven mainly by individual interest and opportunity. Many of those who have trained expressed a lack of clarity as to their role, a lack of fit in the wider team, and in some cases, disillusionment as to how roles had evolved over the years, with more focus on assessment, and much less on therapeutic intervention.

For the multidisciplinary workforce as a whole, there are both practical and cultural obstacles to developing and practising psychological skills.

Training activity varies between and within specialities, and there are positive examples of initiatives, often in partnership with the university. There was a consistent view that there is insufficient time and funding to support the intention of a psychologically-skilled workforce. Training does not appear to be explicitly aligned to the vision of attachment-based care (in AMH).

Anecdotal evidence supports the view that professional supervision is embedded effectively across psychological therapies, e.g. it is job planned, so time is protected. However, there is no BCUHB supervision framework in place, and no supervision audit was available.

This was another of the most popular priorities for improvement through the area-based workshops.

The absence of an integrated electronic data management system hinders clinical information sharing, transparency around service use, demand and capacity management, intelligence-ed decision making, workforce planning, governance, assurance and improvement. This has a knock-on impact on the extent to which the culture of services is data-oriented. A core and dynamic management function in any service is to align resources in such a way that enables delivery of that service's agreed goals and priorities, to make adjustments as needed, and to be clear about residual risks. This requires reliable and easily accessible information about the impact of management resource decisions upon goals – objective data about service performance, including outcomes, triangulated with a narrative account. *This does not exist*. The consequences for all aspects of service delivery, quality and improvement cannot be overstated. More than that, it erodes trust and allows space for opinions and suppositions to become the prevailing narrative. In some parts of the Division's operation, this is plain to see.

Information systems for staffing and finance data exist, but data quality seems to be an issue. The consistent response to our requests for information was that it would first need to be 'cleaned up' or some explanatory narrative added before it could be released. This data cleansing is generally undertaken by the most senior Clinical Psychologist in the organisation. The absence of reliable real time data, accessible close to the locus of activity, is a significant hindrance to effective and transparent resource management.

Standardised information systems for patient experience seem to be confined to concerns and compliments. When we requested information, it necessitated a manual exercise to compile the information and provide it on a spreadsheet.

Information systems within third sector provision are generally more robust, but are still activity rather than outcome oriented (as determined by their contracts).

We were looking for real time integrated information systems that equip managers with intelligence to make timely and smart decisions about service quality, safety and improvement, and which enable a culture of intelligence-led decision making. What we found was an accumulation of manual workarounds to capture isolated snippets of data for discrete reporting requirements, and a lack of engagement in some quarters to engage in providing service information. The risks associated with this situation are only too clear. A desire to prioritise action in this arena was the single most popular recommendation to come from the area-based workshops. We understand a comprehensive solution is delayed with an all-Wales solution (WCCIS). The question for BCUHB is what might it do in the meantime to move some way forward, in light of fundamental deficits in its service intelligence.

To coin a well-known improvement phrase, every system is perfectly designed to get the results it gets. If you wish to change the results, then you must be prepared to change the system. The following diagram attempts to summarise and simplify the basic options for improving access to psychological therapies. The hard work of individuals buried deep in the system will deliver marginal gains at best, while eroding their intrinsic motivation and discretionary effort. In order to achieve a step change – a psychologically-minded offer across the board – there are some courageous conversations that lie ahead.

OPTIONS TO IMPROVE ACCESS TO PSYCHOLOGICAL THERAPIES

PSYCHOLOGICALLY INFORMED

Every clinician works in ways which are psychologically informed. As such, psychological interventions are integral to the mental health 'offer' and delivered by every clinician at every touchpoint

A biopsychosocial model of mental health is grounded in a psychological understanding of need (e.g. trauma -informed), using formulation, shared care planning, therapy, recovery

Psychological understanding & skills feature in every clinician's toolkit. CPs support the wider workforce to develop & sustain skills to deliver low intensity interventions, & focus their 1-1 work only on complex cases where specialist therapy is required

Clinicians work within agreed pathways of care (e.g. condition specific), using evidence-based psychologically-informed approaches with flexibility for individual needs. Specialists are fully integrated into the MDT, providing a mix of 1-1 work and consultation, formulation, training, supervision & development to the team

Embedding psychological interventions within all services enables better system-wide management of demand & therefore access. It is therapeutically oriented, consistent, impactful, and more affordable

TRADITIONAL

Psychological therapies are a distinct & specialist function, working as a discrete element of a wider mental health service, into which other professionals refer

The prevailing model of mental health remains oriented around assessment, diagnosis, treatment, risk & maintenance

Psychological skills are the sole preserve of Clinical Psychologists and accredited Psychological Therapists

Psychological therapies are accessed via internal referral to PT clinicians, and capacity is managed separately from the MDT. PT clinicians spend most of their time in 1-1 work

Improving access in line with national policy requires very significant investment in PT clinicians, which is unaffordable and unrecruitable. The consequences of operating in this way without the necessary resources include long waits, inconsistent & inequitable care, bias towards containment, not recovery

Psychological Therapies Review in North Wales

Our Recommendations

What you read in this chapter are our thoughts, as reviewers, about what would help to move your improvement ambitions forward. It builds on the conversations we had throughout the process, the ideas you have, and our experience and expertise in this field. We have sought to strike a balance between highlighting the areas we see as essential to progress, with sufficient scope for you to shape the recommendations into clear actions that are tailored to your specific circumstances.

The recommendations do not attempt to address every detail of every service. This is not a finite list. Instead, they are focussed on the issues of greatest strategic significance to the design, delivery and continuous improvement of psychologically-informed care to the people of North Wales. They complement each specialty's 'Specific Key Questions' in Chapter 3.

1. Focus first on engaging staff

Staff engagement trumps all other measures for predicting the quality of organisational outcomes. Bring together a cross-specialty group of people, chosen for their passion and expertise in psychologically-informed care, who represent a diverse cross section of the multidisciplinary workforce. Give them dedicated time, a specific brief, the freedom to act and some independent facilitation. Sponsor the work at Board level. Plan from the outset to embed an appreciative style of collaboration, building upon existing work around strategy implementation. Make the primary goal to build trust. Consider if a reverse mentoring initiative between this group and the Divisional leadership team would be valuable.

2. Co-create a vision for psychologically-informed approaches

Come together as a diverse group of stakeholders to explore why this matters to you. Bring the conversation into the heart of the organisation's narrative. What do you mean by 'psychologically-informed care' across the board – from mental health and learning disabilities to cancer to long term conditions? How can it help you to achieve your BCUHB vision? What needs to change in your system and your culture to make this a reality? Clarify the role and accountability of the Psychological Therapies Management Committee and consider if it is constituted and functioning effectively to deliver against that role. Create safe space to explore the particular inter-professional challenges within the mental health field. Co-produce the vision with your partners as well as people who have recent experience, and set out how the voice of lived experience will be embedded in

service delivery. Consider if there are better ways to work together with the third sector, pooling respective strengths to grow community resilience.

Align it with a vision for the relationship that BCUHB wishes to have with its employees – a psychologically safe, values-driven employer of choice, which enables people to thrive.

3. Design and equip pathways of care that are fit for purpose by:

a. addressing the legacy waits in East Adult Mental Health

Design and resource a specific non-recurrent solution for the backlog, which addresses any outstanding cultural change as well as direct clinical capacity. Simultaneously ensure the service is designed to cope with today's work today, participating fully in the work around stepped care described below.

b. making stepped care a reality

Look across the whole system, both horizontally and vertically, to work towards the right care in the right place at the right time. This can't happen in specialist psychological therapies services alone. It requires better collaboration across team, area and organisational boundaries – a strategic approach. The current fragmented system design means there is insufficient capacity at Tier 1 to intervene early and pull demand away from specialist services. Be willing to redesign tiers or services, and to allocate resources differently, to ensure capacity and expertise is aligned for timely access. Make the links with other sources of feedback, such as the Joint Thematic Review of CMHTs and Delivery Unit reviews. Consider operational improvements such as standard operating procedures, step up and step down protocols, information sharing, joint capacity management, supervision and training across tiers, outcome measurement. This may need to look slightly different in different areas, but tackling *unwarranted* variation in access to and quality of care must be a priority to end the postcode lottery. This is a very big challenge for some specialties, so make effective use of pilot approaches to establish proof of concept through iterative change cycles.

c. tackling inequality of access

Service users experience wide variation in access that is unwarranted. They may be disadvantaged in receiving timely evidence-based interventions as a result of where they live, what co-existing needs they may have, how they communicate, whether they are marginalised. While much of this variation can be explained, much less can be justified. There is a known data deficit here, so the first task is to understand what can be achieved to improve your understanding of the specific issues around unequal access.

d. looking at out of county repatriation potential

Local people are leaving their homes and their roots in order to access specialist care out of county, as a result of gaps in local pathways. There is significant potential for psychologically-oriented solutions to make a transformative contribution to the repatriation of people with complex and long term needs. Clinical Psychologists have a unique skills set to offer to these challenges, but lack of capacity and opportunity are barriers to improvement.

4. Devise a strategic workforce plan and phase its implementation, with clear resource commitments at each stage.

Specialities which have made clear progress in embedding psychological approaches across their services have done so by ensuring that workforce design complements a well-informed service vision and strategy. They pull in the same direction. Capacity building requires specialist time and expertise to be allocated to multidisciplinary training, supervision, team consultation and service development. It also requires multidisciplinary role design to be centred around therapeutic outcomes. It is important that additional investment, which is inevitably needed, is not simply ploughed into doing more of the same, but that it considers the development needs of the multidisciplinary workforce as a whole.

Specific actions might include:

- Gaining a clearer understanding of population need alongside existing workforce and capacity design. What do we need and where?
- Developing a clear career pathway for clinicians who specialise in psychological therapies. This might include development of a more diverse skill mix, cross-speciality opportunities for continued professional development, a leadership development offer for Clinical Psychologists, and opportunities for advanced practice (e.g. specialisation; approved clinician role). This should include practitioners who work within primary care (Tier 1).
- Designing a skills escalator, which describes the psychological toolkit that every clinician will have, from support worker through to consultant psychologist and psychiatrist.
- Reviewing the role design of care co-ordinators, to ensure every clinician has the opportunity to practise in therapeutically oriented ways.
- Designing a workforce training plan that serves the needs of the vision and strategy.
- Ensuring that the conditions for psychologically-informed practice are designed into the workforce and what is asked of it. This includes management practices and behaviours that nurture psychological safety and trust.

5. **Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.**

Specialties that are able to demonstrate clear evidence of psychologically-informed care have created the conditions for effective interdisciplinary working to happen. Where this is not the case, it is vital for it to happen. This is unlikely to be a 'one size fits all' solution, as different teams have different starting points, but a common approach to define what you do to nurture team-based working could make a valuable contribution.

6. **Pay attention to the enablers of change:**
   a. **take urgent action to tackle the gaping intelligence deficits in services**

Recognise the scale of risk that is associated with the current paucity of intelligence-driven decision-making, both in terms of quality, safety and effectiveness, as well as less tangible aspects such as transparency and trust. What can you do while you wait for an all-Wales electronic solution?

   b. **strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee**

The fragmentation apparent in existing arrangements is a significant barrier to progress. The need for more effective multidisciplinary join-up is essential for both quality and culture. This should include clarity as to the leadership of the psychological therapies agenda in the organisation, as well as optimal operational management arrangements to nurture interdisciplinary working.

   c. **make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid 'big bangs' and initiative overload**

Organisations that have a consistent approach to continuous quality improvement are able to accelerate progress, by building capacity and capability for improvement into daily work. The change agenda facing NHS services across the UK calls for a co-ordinated and tactical approach that focusses effort where it is most needed, in ways which appeal to the intrinsic motivation of staff to improve care. We strongly urge you to consider how your wide-ranging strategic implementation programme might embrace quality improvement methodology at its heart.

Roles and responsibilities

We strongly urge the Health Board to see the ambition for psychologically-informed care as an organisation-wide responsibility, sponsored and enabled by the Board. While the specialist expertise is held primarily within all-age mental health and learning disabilities services, the potential gains for all patients as well as employees is tremendous. It is not realistic to look to the specialist resource to meet this need. It is not possible to improve access to high quality psychological interventions by ringfencing improvement work in the specialist services. It needs everyone to play their part, and to create the conditions for success.

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Glossary of Terms

Therapies

ACT	Acceptance and commitment therapy
CAT	Cognitive analytic therapy
CBT	Cognitive behavioural therapy
CBTp	Cognitive behavioural therapy for psychosis
cCBT	Computerised cognitive behavioural therapy
DBT	Dialectical behavioural therapy
EMDR	Eye movement desensitisation and reprocessing
ERP	Exposure response prevention therapy
MBCT	Mindfulness-based cognitive therapy
MI	Motivational interviewing
IPT	Interpersonal therapy
TF-CBT	Trauma-focused cognitive behavioural therapy

Outcome Measurement Tools

C-GAS	Children's Global Assessment Scale
GBOs	Goal Based Outcomes
ESQ	Experience of Service Questionnaire
MFQ	Mood and Feelings Questionnaire
PHQ9	Patient Health Questionnaire (depression)
CORE10	Clinical Outcomes in Routine Evaluation (ten items)
GAD7	Generalised Anxiety Disorder Assessment
BSL23	Borderline Symptom List 23
BAI/BDI II	Beck Anxiety Inventory/Beck Depression Inventory II
HADS	Hospital Anxiety and Depression Scale
GDS	Geriatric Depression Scale
AUDIT	Alcohol Use Disorders Identification Test
PTOS	Psychological Therapies Outcome Scale
HCR-20 (risk tool)	Historical, Clinical, Risk Management-20

Psychological Therapies Review in North Wales

Reviewers' Biographies

Anna Lewis (Lead Consultant) helps Board leaders, senior managers and frontline teams to discover new ways of tackling complex organisational problems in sustainable, inclusive and human ways, primarily in the healthcare and third sectors. She draws on a wide range of expertise, from executive coaching, team-based working and asset-based approaches to quality improvement methodologies. She works regularly with the National Collaborating Centre for Mental Health (RCPsych). With 20 years' experience delivering and redesigning NHS mental health and social care services in senior leadership roles, she understands the realities of the work at both operational and strategic levels. She believes the people she works with have the answers they are looking for – her role is to call them forward.

In addition to her consultancy and coaching work, Anna is also a Trustee with Tempo Time Credits and an Independent Board Member with Hywel Dda UHB.

Dr Alison Beck has worked in the NHS for nearly 30 years, and is currently employed as Director of Psychology and Psychotherapy for South London and the Maudsley Hospital NHS Foundation Trust. She is a Consultant Clinical and Forensic Psychologist and a Systemic Psychotherapist. She has a particular interest in organisational development and compassionate leadership. She has completed the Kings Fund Top Manager Programme and the NHS Leadership Academy Nye Bevan Programme. She works regular with other agencies in health and social care. Within her NHS work, Al has been involved in numerous transformation programmes, as a manager, a consultant and an employee. She consistently finds strength and value in working closely with her colleagues to appreciate what works well and to form the fundamental relationships necessary for lasting success.

As a clinician, Al has specialised in the development of staff support services and in the treatment of people who have experienced trauma and their families. She seeks to build alliances and to work with people to harness their resilience and their capabilities to solve wicked healthcare problems. She contributes actively to London-based academic teaching programmes and she has published over 40 articles in peer reviewed journals.

Dr Amanda Clark has worked as a clinical psychologist as a practitioner, leader and transformation facilitator over the last 25 years, often working in partnership with service directors to support programmes of change. Amanda's most recent NHS post was heading up the People Development Team, applying her clinical skills in a more systemic context, contributing a psychologically-informed approach to developing staff and working practices across the organisation. Since leaving the NHS, Amanda has completed training in team coaching and worked with colleagues to develop an organisational development skills programme for health care staff (mostly clinicians) which was nominated for a national award. She has continued to work with teams across all levels of organisations, helping them to find effective and sustainable ways to improve their practice, drawing on her range of clinical, workplace mediation, coaching and organisational development skills.

![GIG CYMRU NHS WALES logo]	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements	

BCUHB
Psychological Therapies Review - Programme Board

TERMS OF REFERENCE AND MEMBERSHIP OF PROGRAMME GROUPS

INTRODUCTION

Programme Board

The Programme Board is responsible for implementation, monitoring and providing assurance of the delivery of the key recommendations within the Psychological Therapies Review (2019). This is a key decision-making group responsible for ensuring the delivery of the agreed outcomes within the Programme timescales. Additional members may be co-opted on a permanent or temporary basis subject to discussion and approval by the Chair.

The Programme Board will:
- Approve the key documents for the Programme:
    - Terms of Reference and membership
    - Governance Framework & Programme Brief
    - Programme plan / programme of work
    - Communications plan
    - Programme Risk and Issues Log
    - Quality criteria and control mechanisms for the delivery of the Programme
    - Health Impact Assessment
    - Equality Impact Assessment
- Receive and approve updates on the work of the individual work streams at every Programme Board meeting and will monitor the Programme plan.
- Ensure that the Programme takes full account of national, regional and local policy drivers and documents.
- Take ownership of the risk and issues log for the Programme that this is reviewed at every Programme Board Meeting, and ensure that mitigating actions are in place where necessary to ensure delivery of the Programme.
- As the Programme's 'voice' to the outside world the Programme Board is responsible for any publicity or other dissemination of information about the Programme. It will approve a communications strategy and information briefings that will be issued after every Programme Board for staff and stakeholders via the Communications Lead.
- To ensure that the emerging work of the individual Programme work streams is co-ordinated and complementary.
- Updating of the Risk and Issues Log.
- Ensuring that all work is identified and any issues/concerns are escalated to the Health Board QSG / QSE
- Ensuring that satisfactory communication mechanisms exist between all elements of the Programme.

- Establishing procedures to monitor time, quality and cost.
- Co-ordinating and production of papers.
- Undertaking and review of Health Impact and Equality Impact Assessments

Meetings will be deemed quorate when the Chair or Vice Chair of the Programme Board is present and at least a third of the membership of the Programme Board. If the Chair or Vice Chair is unavailable to attend the Programme Board they have the authority to delegate responsibility to one of the senior board members for that meeting.

The Programme Board will meet on a bi-monthly basis and all meetings will be minuted, with minutes issued within five working days of each Programme Board meeting. Action points from each meeting will be circulated within five working days after each Programme Board meeting. Agendas and papers for Programme Board meetings will be issued no later than one week prior to each Programme Board meeting.

Programme Work Streams

Programme work streams will be developed and undertake work for each stage as directed by the Programme Board.

The revised Programme work streams shall be:
1. Working Differently
2. Psychological Safety in Workplace
3. Families Across the Lifespan
4. Pathways – Co-occurring
5. Pathways - Adult

The Programme Board will act as a conduit for all project workstreams to consider cross-cutting themes that may require additional projects to be established.

Other work streams and task and finish groups will be established as the Programme progresses.

The core membership of each Programme work stream will be agreed by the Programme Lead and the Chair of each workstream as it is established.

Membership of the work streams may be further extended on a temporary or permanent basis with the agreement of the respective chair.

The Programme work streams will meet as often as necessary to complete their work within the timescales set in the Programme plan. Minutes of all Programme work stream meetings will be produced. Each workstream will complete a written report on progress made to the Programme Board.

Communications Lead

The Communications Lead will have the specific responsibility for ensuring that there is an open, transparent and two way communication system is in place between stakeholders and those directly involved in the Programme.

In particular, the Communications Lead will:

- Promote, support and develop the Programme through the proactive communication of key messages as the Programme progresses, using a variety of communication methods.
- Ensure that all external briefing papers and information sheets are produced bilingually and in appropriate formats.
- Prepare press releases regarding progress with the Programme if required
- Identify a point of contact for stakeholders to raise questions or concerns as the Programme develops and in this way seek to 'rumour bust'.
- Advise the Programme Board of any concerns regarding communications and of corrective actions that may need to be taken.
- Establish and maintain an effective communications log.
- Identify and ensure ongoing links with critical areas.
- Co-ordinate any Stakeholder events

GOVERNANCE ARRANGEMENTS

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                        │        QSE Committee         │
                        └─────────────────────────────┘
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│   T4MHPB     │────────│   Psychological Therapies    │────────│  Local Psychological │
│              │        │      Programme Board         │        │  Therapies Management│
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                        │   Psychological Therapies    │
                        │         Workstreams          │
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SUMMARY

It has outlined the terms of reference and membership for the Programme Board these being founded on the principle of inclusion and transparent partnership working with key stakeholders.

The governance framework will be further underpinned by a Programme risk and issues register and communications strategy.

PROGRAMME BOARD
MEMBERSHIP

Member	Capacity & Position
Marian Jones	Chair / Special Advisor to BCUHB
Lesley Singleton	Director of Partnerships
Dr Dawn Henderson	Director of Clinical Psychology & Psychological Services (Interim)
Dr Alberto Salmoiraghi	Medical Director
Steve Forsyth	Director of Nursing & Operational Delivery
Carole Evanson	Head of Operations
Sara Hammond-Rowley	Consultant Clinical Psychologist
Lee Hogan	Consultant Clinical Psychologist
David Oakley	Psychologist
Alan Dowey	Clinical Psychologist
Llinos Edwards	Service Improvement Programme Manager
Patrick Roberts	Communications Lead
Nicola Stubbins	Director of Social Care (Denbighshire)
Sue Green / Peter Bonam	WOD Lead
Joanna Garrigan	Finance Lead
Tom Regan	Head of Nursing
Marilyn Wells	Regional CAMHS Clinical Lead
Rob Callow	Head of Engagement
Adrian Thomas / Gareth Evans	Therapies
Faith Kay	Secretary & Lead Programme Administrator

Signed:………………………………………… (Chair)

Date:…………………………………………..

Board/Committee report template

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Thematic Review of Suicides
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Lesley Singleton Interim MHLD Director/Director of Partnerships Alberto Salmoiraghi Medical Director Mental Health & Learning Disabilities Steve Forsyth Director of Nursing and Operations, Mental Health & Learning Disabilities
Awdur yr Adroddiad Report Author:	Francine Moore, Risk and Governance Lead Mental Health & Learning Disabilities
Craffu blaenorol: Prior Scrutiny:	Reviewed by the Interim MHLD Director
Atodiadau Appendices:	*N/A*

Argymhelliad / Recommendation:
The Quality Safety & Experience Committee is asked to note this report which provides additional data relating to deaths in the West locality and to note the work being undertaken to implement learning from deaths.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)					
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	☞	Ar gyfer sicrwydd For Assurance	Er gwybodaeth For Information

Sefyllfa / Situation:
Executive summary The Mental Health and Learning Disabilities Division (MHLD) within Betsi Cadwaladr University Health Board (BCUHB) have conducted a thematic review of all deaths by suicide of people within 2018 as concluded by HM Coroner. This was shared with the wider BCUHB Organisation in January 2020. The death by suicide rate was reviewed against local data provided by Public Health Wales and Public Health England definitions of Types of Suicide clusters and the Division has concluded there has been not been a cluster of suicides in the West locality with figures provided by Public Health Wales supporting that conclusion. The information within this report identifies an increase in the number of unexpected deaths in 2019 however the Division is able to demonstrate that each death has been robustly reviewed through mortality review or the serious incident review process with learning, recommendations and actions captured. No avoidable harm has been identified.

Cefndir / Background:
This report is a follow up report to the thematic review on suicides presented in the QSE report January 2020.

Asesiad / Assessment & Analysis
The Division has been asked how expected and unexpected deaths are managed in the West Locality and how the learning from deaths is disseminated. The diagram below identifies how notifications of deaths are managed according to whether they are expected or unexpected, which determines the type of investigation required. Expected deaths are presented for Mortality Review, Stage 1 or Stage 2. Unexpected deaths are reportable to Welsh Government (WG) and investigated via Putting Things Right (PTR). Some unexpected deaths are subject to an HM Coroner Inquest and these are reportable to WG by the Division unless the deceased person has not been under the care of the Division within the last 12-month period preceding death.

Deaths Reported to the West Area MHLD

Unexpected 36 — Expected 8

WG SUI 36 — MRG Stage 1 8 — MRG Stage 2 6

Inquest 9 — Inquest 0

Inquest Outcome Suicide 3
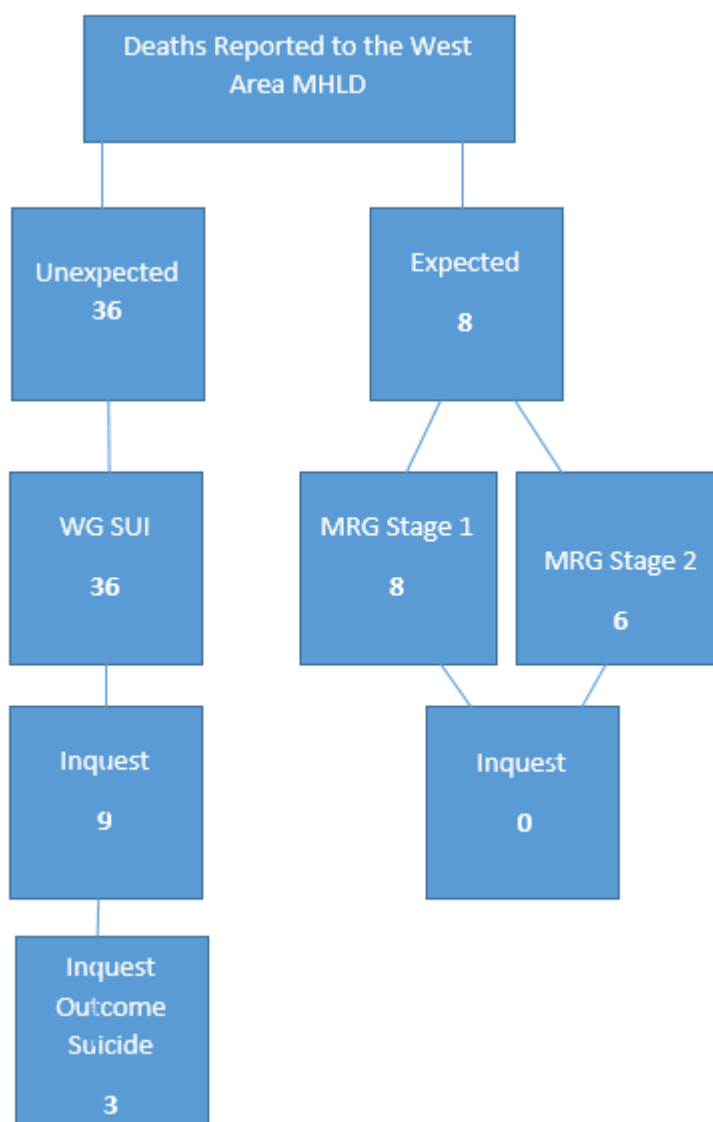
Within the West area 44 deaths were reported in total in 2019. All notifications of death are discussed at Local Putting Things Right (PTR) Meetings, where it is identified if the death was expected or unexpected. These deaths include Mental Health (MH), Learning Disability (LD) and Substance Misuse Service (SMS).

Comparative data for 2018 and 2019 has been provided in the table below and identifies an increase in the number of unexpected deaths for the year 2019. Whilst an increase is noted for 2019 this report will demonstrate that each death has been robustly reviewed via the Divisions Mortality Review Process or via the Serious Incident Investigation Process. The report will also demonstrate that despite an increase in unexpected deaths the number of HM Coroner confirmed suicides has decreased in 2019.

Number of Unexpected Deaths Reported to WG

	Deaths reported to WG 2018	Deaths reported to WG 2019
Value	29	37
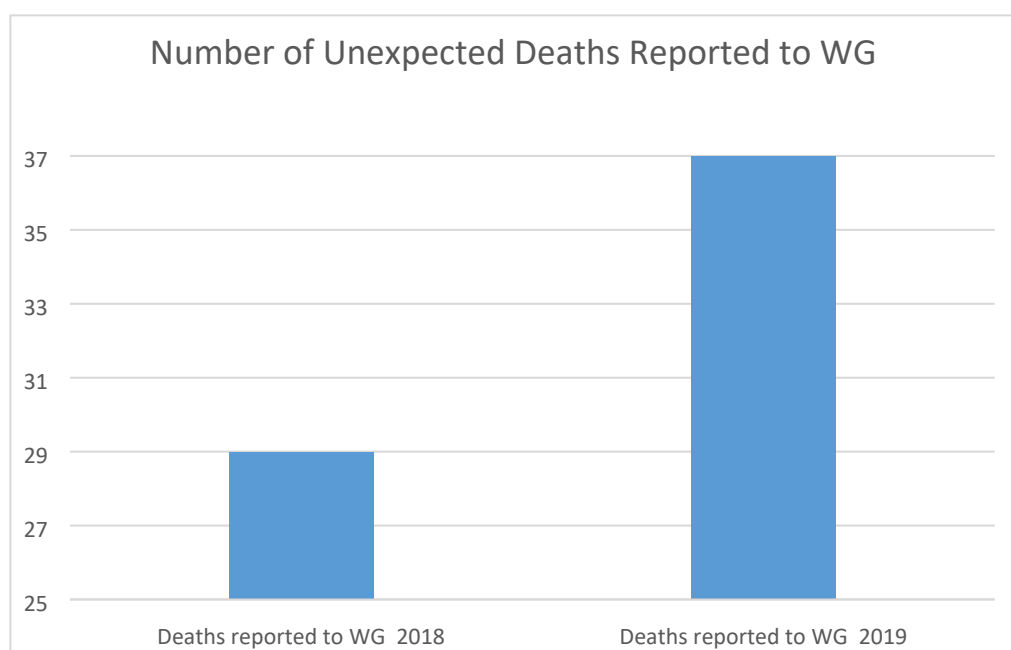
The following flow chart identifies how the Division identifies if deaths are expected or unexpected and the criteria for determining the type of investigation required.

Mortality Review Process – Mental Health Only

Stage 1 and 2 Review

Notification of Death via: Coroner, DGH, MH/LD Team, Medical Examiner, Family - reported via Datix

Divisional Risk and Governance Team alerted via Datix - Q&S Lead informs locality SMT

Locality SMT review notification to identify if WG Reportable SUI and report to WG if appropriate and investigate according to PTR Guidelines

Deaths not reportable to WG discussed in weekly local TWC - Those for Mortality Review shared with the locality CD for Stage 1 Mortality Review

Stage 1 Mortality Review (within 7 days of notification of death)

Locality Clinical Director completes Stage 1 Review Toolkit and shares with the Mortlaity Review Coordinator for collation - themes/trends/issues/good practice recorded within toolkik

OR

Locality Clinical Director identifes the death required a stage 2 Mortality Review and informs the Mortality Review Coordinator

Stage 2 Mortality Review (within 6 weeks of Notification of Death)

Stage 2 mortality review undertaken by the MH mortality review group chaired by the Divisional Medical Director themes/trends/issues/good practice recorded within toolkit

Collation of Stage 2 Mortality Data

completed stage 2 toolkit sent to Mortality Coordinator for collation and record of issues/learning

Analysis and Report

Written Bi-monthly Chairs Assurance Report to QSEEL outlining mortality activity and analysis for Stage 1 and Stage 2 Mortality Reviews

During 2019 the West Area was notified of 44 deaths of patients in receipt of MH, LD or SMS services within the 12 months preceding their death. The table below identifies the number of expected and unexpected deaths for the West Area in 2019.

Total Number of Notifications of Death 2019 - West
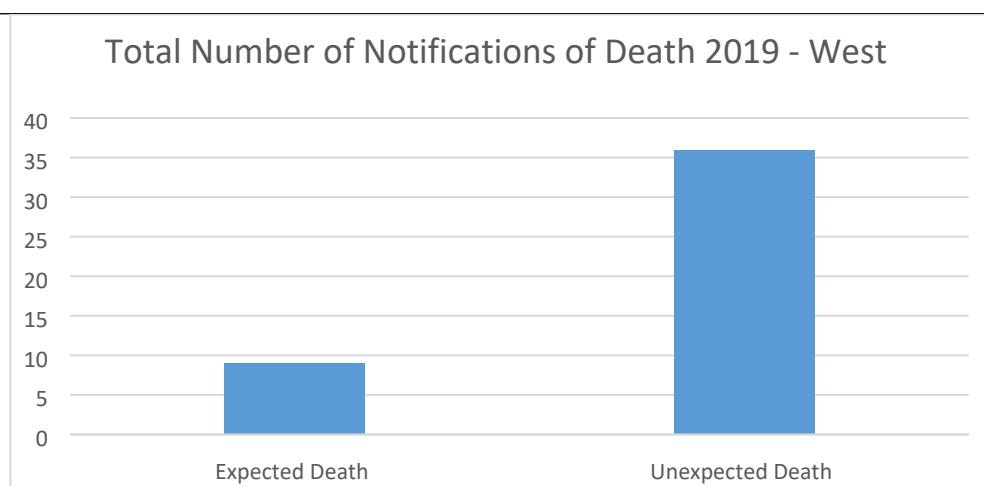
Type of Review

Of the 44 deaths reported to the Division in 2019, the West Area referred 8 expected deaths to Mortality Review Group (MRG) Stage 1 and 36 unexpected deaths were reported to WG as serious incidents requiring review. Of the 36 reported to WG 9 of these were also subject to inquest by HM Coroner.

Referred to Mortality Review/WG Serious Incident 2019 West
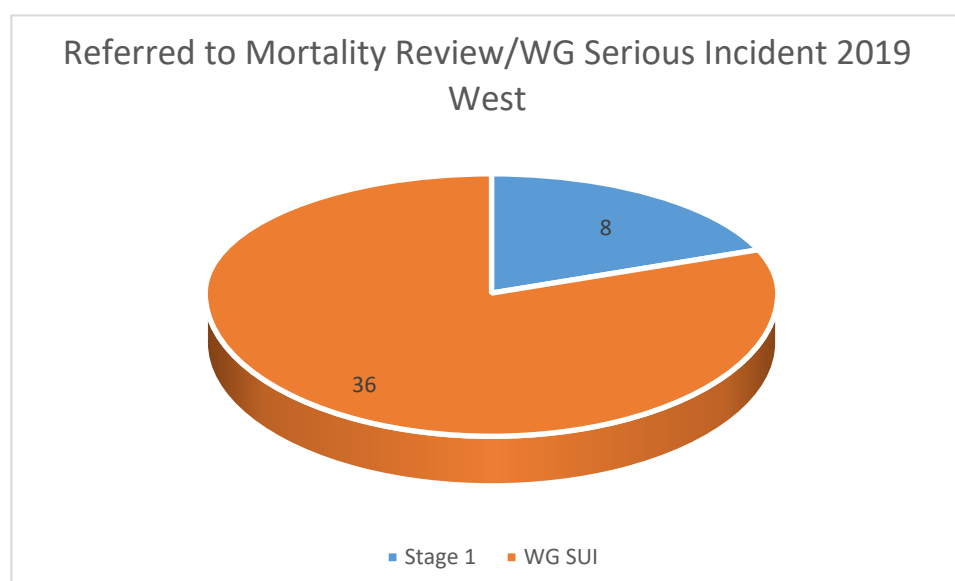
8 deaths were reviewed using the 2-stage mortality review process used by the MHLD Division.

West Mortality Review Data 2019
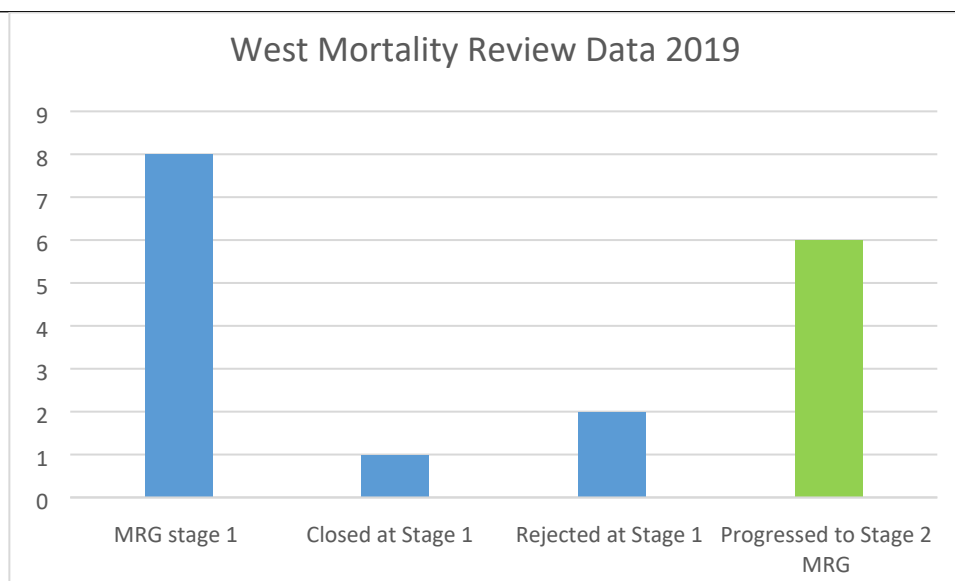
- One Stage 1 Mortality Review was closed with no learning or further investigation required.
- Two were rejected at Stage 1
    - Patient not open to the team
    - Reported to WG and being investigated as a Serious Incident (duplication)
- Six Stage 1's progressed to MRG Stage 2. Each of the six related to patients receiving learning disability services.

The stage 2 MRG identified evidence of good inter-agency care of patients on the palliative care pathway with clear assessment of needs and evidence of Best Interests and Capacity documented. More generalised learning centered around evidence of use of Advocacy, access to CHC funding, receipt of psychiatric review and involvement of the Learning Disability Health Liaison.

WG Reported Deaths 2019 West
36 Deaths for the West were reported to WG in 2019, inclusive of MH, LD and SMS. Each of these was investigated according to PTR with the learning feeding into the Divisions Learning Project.

Though the project focuses on the Division as a whole, learning relevant to the West has been provided below, the learning relates to both Care and Service Delivery Problems and Incidental Learning and is not restricted to cases of Suicide and includes learning from all Deaths:

Single Point of Access (SPOA)
There were problems highlighted around teams not adhering to the SPOA process when making referrals and inadequate recording of rational for decision making during SPOA meetings. The Adult Service Manager was tasked with reviewing the SPOA process and providing support to SPOA chairs to make sure that the processes were adhered to and that decisions were formally recorded at each meeting. A further action was given to the manager of the psychiatric liaison service, to remind practitioners that all referrals need to go through the SPOA process and that this must not be bypassed.

Risk assessment
Some of the risk assessments and management plans were not of the expected standard. Team managers were asked to share the outcomes of the reviews with practitioners and support them to reflect on the recommendations. The Wales Applied Risk Research Network (WARRN) trainers were asked to update their training programme to ensure that the subject of asking difficult questions around information sharing to be covered in the training. Additionally, an audit of attendance rates at WARRN training was requested, so that teams with poor compliance can be targeted. Team managers reminded that WARRN training is mandatory for CMHT and Liaison practitioners. A lessons learned bulletin was circulated to remind staff of the importance of considering current and historical presentation which formulating treatment and risk management plans.

Mental Health Measure
There were some problems noted with non-compliance with the Mental Health Measure, to resolve this Mental Health Measure team were asked to update training programme to include a case management approach. Quality of Care & Treatment Plans (CTP) to be discussed during practitioner's monthly supervision, to include an audit of three random clinical files.

Record keeping
Record keeping is a persistent theme in all areas. There was a specific problem relating to Early Intervention Psychosis Team (EIPT) notes being kept separately, this was addressed by the Head of Psychology with an action to arrange for all EIPT care plans and treatment related documents to be kept in the integrated notes and for arrangements to be put in place for this to be audited. Additionally there were more general issues highlighted around poor standard of record keeping, illegible handwriting and unclear content, the team managers have recirculated the good record keeping guidance among all teams.

Co-occurring framework
There were some problems with communication between teams, which was identified to relate to poor understanding of the principles of the co-occurring framework. Mental health and substance misuse teams have been working to embed the principles in their daily practice. An audit has been requested to review compliance with the co-occurring framework.

Safeguarding
It became evident that some staff were not up to date with safeguarding training. An audit of compliance was requested so that any staff who were out of date with this mandatory training could be booked onto training sessions as a matter of urgency.

Acute care inpatient pathway
It was noted that the inpatient pathway is not always consistently adhered to. An action was formulated by the inpatient unit to re-launch the acute care pathway with awareness sessions for key nursing and clinical staff from inpatient, home treatment and community mental health teams.

Waiting lists
There were some problems noted with people waiting for allocation to care coordinator, with insufficient support provided in the interim. Team managers have all been reminded that if they are struggling to allocate care co-ordinators, to escalate the problem. Arrangements also made for duty workers to make minimum monthly contact with anyone on the waiting list, to review and support.
In addition to the themes noted above, there was a problem with delays in sending letters to GP following consultant clinics. This was found to stem from a staffing problem, which had resulted in a backlog of letter, a vacant medical secretary post was filled with a permanent member of staff and this

resolved the issue. There was a problem noted around awareness of the Veteran's service, a practitioner had not been aware that they could re-refer the person they were supporting to the Veteran's service, this has been resolved by recirculating information about the Veteran's service to all teams to raise awareness.

Inquest

There were 9 inquests for the West for deceased persons who were either in receipt of MHLD Services at the time of their death or in receipt of MHLD in the 12-month period preceding death. Of the 9 inquests each death had been reported to WG as a Serious Incident and was investigated according to PTR. The investigation report for each death was shared with the Coroner's Office.

Number of Inquests West 2019

A bar chart titled "Number of Inquests West 2019" with a y-axis ranging from 0 to 10. The bar "Number of Inquests 2019 in Total" reaches 9. The bar "Number Concluded as Suicide" reaches 3.
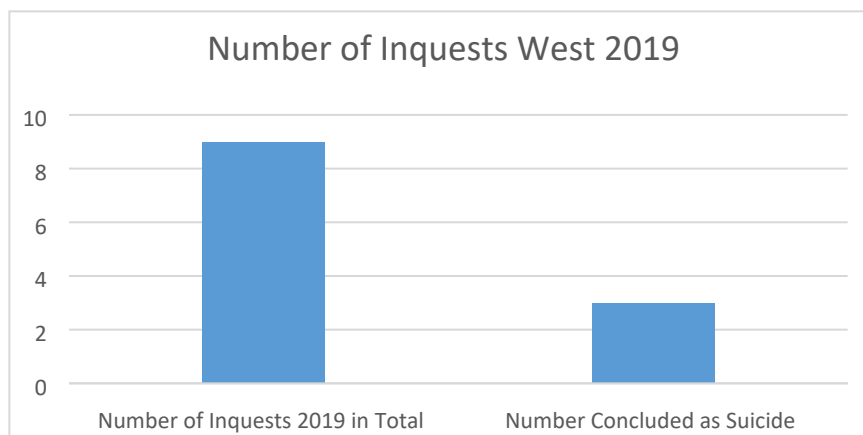
Conclusion

In summary, during the year 2019 the West Locality was notified of 44 deaths of patients in receipt of MHLD services within the 12 months preceding death. This is an increase compared to the year before, but the absolute number remains within an acceptable range for the area. 8 of the deaths were referred for Stage 1 Mortality Review where 2 were rejected and 1 was closed. The remaining 6 progressed to Stage 2 review and the learning is recorded within the report. 36 deaths were reported to WG and investigated according to PTR and 9 of these were also subject to Inquest. Of the 9 presented to Inquest a conclusion of suicide was recorded for 3 deceased patients. No Regulation 28 were issued to the Division.

The West area and the wider Division are able to demonstrate how notifications of both expected and unexpected death are progressed through process and how the outcomes can be identified. Each of the deaths reviewed by either MRG or the serious incident review process has been robustly reviewed resulting in learning for the West area and implementation of recommendations and actions to facilitate improvement. No avoidable harm has been identified.

The Thematic Review of Suicides in 2018 and the analysis of the Public Health Wales review of Gwynedd 2002 - 2017 and the Public Health England definitions of Suicide Clusters have identified that there has not been a historical cluster of suicides in the West area. The draft Learning from Deaths Policy needs to be finalised and shared across the Division.

Recommendations
- The Quality Safety & Experience Committee is asked to note this report which provides additional data relating to deaths in the West locality and to note the work being undertaken to implement learning from deaths

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Primary & Community Care Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Clare Darlington, Assistant Director Primary Care
Craffu blaenorol: Prior Scrutiny:	The development of the report has been progressed as a result of discussions at the North Wales Primary Care Quality & Safety Group and Primary Care Panel, as well as Quality & Safety meetings at an Area level. All such reports will be considered at the North Wales Primary Care Quality & Safety, Primary Care Panel and Area Quality & Safety groups that immediately follow the quarter for which information has been collated.
Atodiadau Appendices:	Appendix 1: Primary Care Q&S Indicators Appendix 2: Inspections Appendix 3: GMS 5 Domains Assessment

Argymhelliad / Recommendation:

It is recommended that the QSE Committee:

- Reviews the core primary care Q&S indicators and assurances, and notes the actions taken;
- Notes the 'Focus on' topics and considers any future related reporting that is required;
- Considers any further 'focus on' topics that the Committee would find useful.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	✔

Sefyllfa / Situation:

The QSE Committee receive specific detail in relation to primary care in March, July and November. In addition exception reports are provided in relation to wider community services.

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

Cefndir / Background:

In line with the request of the QSE Committee, the content of the following paper is as follows:

- Primary Care Q&S Core Indicators and related data in relation to primary care services for 2018/19 and the first 3 quarters 2019/20;
- Primary Care Assurance;
- Primary Care Sustainability;
- A 'Focus On' highlighted topic areas.

In addition, each Area provides a community services monthly report to QSG detailing any issues of significance that have been identified through their divisional quality and safety governance frameworks. QSG review these reports and agree any issues that require escalation to QSE.

Asesiad / Assessment & Analysis

1   Primary Care Q&S Core Indicators
1.1   Incidents Reported

The trend in primary care incident reporting is shown in the table below, with further detail provided in Appendix 1.

Main Incident Classification	Trend in 2019/20	Incident Sub-category	Trend in 2019/20
Access	⇩	Ambulance delays	⇩
		TR patients	⇔
		Pharmacy closures	⇩
Medication	⇧	Prescription errors	⇔
		Dispensing errors	⇧
TOTAL	⇧		

The most notable sub-categories to these include:
- Temporary Pharmacy closures which account for 80% of the incidents relating to Access;
- Preparation of medicines / dispensing in pharmacy, which account for 54% of the incidents relating to Medication;
- Medication error during the prescription process which account for 19% of the incidents relating to Medication.

In response to the incidents reported various actions have been taken, for example:
- Temporary Pharmacy Closures – this has been discussed within Pan North Wales Quality and Safety meetings. A Pharmacy Sustainability tool is being piloted to help map and predict where issues may arise.
- All medication errors are investigated and any lessons learnt shared via the Primary Care 'Stories for Sharing' newsletter to reduce the likelihood of future errors.

1.2   Concerns Reported

The trend in primary care concerns reporting is shown in the table below, with further detail provided in Appendix 1.

The main categories of concern in GP practices in Quarter 3 related to Access, Appointment, Admission, Transfer, Discharge (18), with most of the 'On the Spot' (OTS) complaints relating to access to an appointment (58); almost half of which were in relation to managed practices (noting that independent practices are not required to report concerns to the Health Board).

Concern Type	Trend in 2019/20			
	GP Practice	General Dental Practice	Community Pharmacy	Optician
'On the Spot' (OTS)	⬆	⬆	⬆	⬆
Formal	⬇	⬇	⬇	⬌
TOTAL	⬆	⬇	⬆	⬆
AM/MP Enquiry	⬆	⬇	⬌	⬆

1.3   Contract Breaches

The trend in primary care contract breaches reporting is shown in the table below, with further detail provided in Appendix 1.

Type	Trend in 2019/20	
	GP Practice	General Dental Practice
Remedial Notices	⬌	⬆
Breaches	⬌	⬇
TOTAL	⬌	⬇

In Quarter 3, three GDS contractors were issued remedial notices. The notices related to operation of satisfactory practice quality assurance processes.

1.4   Performance Issues

Between October 2019 - January 2020 the number of suspensions and GMC/GDC concerns notified to the Health Board were as follows:

Area	Suspensions		GMC concerns	GDC concerns	Conditions (DPL)
	GPs	Dentists	GPs	Dentists	Dentists
East	2	0	1	0	1
West	0	1	2	1	4
Central	0	0	1	0	2
Total	**2**	**1**	**4**	**1**	**7**

1.5   Prescribing Indicators

Primary care prescribing continues to make a steady improvement on a number of national safety indicators including antimicrobial stewardship. There is further focused work to be done on others which is included in the work plan for primary care through the local enhanced service for clinical effectiveness 2020/21. The plan for 2020/21 includes:

- A reduction in antimicrobial prescribing and one other national indicator e.g. reduction in inappropriate prescribing of hypnotic medicines which are linked to risk of falls in the elderly;
- Embedding the NICE standards around the care of COPD patients to improve outcomes for patients;
- A focus on frailty and dementia and the need for medication in this vulnerable groups of patients;
- Cost effective prescribing.

Antimicrobial stewardship

For the last three years, antibiotic prescribing has been included within the collaborative work program embedded within the BCUHB Local Enhanced Service. The primary care pharmacy team work jointly with the Consultant Antimicrobial Pharmacist and the antimicrobial pharmacist team to support GP Practices, as well as the acute and community hospitals, and care homes. An enormous amount of work has been carried out within each cluster around reducing antibiotic items. The team provide regular prescribing reports, support review, audit and education. BCUHB have met the 2019/20 target of 5% reduction with a reduction in total antibiotic items adjusted of 5.27% for the quarter ending 30th September 2019 (latest available data).

Work is continuing to reduce the number of prescriptions for four high risk antimicrobial drugs: Quinolone, Co-amoxiclav, Clinamycin and Cephalosporin. The combined prescribing rate was 12.9% for the quarter ending 30th September 2019 (latest available data), a reduction of 20%.

BCUHB performance is ranked 3rd best in Wales.

Efficiency indicator – Proton pump indicator (PPI)

Although PPIs are generally well tolerated, there is emerging evidence that serious adverse effects may be linked with long-term PPI use. Prescribers are encouraged to review and reduce PPI prescribing by lowering the dose or de-prescribing where possible. Over the last five years there has been a significant reduction of prescribing which has been supported by a combined strategy involving primary and secondary care pharmacy teams.

BCUHB remains ranked 3rd best in Wales.

Falls prevention

It is noted that some prescribing may contribute to the problem of physical and psychological dependence, and/or may be responsible for masking underlying depression. There continues to be a focus on the 10% of practices with the highest prescribing rates to improve further. There are 25 practices achieving the target; 39 practices demonstrating improvement and 40 practices demonstrating deterioration in prescribing trend.

1.5   General Dental Services (GDS) Indicators

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

Quality indicators for the last quarter of 2018/19 and first 3 quarters for 2019/20 are set out below:

Quality Indicators	Q4 2018/19		Q1 2019/20		Q2 2019/20		Q3 2019/20	
	LHB	Wales	LHB	Wales	LHB	Wales	LHB	Wales
Radiographs Rate per 100 FP17s *	22.6	20.8	22.8	21.0	22.5	20.6	22.6	21.3
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	43.6	42.9	44.6	45.2	45.8	49.2	49.1	54.4
Extractions Rate per 100 FP17s	5.9	6.0	5.6	6.0	5.9	5.9	5.9	6.1
Re-attending within 3 months – Child	5.6	6.0	5.5	6.0	5.6	6.0	5.9	6.3
Re-attending within 3 months – Adults	12.5	12.9	12.0	12.4	12.3	12.4	12.3	12.6
% satisfied with dentistry received	92.7	92.4	92.9	92.9	92.9	93.1	93.5	92.6
% satisfied with wait for an appointment	87.0	87.2	86.7	87.4	85.1	87.4	86.0	86.8

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

GDS quality indicators for most metrics reported are close to the All Wales average.

To improve performance two levels of increased service provision through GDS have been commissioned, with a focus on improving access.

This is delivering an ongoing 8 scheduled sessions a week, with a mixture of Access and Emergency sessions. These will continue across the innovation funding period (5 years) and to date the sessions are securing high attendance.

In year £100k has been invested to deliver additional activity in Buckley, Denbigh and Dolgellau. This will be delivered until end of March 2020. The take up is being evaluated and used to inform further commissioning moving forward.

2   Primary Care Quality Assurance
2.1   Quality Assurance Visiting Programme

A revised QAVP approach has been developed for GP practices, which utilises information from the Clinical Governance Self Assessment Tool (CGSAT) as a focus and also includes learning from HIW inspections and performance issues. The programme will commence in Q1 2020/21 with a multidisciplinary team visiting each GP practice, including an Area Medical Director representative and Primary Care Lead Nurse.

Exception reports will be developed for future QSE papers.

2.2   Health Inspectorate Wales (HIW) & General Pharmaceutical Council Visits (GPC)
HIW and the GPC liaise directly with independent contractors to undertake their inspections.

The number of visits that have been undertaken are detailed below, with detail provided in Appendix 2.

Contractor	Number of Visits 2018/19	Number of Visits Q1 2019/20	Number of Visits Q2 2019/20	Number of Visits Q3 2019/20
GP Practices	5	1	3	0
General Dental Practices	9	1	3	0

2.3   Lessons Learnt
'Stories for Sharing' is a pan North Wales learning bulletin shared with Primary Care providers. It is issued on a bi-monthly basis bringing together learning from incidents or concerns.

As with any previous lessons or stories shared, information is anonymous and provides reminders about good practice under a number of sections including; medication, communication, patient information, medical emergencies, infection control, building safely and security measures, complaints handling and learning from individual concerns.

3   Primary Care Sustainability
The 5 Domains risk assessment process is now well established within BCUHB as a means of reviewing GMS practice sustainability. It assesses risk across a range of areas, utilising hard objective data as well as "softer" subjective information based on local knowledge of the practices from the Area and Primary Care Contracting Teams.

For each of the 5 domains criteria, a score of between 0 and 5 is allocated with 0 being classed as excellent and 5 indicating significant risk. A score of 2 is utilised as the benchmark for standard performance for all domains, hence the RAG ratings are as follows:

	Score
Red	15 -25
Amber	11-14
Green	0-10

The assessment is conducted on a six-monthly basis. At the July 2019 assessment, 16 out of 104 practices (15%) were assessed at 15 or above/red, and at January 2020 22 (21%) were assessed at this level. This compares to 21 practices (19%) out of 109 when the exercise was conducted in September 2016. Within these figures there have been movements in Area ratings which are detailed in Appendix 3.

4   'Focus On'

4.1   GDS Contract Reform Programme

Further expansion of the programme in October took the number of participating dental practices within BCUHB to twenty.

The aim of the project is to develop and adopt methods of working within the dental practices that move away from a culture of "chasing UDAs"# to a more preventative based one that utilises the whole of the practice clinical team. It is anticipated the programme will eventually deliver:

- actively engaged patients,
- increased patient access,
- more effective use of current (practice) resources,
- a preventative and prudent approach to oral health care, and more opportunities for specialised service provision within the primary care environment

UDA = Units of Dental Activity

4.2   Quality Assurance and Improvement Framework (QAIF) Project – Acute Kidney Injury (AKI)

The mandatory Patient Safety Programme of the QAIF focuses on medicines-related harm.

Health Board pharmacists have identified that the majority of medicines-related admissions are as a result of acute kidney injury (AKI). Thirteen of the fourteen clusters have agreed that they will focus their quality improvement interventions to reducing the harm from medicines that can cause AKI in acute illness. The work is being supported by 'Improvement Cymru' and has been endorsed by a letter from Welsh Government to GMS contractors that has identified AKI as one of three priorities that will be worked on next year.

Appendix 1: Primary Care Q&S Indicators

Incidents in 2018/19, and the three quarters of 2019/20

	Access	Medication	Total
2018/19	412	259	1069
Qtr 1 2019/20	80	64	236
Qtr 2 2019/20	79	70	256
Qtr 3 2019/20	73	81	269
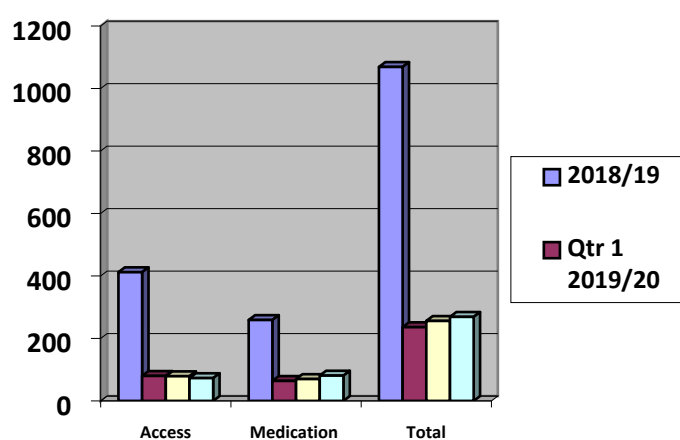
Sub-categories of Incidents:

	Pharmacy Closures	Ambulance delays	TR patients	Dispensing errors	Prescription errors
Qtr1 2019/20	73	4	0	29	15
Qtr 2 2019/20	67	1	0	30	15
2018/19	320	21	16	108	71
Qtr 3 2019/20	58	0	0	44	15
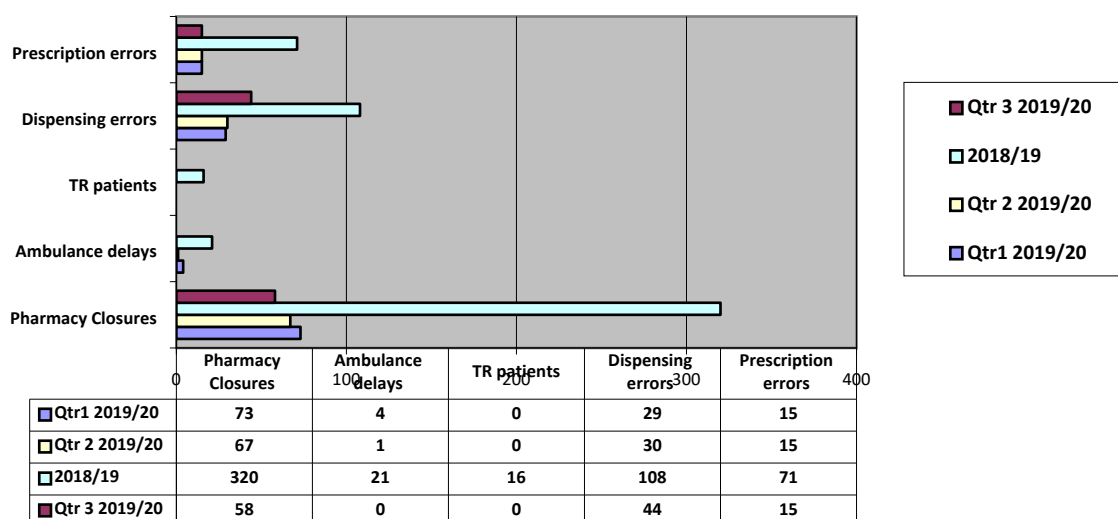
Concerns in 2018/19, and the three quarters of 2019/20

Contractor	Number of 'On the Spot' 2018/2019	Number of Formal Concerns 2018/2019	AM/MP Enquiry 2018/19
GP Practices	446	160	16
General Dental Practices	58	19	1
Community Pharmacies	16	4	0
Optician	3	0	0

Contractor	No. of OTS* Q1 (19/20)	No. of OTS Q2 (19/20)	No. of OTS Q3 (19/20)	No. of Formal Q1 (19/20)	No. of Formal Q2 (19/20)	No. of Formal Q3 (19/20)	AM/MP Enquiry Q1 (19/20)	AM/MP Enquiry Q2 (19/20)	AM/MP Enquiry Q3 (19/20)
GP Practices	107	43	127	50	92	49	2	4	6
General Dental Practices	8	5	12	3	15	1	1	6	0
Community Pharmacies	1	7	10	1	3	2	0	0	0
Optician	0	0	1	0	0	0	0	0	1
Total	116	55	150	54	110	52	3	10	7

GP Practices:
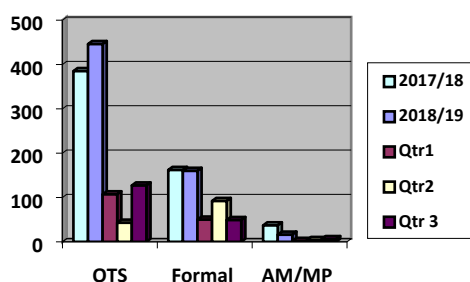
GDS Practices:
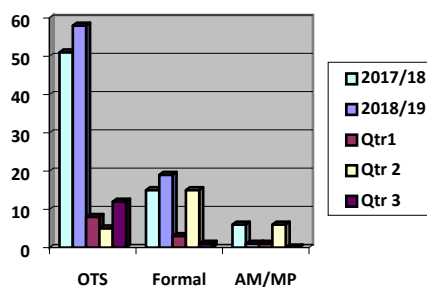
Community Pharmacies:

Opticians
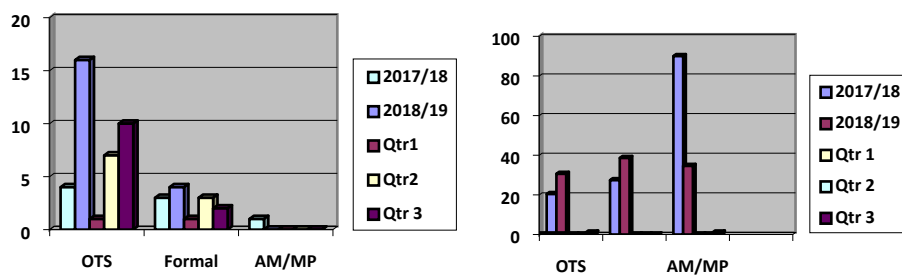
Contract Breaches in 2018/19, and the three quarters of 2019/20

Contractor	Number of Remedial Notices Q1(19/20)	Number of Remedial Notices Q2(19/20)	Number of Remedial Notices Q3(19/20)	Number of Breaches Q1(19/20)	Number of Breaches Q2(19/20)	Number of Breaches Q3(19/20)
GP Practices	0	0	0	0	0	0
General Dental Practices	1	0	3	0	33	0
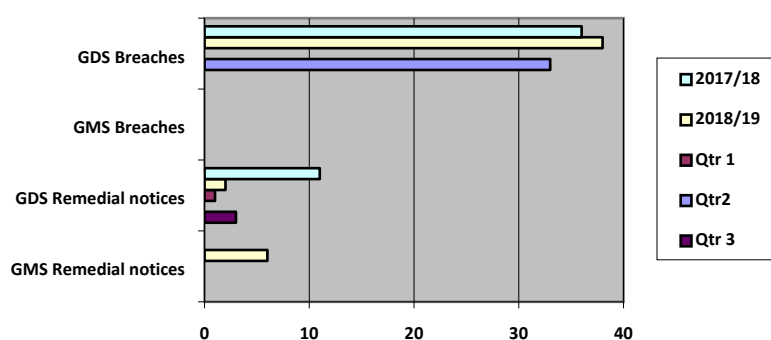
Note: During Q2, 33 GDS contractors were issued contract breach notices relating to under delivery of contract activity by more than 5% during 2018/19.

Details of GP Practices visits and report dates in 2019/20

GP Practice	Date of visit	Date of report
Bradley's Practice, Buckley	26/03/19	27/06/19
The Stables Medical Centre, Hawarden	18/06/19	19/09/19
Bron Derw Medical Centre, Bangor	14/08/19	15/11/2019
Meddygfa Gyffin, Conwy	12/09/19	13/12/2019

Details of Dental Practices visits and report dates 2019/20

Dental Practice	Date of visit	Date of report
The Hollies Dental Practice, Denbigh	19/03/19	20/06/19
Flint Dental Centre	03/06/19	04/09/19
Talking Teeth, Chirk	02/07/19	04/09/19
Signature Smiles, Gwersyllt	24/09/19	30/12/19
My Dentist Mona Road Menai Bridge	01/10/19	20/01/20

Details of Community Pharmacies Visits and report dates 2019

Pharmacy	Date of visit
Boots Prestatyn Shopping park	04/04/2019
Boots Colwyn Bay	15/04/2019
Vale Road Pharmacy Rhyl	23/05/2019
Rowlands Pharmacy, Maelor Pharmacy	28/05/2019
Tesco Holyhead	30/05/2019
Rowlands Pharmacy high street Prestatyn	06/06/2019
Rowlands Pharmacy Overton on Dee	11/06/2019
Rowlands Pharmacy the medical centre Ruabon	11/06/2019
Rowlands Pharmacy the medical centre Ruabon	11/06/2019
Glyn Pharmacy Llangollen	24/06/2019
Fferyllwyr Llyn Llanbedrog	09/07/2019
Rossette Pharmacy Wrexham	23/07/2019
Morrisons Pharmacy Colwyn Bay	27/08/2019
Caerwys	29/08/2019
Rowlands Pharmacy Chirk	02/09/2019
Rowlands Pharmacy Caernarfon	19/09/2019
Rowlands Pharmacy Barmouth	26/09/2019
Lloyds pharmacy Prestatyn	10/10/2019
Rowlands Pharmacy Benllech	21/10/2019
J A Davies CYF Criccieth	18/11/2019
Rowlands Pharmacy Cemaes Bay	29/11/2019
Cohens chemist west end medical Centre	05/12/2019
Greenfields Pharmacy Holywell	09/12/2019
The pharmacy Rhosneigr	11/12/2019
Rowlands High Street Abersoch	12/12/2019
Rowlands Y Maes Pwllheli	16/12/2019
Lloyds Pharmacy Flint	16/12/2019

GMS 5 Domains Assessment

Area	Number of practices	January 2020			July 2019		
		Red	Amber	Green	Red	Amber	Green
West	32	3	15	14	1	18	13
Central	31	6	17	8	4	18	9
East	41	13	21	7	11	19	11
North Wales TOTAL	**104**	**22**	**53**	**29**	**16**	**55**	**33**

Quality Safety & Experience Committee 17.03.2020	GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care

Advisory Group Chair's Report

Name of Advisory Group:	**Quality and Safety Group**

Meeting date:	**18th February 2020**

Name of Chair:	**Gill Harris**

Responsible Director:	**Gill Harris - Executive Director of Nursing and Midwifery**

Summary of key items discussed:	**Nursing Strategy secondary care update – Debra Hickman** The Nursing Framework is aimed at providing structure and clear milestones to both existing and new programs of work within the Health Board that impact the Nursing Agendas within Secondary Care. The Nursing Framework builds on the Nursing Priorities identified from the Corporate Nursing Team as endorsed by the Executive Director for Nursing & Midwifery. Reporting will continue through existing structures within the Health Board with an overarching quarterly summary provided to this group for information and noting, thus allowing triangulation of information received. QSG are asked to note the update against the milestones for information and asked to be included in a governance structure – GH agreed that QSG will oversee the report/ work and receive quarterly updates Group suggested that it needs to include the rest of allied health professionals and that there should be similar for others areas and MH. Further discussion will take place at Seniors. **YGC food safety score – Rod Taylor** RT talked through the recommendations, and identified the breadth of the assessment. The score has changed from a 4 to a 1, for which an action plan has been developed and will be worked through. The review identified issues with control and management systems at ward level for which a system and auditing programme has been put in place. An update will be provided into the March meeting

Key advice / feedback for the QSE:	**Risks to highlight:** • S136 – recent situation where a youth person was evicted from their placement in Wrexham late Friday, this resulted in them being detained under section. Progressing with commissioner for an appropriate placement, this has been highlighted as a risk with the CAMHS service – Executive Director of Nursing will discuss with the Medical Director and feedback to QSE • Psychological review now completed and actions identified, plan being developed and business case being submitted to mitigate issues • Defibrillators – Tender been agreed and going through the process, in the meantime an issue with the model being used on 2 acute and community sites is no longer supported. There has been two failure incidents on testing on this models. **Score – 15 – review.** • Radiotherapy capacity due to staffing levels within the department. This is due to a combination of staff leaving to take up higher banded posts in other Health Boards/Trusts and maternity leave. **– score 16** • Vascular – the discussion focused on the work needed to ensure that the review is concluded in order to be taken to QSE and Board in March. • There has been an increase in still birth numbers from 21 – 28, still slightly under all wales average – all have had an independent review, with a thematic review now taking place. Concerns were raised outside BCU following discussion at the safeguarding Childrens board, for which a report will be produced for a future meeting before going to QSE.
Special Measures Improvement Framework Theme/Expectation addressed	
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	13th March 2020

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Progress Update against the Delivery Unit Recommendations following the All Wales review of Primary Care Child and Adolescent Mental Health Services (CAMHS)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Chris Stockport, Executive Director for Primary & Community Care
Awdur yr Adroddiad **Report Author:**	Alison Cowell, Assistant Area Director, Childrens Services
Craffu blaenorol: **Prior Scrutiny:**	CAMHS Performance Improvement Group Bethan Jones Central Area Director
Atodiadau **Appendices:**	*N/A*

Argymhelliad / Recommendation:

The Committee is asked to note the progress being made and advise of any future assurances required.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	☞

Sefyllfa / Situation:

The Delivery Unit (DU) Assurance and All Wales review of CAMHS 2019 identified five key recommendations that BCUHB should implement:-

1. To review the application of the thresholds developed for its CAMH services paying particular attention to ensuring a genuinely primary care approach within its Primary Care CAMH service (PCAMHS);
2. To ensure the use of comprehensive reporting methods to ensure that the full range of PCAMHS activity undertaken is demonstrated;
3. To devise a strategic approach to ensuring timely access to clinically suitable and age appropriate environments;
4. To ensure that its PCAMH service engages with GPs to ensure a clear and shared understanding of CAMH service thresholds and pathways;
5. To review its Single Point of Access (SPOA) to ensure consistency of approach in all service components and the avoidance of potential duplication.

Cefndir / Background:

- In 2010 Welsh Government (WG) introduced the Wales specific legislation, Mental Health (Wales) Measure (MHW), with the aim of improving accessibility to services. This legislation included the development of Local Primary Mental Health Support Services (LPMHSS), including services to people under the age of 18.

- As a result of Welsh Government concerns about CAMHS nationally, additional revenue investment was made in 2015 to all Health Boards which led to the development of the current service in BCUHB.

- The DU assurance review was commissioned by Welsh Government to analyse the impact these initiatives have had on improving primary care mental health services (Part 1 of the Measure), for people under the age of 18years.

- The review of primary care CAMHS in Betsi Cadwaladr University Health Board took place in April 2019. The formal report was received 2nd August 2019.

- The paper detailing the recommendations and required action plan was reported at the Mental Health Act Committee in September 2019.

- A CAMHS Improvement Group was established in September 2019, to take this and other quality improvement work forward.

Asesiad / Assessment & Analysis

Progress against the Recommendations:

1. **BCUHB should review the application of the thresholds developed for its CAMH services paying particular attention to ensuring a genuinely primary care approach within its PCAMH service.**

The reviewers found that by having one team that provides care under both Part 1 and Part 2 of the MHM, delivering seamless care, may result in there being a blurring between the thresholds with practitioners managing complex care without a Care Co-Ordinator and a Care and Treatment Plan in place.

Within BCUHB there are no system gaps or referral barriers between services under the Primary and Secondary elements of the Mental Health Measure. From a child or young person's perspective they will have continuity of care and often the same practitioner.

2. **BCUHB should ensure the use of comprehensive reporting methods to ensure that the full range of PCAMHS activity undertaken is demonstrated.**

The reviewers found the current all Wales performance monitoring data set did not include the CAMHS early intervention activity and outcomes, resulting in WG and the Board not being sighted

on this provision. The reviewers also found that risks and safeguarding concerns were not always well documented or easy to find in the records.

Agreed Action for recommendations 1 and 2.

    i.   Audit tool to include whether the application of MHM thresholds is clear, adherence to the CAPA (Choice and Partnership Approach) Components Rating Scale, compliance with the CAMHS Operational Procedure and the BCUHB Record Keeping Policy.

    ii.   The work commenced in North Wales on recording outcomes for early intervention to be progressed.

    iii.   Involvement in developing the All Wales Peer Review framework to continue. BCUHB will participate in the reviewing of other Health Boards to increase learning, with peer review of the BCUHB service in 2020.

Progress to date

    i.   The audit tool has been agreed and the audit of health records is being implemented. All reviews are signed and submitted to the responsible manager. This audit will provide the assurance required, so that the thresholds between Primary and Secondary care under the Mental Health Measure are understood in practice and clearly documented.

    ii.   The current IT infrastructure limits the collation of early intervention information. The Welsh Community Care Information System (WCCIS) should help to address this. The service has defined what is required within the activity data set and contributed to this all Wales work. Outcome measures have also been identified. In the meantime some of the activity is collated manually and included in reports, for example, ADTRAC (European funded project with Llandrillo and the Local Authorities), "Friends" project and the SPOA activity. However, this is not the totality of CAMHS early intervention work and currently excludes the work with the schools for example.

    iii.   CAMHS managers and practitioners have contributed to the Peer Review Framework and are participating in the reviews of other Health Boards. The Peer Review for the BCUHB CAMHS will be at the end of May 2020.

3. BCUHB should devise a strategic approach to ensuring timely access to clinically suitable and age appropriate environments

The reviewers reported that some staff raised concerns about the environments that they are able to access, in terms of availability and appropriateness. Some concerns were also raised by staff regarding the tracking and transportation of records between sites.

Agreed Actions:

   i.   The Children's Services operations managers to work with Estates colleagues to address these specific concerns and to develop a longer term estates strategy that gives consideration to the needs of children and young people.
   ii. The Children's service operations managers to review the record keeping, tracking and transportation policy, ensuring adherence.

Progress to Date

   i.   The Area teams are taking forward estates plans to meet their local needs. The specific concerns in the West Area regarding clinic space availability have been addressed.

   ii. The record keeping, tracking and transportation policy has been reviewed with operational changes implemented to improve the current tracking system. A business case for an electronic record tracking system (IFIT) is being progressed specifically for the West Area where there is no electronic system. In the East Area, IFIT is in place and awaiting bar codes and a scanner. In the Centre, IFIT is in place and working effectively. While the electronic systems are fully implemented, manual tracking systems are in place.

> **4. BCUHB should ensure that its PCAMH service engages with GPs to ensure a clear and shared understanding of CAMH service thresholds and pathways.**

The Review included an all Wales stakeholder review, this reported that GPs in North Wales found the service was variable in waiting times and thresholds. The report identified that GPs did not differentiate between CAMHS and the Neuro-Development service where the waits are lengthy.

Agreed Actions:

   i.   The Assistant Area Directors (AADs) for Children Services to work with the AADs for Primary Care and the Cluster Leads to improve communications and awareness of the services.

Progress to Date:

   i.   Clarity regarding the Neuro-development pathway has been provided to the Local Medical Committee (LMC).

   ii. Consultation via the Single Point of Access is taken up and reportedly valued by Primary Care.

       The service is using the opportunity of developing the Wellbeing Cluster project to ensure that Primary Care have a good understanding of the CAMHS offer. The Wellbeing project is focussed on ensuring 'no door is the wrong door,' for families experiencing difficulties with children or young people with mental health problems. Each Cluster will have a CAMHS practitioner that will support Primary Care to provide early mental health help to children, young

people and their families, and enable them to risk assess safely in the community. The pilot in North Denbighshire saw a reduction in referrals to CAMHS compared with demand from neighbouring Clusters, and Primary Care reported positive outcomes. It has gained Bevan exemplar recognition and will be fully evaluated as the pilot rolls out across North Wales.

5. BCUHB should review its SPOA to ensure consistency of approach in all service components and the avoidance of potential duplication.

The reviewers found that some referrals were bypassing the SPOA. These were from the crisis practitioners based on the paediatric wards and child health psychologists supporting children with chronic conditions, such as diabetes, cystic fibrosis, epilepsy, or who have been diagnosed with life limiting conditions or under the care of oncology. These direct referrals are appropriate from a clinical perspective. However, they were not all being logged as referrals and the pathway for referrals does not capture this.

The reviewers also found that some practitioners undertaking SPOA responsibilities were logging consultations as new referrals when ongoing work is underway. The chronologies for some of these were not clear or easy to find in the records.

Agreed Actions

i.   To undertake a review of the SPOA functioning including the consistency of thresholds and recording.

ii. Processes will be refreshed to ensure that all referrals are handled consistently and captured within SPOA.

Progress to Date

i.   These actions are being progressed across the three Area teams and will conclude the programme of work by July 2020.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Occupational Health and Safety Policy
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green Executive Director of Workforce and Organisational Development.
Awdur yr Adroddiad Report Author:	Peter Bohan Associate Director of Health Safety and Equality
Craffu blaenorol: Prior Scrutiny:	The Strategic Occupational Health and Safety Group approved the Policy on the 10th January 2010.
Atodiadau Appendices:	1. BCUHB Health and Safety (H&S) Policy (HS01) 2. Equality Impact Assessment

Argymhelliad / Recommendation:

The Quality Safety & Executive is asked to approve the Occupational Health and Safety (OHS) Policy (Appendix 1) to ensure BCUHB recognises its legal and moral responsibilities in relation to OHS and will, in consultation with its employees, create and maintain, 'so far as is reasonably practicable' a working environment which will ensure the health, safety and welfare of its employees and any other persons who may be affected by its work activities. The overall responsibility for OHS and for the successful implementation of this policy and associated guidelines rests with the Chief Executive acting through the respective Executive Directors, Area Directors, Assistant Directors, Managing Directors, Managers and Heads of Service.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	X	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	

Sefyllfa / Situation:

The BCUHB Health and Safety (H&S) Policy and Strategic approach embraces the concepts of sensible OHS by ensuring control measures are proportionate to risk. Awareness will be key to ensuring that staff can deliver on their service priorities whilst ensuring risks are managed in a sensible, proportionate and legally compliant way. BCUHB is committed to take all practicable steps, consistent with the provision of health care services, to safeguard its patients, visitors and staff from injury or ill health whilst on the premises. The Policy is to provide healthy and safe working conditions for all of its staff and to abide by and satisfy the requirements of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007. In pursuance of this objective the Board will:

▪ Observe in full the legislation relating to the H&S of employees at work

- Cause this to be observed by its employees, both management and staff
- Ensure adequate education and training for this purpose
- Ensure that any accidents occurring, however minor, are fully recorded, investigated, and where necessary, reported to the Health and Safety Executive (HSE)

To achieve the provision of the proper facilities for patients, whilst ensuring that personal injuries and hazards to the health of staff and others are reduced to the minimum, management and staff must work together with a view to achieving a safe working environment. BCUHB will therefore, expect all staff to exercise responsibilities to maintain healthy and safe working conditions by:

Taking reasonable care for their own H&S and that of others who may be affected by their acts or omissions.

1. Co-operating as far as is necessary with their employer to enable BCUHB to carry out its duties laid down under the Health and Safety at Work etc. Act 1974
2. Fully using all the safety equipment, devices and protective clothing provided
3. Helping in the formulation of and adherence to safety procedures and safety policies

Cefndir / Background:

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health and Safety within BCUHB. The Occupational Health and Safety Team have developed a comprehensive action plan to identify and mitigate the risks identified. The action plan includes key areas of risk including, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security V&A, fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. The OH&S Policy is a key element of implementing a safety management system.

Asesiad / Assessment & Analysis

Successful implementation of the OHS Policy will lead to a range of benefits including improved infrastructure, compliance with the law, staff support systems for recording and tracking contractors, physical security of buildings and assets addition to improvement of moral and perception of investment in the workforces safety and security which, with appropriate relevant training, and acknowledgment would result in reduction of risks and subsequent reduction in staff ill health conditions arising as a result of their work activity. Benefits and improvements will be measured via the improvement governance structure underpinning the gap analysis work.

Strategy Implications
The Health Board will be required to implement the OHS 3 year Strategy which relies on identifying and wherever practicable eliminating or minimising hazards based on the HSE Safety Management System HSG65 and principles of Plan, Do, Check, Act. The process described in the Policy will not only help to reduce the likelihood of accidents and ill health, it will also help to improve time for staff to give care to patients, help to reduce financial waste and will help to improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 3-year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to endeavour change.

Financial Implications
There are significant budget implications which are not budgeted for. A business case has been produced and shared with the Executive Director of finance. The major financial implications including staffing for Security and Health and Safety. Training packages including the Institute of Occupational Health Director and Managing safely programmes. Software including MiCad, for schematic drawings of the estate, Sypol for Control of Substances Hazardous to Health. Re-surveys of premises for asbestos, implementation of risk assessment findings for fire and compartmentation and health surveillance systems for staff.

Risk Analysis
The significant risks have been escalated to Tier 1 risk register and agreed by QSE. These include Leadership of OHS, Security, Contractor Management and Control, Asbestos, Legionella and Fire Safety. All risks have mitigation plans but will require investment. A business compliance case has been produced to support the implementation of the control measures. The risks are scored as 20 with significant consequences if limited controls are implemented. The risks are monitored by the Strategic OHS Group and QSE Committee.

Legal and Compliance
The overall aim of this policy is to promote a continual positive safety culture and encourage ownership at every level of OHS as well as the development of sustainable high quality support services and systems that as a minimum comply with the Health & Safety at Work etc. Act 1974 and other relevant legislation. This will be achieved through a strong, visible and consistent leadership, delivering safety management in a timely, efficient, effective and affordable manner. This will ensure the organisation meets its legislative obligation to safeguard the health, safety and welfare of patients, staff, visitors, property, and others as well as the organisations reputation. This will enable the Health Board to meet and, where possible, exceed the statutory obligations placed upon the organisation to safeguard everyone who might otherwise be affected by the actions and/or omissions of BCUHB. The KPI's will include number of training events, accident investigation, policy development and implementation, self-assessment audits/inspections and gap analysis reports described below.

Audit / Inspection Systems
Organisational Leads and Departmental Managers are required to ensure the following arrangements are in place in order to manage OHS within their areas of responsibility. These arrangements have been broken down into annual, quarterly and ad-hoc to ensure clarity.

Departmental managers need to ensure they fully cooperate with the H&S Team during the audit process. Annual audits of areas and departments are carried out by the H&S team using the H&S Management audit proforma or gap analysis tool. Results of the audits will be feed back to the Strategic OHS Group who will monitor progress against the associated action plans. Divisional specific actions following the audit process will also be discussed at the relevant Divisional H&S Groups. This will

ensure the Health Board is monitoring organisational H&S compliance. Independent assurances will include but not be restricted to, participation in the Health and Care Standards and performance reports provided by the HSE, Welsh Audit Office and Internal Audit following inspections and audits of the Health Board.

Quarterly
Inspections should be undertaken of all departments and areas within their areas of responsibility using the Health Boards workplace inspection proforma. Issues identified during the quarterly inspections that cannot be resolved locally must be escalated to the relevant Divisional H&S group or committee meetings or equivalent for resolution or, escalation through the governance structure of the Strategic OHS Group.

Ad hoc
Risk assessments should be completed by management for all activities undertaken by their employees where it is 'foreseeable' that persons could suffer significant harm, this may be when introducing a new product or work activity. It may be necessary to cooperate with other departments to ensure staff working in their areas of responsibility, that they are not directly responsible for, have appropriate risk assessments in place for the activities they are carrying out.

Corporate-H&S and Self-Reviews
Corporate H&S Advisors will undertake formal H&S Reviews of each Department within their respective area. Frequency of reviews are based on the identified overall level of risk from the previous reviews or incident investigations, risk register entries or Departmental H&S Self-Assessment, as follows:

Score banding	Equivalent RAG status	Frequency
0% to 64%	Red	6 months
65% to 84%	Amber	12 months
85% to 100%	Green	24 months

Impact Assessment
A full EqIA (Appendix 2) has been undertaken and the findings indicated that the Policy and subsequent OH&S Management system will have a positive impact on wellbeing. This includes risk assessments in all areas of BCUHB and appropriate adjustments would be made for staff to return to work safely or adjustments whilst in work. The sole purpose of the legislation is to protect staff and others from ill health affects injury or death as a result of a workplace accident or long term ill health condition. The overall assessment is considered to be positive.

HS01 OCCUPATIONAL HEALTH AND SAFETY POLICY

Date to be reviewed:	March 2021	**No of pages:**	40
Author(s)	Associate Director of Health, Safety and Equality		
Responsible dept / director:	Executive Director of Workforce and Organisational Development		
Approved by:	Occupational Health & Safety Group (date) Quality, Safety & Experience Committee (date) BCUHB Health Board (date)		
Date approved:			
Endorsement by:	BCUHB Health Board		
Date endorsed:			
Date activated (live):			

Date EQIA completed:	November 2019					
Documents to be read alongside this policy:	Health and Safety Management Procedure (Template) and related Policies and Procedures Occupational Health & Wellbeing Scope of Service / Operational Guidelines					
Current Review Changes	New Occupational Health and Safety Policy to take account of legislation updates giving clear lines of ownership of Occupational Health and Safety to those directly responsible.					
First Operational:	June 2010					
Previously reviewed:	June 2013	April/May 2014	June 2015	June 2016	June 2017	March 2020
Changes made yes/no:	Yes	Yes	No	Yes	No	Yes

Contents Page

STATEMENT OF INTENT

The Betsi Cadwaladr University Health Board (hereafter known as the Health Board) exists to provide safe healthcare services of high quality to the local community. It recognises its legal and moral responsibilities in relation to Occupational Health and Safety (OHS) and will, in consultation with its employees, create and maintain, 'so far as is reasonably practicable' a working environment which will ensure the health, safety and welfare of its employees and any other persons who may be affected by its work activities. The overall responsibility for OHS and for the successful implementation of this policy and associated guidelines rests with the Chief Executive acting through the respective Executive Directors, Area Directors, Assistant Directors, Managing Directors, Managers and Heads of Service.

The control of OHS is a management function and as such, the Health Board will ensure progressive improvement in OHS by pursuing the corporate arrangements made in this policy and the implementation of the OHS management system (Plan, Do Check and Act). Managers are directly accountable, for the prevention of accidents, injuries and occupational illness, as well as damage to BCUHB property within their areas of concern. All staff are expected to co-operate by taking reasonable care for their own safety and that of others who may be affected by their actions, and to comply with regulations and systems of work that are in place to protect all employees and others in the workplace.

The Health Board will effectively consult employees on matters affecting their OHS. BCUHB will ensure that employees have suitable information, instruction and training to enable them to undertake their duties competently. All employees are to be provided with safe plant, machinery and equipment, suitable systems for safe handling, storage of substances and equipment. The Health Board will ensure there is adequate access and egress from premises and suitable welfare facilities. The Health Board will review the resources required for effective and efficient health, safety and welfare management as a minimum on an annual basis or sooner if there are significant changes. The Chief Executive and Board are committed to improving and developing a learning culture where health and safety is a key priority that is seen as equal importance to quality, clinical care and service delivery.

Signed   ………………………………………….Chief Executive Officer

1. INTRODUCTION

The Health and Safety (H&S) Policy and Strategic approach embraces the concepts of sensible OHS by ensuring control measures are proportionate to risk. Awareness will be key to ensuring that staff can deliver on their service priorities whilst ensuring risks are managed in a sensible, proportionate and legally compliant way. The Health Board is committed to take all practicable steps, consistent with the provision of health care services, to safeguard its patients, visitors and staff from injury or ill health whilst on the premises. The Policy is to provide healthy and safe working conditions for all of its staff and to abide by and satisfy the requirements of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007. In pursuance of this objective the Board will:

- Observe in full the legislation relating to the H&S of employees at work
- Cause this to be observed by its employees, both management and staff
- Ensure adequate education and training for this purpose
- Ensure that any accidents occurring, however minor, are fully recorded, investigated, and where necessary, reported to the Health and Safety Executive (HSE)

To achieve the provision of the proper facilities for patients, whilst ensuring that personal injuries and hazards to the health of staff and others are reduced to the minimum, management and staff must work together with a view to achieving a safe working environment. The Health Board will therefore, expect all staff to exercise responsibilities to maintain healthy and safe working conditions by:

Taking reasonable care for their own H&S and that of others who may be affected by their acts or omissions.

1. Co-operating as far as is necessary with their employer to enable the Health Board to carry out its duties laid down under the Health and Safety at Work etc. Act 1974
2. Fully using all the safety equipment, devices and protective clothing provided
3. Helping in the formulation of and adherence to safety procedures and safety policies

The Health Board will ensure that comprehensive advice and assistance is available on all matters of H&S and that arrangements exist for identifying and wherever practicable eliminating or minimising hazards based on the HSE Safety Management System HSG65 and principles of Plan, Do, Check, Act and the 3 years OHS & Wellbeing Strategy. The process described in this Policy will not only help to reduce the likelihood of accidents and ill health, it will also help to improve time for staff to give care to patients, help to reduce financial waste and will help to improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 3-year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to endeavour change.

2. SCOPE

This policy shall apply to all premises and undertakings of the Health Board and to commissioners, volunteers, contractors or visitors to the premises.

3. AIM

The overall aim of this policy is to promote a continual positive safety culture and encourage ownership at every level of OHS as well as the development of sustainable high quality support services and systems that as a minimum comply with the Health & Safety at Work etc. Act 1974 and other relevant legislation. This will be achieved through a strong, visible and consistent leadership, delivering safety management in a timely, efficient, effective and affordable manner. This will ensure the organisation meets its legislative obligation to safeguard the health, safety and welfare of patients, staff, visitors, property, and others as well as the organisations reputation. This will enable the Health Board to meet and, where possible, exceed the statutory obligations placed upon the organisation to safeguard everyone who might otherwise be affected by the actions and/or omissions of BCUHB.

4. OCCUPATIONAL HEALTH AND SAFETY MANAGEMENT SYSTEM

The Safety Management System is based on the HSE HSG65 process of Plan, Do, Check, Act. The approach is described below:

4.1 Plan - This is a key element in building effective foundations required for the Safety Management System. A key part of the planning process is to develop clear policies, guidance and safe working practices that covers all aspects of the OHS management system. The three year strategy aims to measure the success of the plans for OHS by systematically evaluating performance against the Policy. A range of Policies will be designed to ensure they can be audited against. The strategy will measure pro-active and re-active work being undertaken by the organisation leads. A health surveillance program will enable the Board to identify emerging risks from known indicators such as night work, latex, dermatitis, vibration, noise assessments, training feedback, inspections and pro-active audits and self-audit review system. When accidents occur they will be reported in a timely manner to enforcing authorities and lessons learnt, not just in one area, but pan BCUHB.

The plans include developing an effective intranet site to provide up to date information and guidance. Part of the planning process will be to develop a fully accredited Safe Effective Quality Occupational Safety and Health (SEQOSH) service. Suitable provision for fire, security and other emergencies is required to be in place. Co-operation is required with anyone who shares our workplace, BCUHB will co-ordinate plans with them, and this includes contractors and subcontractors to make it clear who has responsibility for safety and how it is monitored. The plans require to clearly state who is responsible at site level for OHS matters.

4.2 Do – The 'do' section requires specific pieces of legislation to be adhered to that apply to the Health Board, examples include bio-hazards, environmental, radiation, legionella, asbestos, COSHH, vibration, pseudomonas etc. The system of evaluation is required to inform the Board that the systems in place provide assurance of compliance in all service areas. This applies to all staff and any significant gaps will be identified to develop the risk profile both positive and negative. The strategy will identify what could cause harm in the workplace, who it could harm and how, and what the individual should do to manage the risk. The right people and equipment in the right place is key to a successful business and a pro-active OHS strategy. The strategy aims to identify the highest risks, risk rank them and decide on an action plan to mitigate such risks. All Senior Leaders have the ability to influence the safety culture, decide on the preventive and protective measures needed and put them in place. The Manager and supervisors act as role models to make sure that arrangements for OHS are in place at all times, this Policy provides a clear framework for what leaders are required to do.

4.3 Check - This element will place an emphasis on a shift from reactive to pro-active measuring of performance. The Health Board will establish Key Performance Indicators (KPI's) that give evidence that the safety plans put in place are working. The plans require implementing to make sure that they are in place, 'paperwork' on its own is not a good performance measure. What actually happens on the ground is the reality of the OHS system. The Health Board will assess how well the risks are being controlled through inspections, tours, audits, self-assessment reviews and an annual gap analysis of all legislation, to ensure that what was intended to happen has been implemented. Reports on activities and findings will be reported quarterly and annually to the Board through the Strategic Occupational Health and Safety Group and Governance structure. Root Cause Analysis investigations will identify the causes of accidents, incidents or near misses and actions will be centrally logged for Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) to ensure they are completed and reoccurrence of the same event minimised. The Health Board will also check that Senior Directors are suitably trained on their corporate responsibilities.

4.4 Act - A review of the OHS management system in all service areas through additional gap analysis. The Health Board will identify if what was planned to happen actually happened in reality. Furthermore, the Health Board will learn from accidents and incidents, ill-health data, errors and relevant experience. Sharing of best practice from other organisations will ensure it follows best practice. The act part of the process will involve revisiting plans, training, policy documents and risk assessments to see if they are adequate and are still relevant in controlling the hazards at source. Working to ensure risk assessments are site specific not generic in nature. This will ensure a continued cycle of improvement is effectively implemented.

5. BCUHB GENERAL ARRANGEMENTS FOR OCCUPATIONAL HEALTH & SAFETY

Planning is an integral part of the Health Board's operations and it recognises that legislation requires it to make arrangements for effective planning.

5.1 Plan- Health & Safety Policies

The Health Board has in development a comprehensive suite of policies to supplement the Occupational Health and Safety Policy, they are to be adhered to and effectively implemented by all staff:

- Asbestos Policy
- Construction, Design and Management Policy
- Control of Contractors Policy
- Control of Noise at Work Policy
- Confined Spaces Policy
- Control of Substances Hazardous to Health Policy
- Display Screen Equipment Policy
- Driving at Work Policy
- Electricity at Work Policy
- First Aid at Work Policy
- Ionising Radiation Protection Policy-Non-ionising Radiation Protection Policy
- Incident Reporting and Management Policy and Procedures (Putting Things Right)
- Inoculation and Exposure to Needlestick / Bodily Fluids Policy
- Latex Sensitisation Policy
- Lifting Operations and Lifting Equipment Regulations Policy
- Lone Worker Policy
- Management of Violent & Aggression Policy
- Manual Handling Policy
- Mental Health, Wellbeing and Stress Management Policy
- New and Expectant Mothers Policy
- Occupational Health Surveillance Policy
- Occupational Health & Wellbeing Scope of Service / Operational Guidelines
- Occupational Immunisation & Screening Procedure / Communicable Diseases Management
- Personal Protective Equipment Policy
- Policy for the Management of Fire Safety
- Policy for the Management of Safe Water Systems
- Provision and Use of Work Equipment Policy
- Risk Management Strategy
- Safety Signs and Signals Policy
- Security at Work Policy
- Slips, Trips and Falls Policy
- Vibration at Work Policy
- Violence at Work Policy
- Working from Heights Policy
- Young Persons at Work Policy

The above policies will be used as a framework to Audit the OHS system in place. They are working documents that are required to be realistic and effectively implemented by all staff and contractors who work directly or indirectly for the Health Board.

5.1.1 Training

Training will be based on a training needs analysis. Training will be suitable and sufficient to enable staff to identify hazards and risks they may face in the workplace and how to deal with them. This approach applies to all staff. Training should be based on the level of competence required for the service areas individuals involved and level of expertise required.

Associate Directors/Assistant Directors and Divisional Heads of Service will be required to attend specific Corporate Manslaughter and Corporate Homicide Act 2007 training to understand their responsibilities under the Act. This is of particular importance when decisions may directly influence safety outcomes. Training, information, instruction and supervision should be to the appropriate level of expertise required. It is necessary to be provide suitable training on induction. It is also necessary to identify H&S Leads (Champions) in each service area and support services and managers to deliver their safety remit.

5.1.2 Workplace Induction

All new employees shall benefit from a comprehensive induction to the workplace. These inductions will not only focus on the duties of the individual but are to provide staff members with information in respect of the hazards and risks they may face and the control measures in place to mitigate such risks. Workplace risk assessments shall be made available to new employees via the manager or service lead.

5.1.3 Training for Health Board Executive Directors and Independent Members

In response to identified training needs, the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007.

5.1.4 Training for Managers

The Health Board will ensure, through training needs analysis, that managers receive H&S training, in respect of their role in the day-to-day management of health safety, for example providing the 'Institution of Occupational Safety & Health' (IOSH) and the 'Managing Safely' course. Health Board managers will ensure that H&S procedures, risk assessments and safe systems of work, as applicable are brought to the attention of their staff and observed by them. They will make provisions such that every member of staff can participate in H&S training activities.

5.1.5 Roles Specific to Health and Safety Training

This training will be identified by Managers and provided to employees as a direct result of the training needs analysis and the risk assessment process. The Corporate

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H&S department will provide advice and guidance in respect of the training required. This training will include but is not restricted to:

- Risk Assessment
- Workplace Induction
- Personal Protective Equipment
- Provision and Use of Work Equipment
- Working at Height
- Confined Spaces
- Electrical Regulations
- Noise at Work
- Display Screen Equipment
- Manual Handling
- Violence and Aggression
- Control of Substances Hazardous to Health (COSHH), Sharps/Body Fluid Contamination Incidents
- Stress at work
- Wellbeing

Records of instruction received will be maintained in a central point for inspection and review.

5.2 Do - Ensure Policies are Implemented

To support the development of an effective OHS system a 3-year strategy and action plan has been developed as a framework for the overarching OHS improvement plan. This has been devised by the OHS Team. This detailed plan will ensure that the aims set out in the Strategic Plan are met and actions are identified, which are monitored and reviewed on a regular basis by the Strategic OHS Group. The Strategic OHS Group reports directly to the Quality, Safety and Experience Group on OHS and risk issues, which in turn reports to the Health Board.

5.2.1 Control of Infection

The ongoing responsibility for the Control of Infection Policy will be exercised by the Strategic Infection Protection Group.

5.2.2 Management of Fire Safety

The Health Board acknowledges its obligation to take suitable precautions against fire in its premises in accordance with official guidance and statutory requirements and it has overall accountability for the activities of the Organisation. The Chief Executive is responsible for ensuring compliance with current fire safety legislation and where appropriate the Department of Health Firecode guidance is implemented in all BCUHB premises and for assuring the Health Board that such measures are being met. The Executive Director of Planning and Performance will champion fire safety issues at Board level, which includes proposing programmes of work relating to fire safety for consideration as part of the annual business plan. The Director of Estates and Facilities is the Health Board's Fire Safety Manager and is responsible

for ensuring the Health Board maintains its premises in accordance with current legal requirements. The nominated Senior Estates Officer responsible for Legislation and Compliance for BCUHB and has responsibility for the day to day activities associated with fire safety including, amongst others, training, risk assessment and maintenance of equipment. The Fire Safety Advisor in each area is responsible for providing technical expertise to all staff in order for them to fulfil their duties effectively.

5.2.3 Contractor Management and Control

Contractors require effective competence evaluation, pre-employment reviews and site induction. The local induction will also require a thorough review of their documentation to assess the suitability of the risk assessment and method statements by the Estates Department/Facilities or Capital Projects. The contractor should be inducted by a competent staff member within the Capital Projects or Estates and Facilities Department. All contractors are required to report to the Estates and Facilities Department to sign in and be provided with relevant information regarding the area they will be working in this relates to IT or other contractors on site. This will apply if the contractor is in contact with the fabric of the building or if it may affect its integrity of the building or processes within it. A permit to work system will be provided and managed via Estates and Facilities were there is a significant hazard identified, work at height, confines spaces, hot works fire etc. This will require sign in and off procedures to be effectively implemented.

5.2.4 Water Safety Group

The Water Safety Group will be responsible for co-ordinating and overseeing the safe management of Water Systems in compliance with HSE Approved Code of Practice L8. The water systems and implementation of Policy positively contributes to the health and wellbeing of patients/visitors and staff in all BCUHB premises. The Water Safety Group will work closely with Clinical Groups/Infection Prevention, Estates/Facilities and Corporate Departments to ensure that suitable and sufficient arrangements are in place for the safe management of all water systems. The risk assessments in relation to water systems require reviewing and implementation of the findings. Any issue identified that result in risks of legionella; pseudomonas or any other water borne pathogen requires escalating through the governance system and to the Strategic Occupational Health and Safety Group.

5.2.5 Asbestos Management Group

The Asbestos Management Group identifies and recognises BCUHB's responsibilities (as the Duty Holder) under current asbestos legislation and has a moral obligation to eliminate or control the risk of exposure to asbestos. The purpose of this group is to provide the means by which management develop and maintain the asbestos management process across the Health Board. The Group ensures that the following:
- An integrated approach to the identification and management of workplace asbestos hazards are maintained throughout the organisation.
- Provides assurance in terms of the effective management of Asbestos risk across all activities and facilities.

- Develop and monitor the asbestos management plan and address significant asbestos risks within the organisation.
- Further, develop the Asbestos Policy and supporting arrangements.
- Monitor performance in respect of the Key Asbestos Management Performance Indicators within the Health Board.

The roles within the Group are as follows:

Position	Responsibility
Director of Estates & Facilities	The Duty Holder
Head of Operational Estates	Responsible for the development and implementation of the asbestos policy and management plan
Operational Estates Managers (Central, East & West)	Application of the asbestos management plan at operational level
Senior Estates Officer – Asbestos Management	Responsible for the application of asbestos statutory compliance work packages
Estates Development	Application of the asbestos management plan during capital redevelopment work

5.2.6 Security Group

The Security Group provides an objective view of command and control of security functions within the organisation authorising it to take decisions on behalf of all services, functions, and departments within the Health Board. The Group adheres to an agreed set of objectives including, but not limited to:

- To develop a community approach to security and crime prevention, working together to ensure that there is a secure environment that protects patients, staff, visitors and property as well as the physical assets of the Health Board.
- For the Health Board, to work collaboratively with North Wales Police and those having responsibility for community safety and security to promote an effective security policy.
- To promote good practice across all agencies and develop a common understanding of the issues pertinent to each agency.
- To establish partnership links with crime reduction and community safety groups to help promote security awareness amongst all employees of the Health Board together with patients and visitors to the organisation including contractors to all Health Board sites.
- To contribute legally and effectively to the collection and sharing of information with partners.
- To support Home Office and Welsh Government initiatives and contribute to tackling violence in the community.
- To promote Operational Initiatives for example; 'Obligatory Response's to Violence in Healthcare' that will ensure patients, staff and visitors feel, and are

indeed, safe in their working environment and during their visits to Health Board sites.

- To reduce crime (and fear of crime) on Health Board sites and, through its work, within communities across the Health Board area of operations.
- To monitor and review current practice, feedback from services, functions and departments and identify operational difficulties.
- To establish and maintain effective channels of communication to relevant services, functions and departments, for all staff relating to security.
- To identify resource requirements and potential funding.
- To continue to monitor and review the Health Board security policy, strategy, plans and progress.
- To produce an annual report on the progress of the Health Board security strategy, the system of security management in place and its effectiveness and recommend any improvements that may be required.
- Escalate issues to the Strategic OHS Group as required.

5.2.7 Radiation Protection

The Health Board as the employer is responsible for ensuring compliance with radiation protection legislation. There are a number of pieces of legislation that cover work with both ionising and non-ionising radiation. In terms of H&S, the main regulations for ionising radiation are the Ionising Radiation Regulations 2017 (IRR17) which places a number of requirements on BCUHB to ensure safe use of ionising radiation. Under IRR17, BCUHB has appointed Radiation Protection Advisers (RPAs) to provide advice on compliance. Also for each work area, local rules have to be established and Radiation Protection Supervisors appointed to ensure that the local rules are adhered to.

Other legislation covers medical exposures (The Ionising Radiation (Medical Exposures) Regulations 2017), use and disposal of radioactive substances (The Environmental Permitting (England and Wales) Regulations 2016, as amended 2018), and the transport of radioactive substances (The Carriage of Dangerous Goods and Transportable Pressure Equipment Regulations 2009, amended 2019) as detailed in BCUHB Policy RP01.

All matters related to both ionising and non-ionising radiation protection are overseen by the Radiation Protection Committee (RPC) under the chairmanship of the Executive Director of Therapies & Health Sciences

The Committee provides leadership and direction with regards to radiation protection and safety across the organisation providing assurance that the Health Board is compliant with current legislation, good practice guidance and external standards, monitoring and auditing of radiation protection arrangements including reviewing staff radiation doses and radiation incidents affecting staff, patients or public. The Committee will provide an Annual Report to the clinical effectiveness sub-group and Quality, Safety and Experience Sub-Committee.

5.2.8 Updating of the Health & Safety Policy

The H&S Policy will be updated to take account of changing regulations and legislation and will be reviewed as a minimum every three years by the Associate Director of Health, Safety & Equality.

5.2.9 Reports from the Health & Safety Executive and Others

The Associate Director of Health, Safety and Equality will ensure that all reports from the HSE are copied to the appropriate Director or Manager for implementation and will co-ordinate the formal response to the HSE from the Health Board.

5.2.10 Voluntary Organisations

All voluntary organisation that operate in conjunction with or alongside BCUHB require to have suitable policies, risk assessments, induction/training and safe working practices that align to the requirements of this Policy. They must co-operate fully with BCUHB instructions and guidance in relation to this Policy including fire and emergency procedures. Periodic reviews of services may be undertaken by competent persons from BCUHB as required to ensure that they adhere to appropriate legislation and approved codes of practice.

5.3 <u>Check</u>- Audit / Inspection Systems

Organisational Leads and Departmental Managers are required to ensure the following arrangements are in place in order to manage OHS within their areas of responsibility. These arrangements have been broken down into annual, quarterly and ad-hoc to ensure clarity.

5.3.1 Audit

Departmental managers need to ensure they fully cooperate with the H&S Team during the audit process. Annual audits of areas and departments are carried out by the H&S team using the H&S Management audit proforma or gap analysis tool. Results of the audits will be feed back to the Strategic OHS Group who will monitor progress against the associated action plans. Divisional specific actions following the audit process will also be discussed at the relevant Divisional H&S Groups. This will ensure the Health Board is monitoring organisational H&S compliance. Independent assurances will include but not be restricted to, participation in the Health and Care Standards and performance reports provided by the HSE, Welsh Audit Office and Internal Audit following inspections and audits of the Health Board.

5.3.2 Quarterly

Inspections should be undertaken of all departments and areas within their areas of responsibility using the Health Boards workplace inspection proforma. Issues identified during the quarterly inspections that cannot be resolved locally must be escalated to the relevant Divisional H&S group or committee meetings or equivalent

for resolution or, escalation through the governance structure of the Strategic OHS Group.

5.3.3 Ad hoc

Risk assessments should be completed by management for all activities undertaken by their employees where it is 'foreseeable' that persons could suffer significant harm, this may be when introducing a new product or work activity. It may be necessary to cooperate with other departments to ensure staff working in their areas of responsibility, that they are not directly responsible for, have appropriate risk assessments in place for the activities they are carrying out.

5.3.4 Corporate-H&S and Self-Reviews

Corporate H&S Advisors will undertake formal H&S Reviews of each Department within their respective area. Frequency of reviews are based on the identified overall level of risk from the previous reviews or incident investigations, risk register entries or Departmental H&S Self-Assessment, as follows:

Score banding	Equivalent RAG status	Frequency
0% to 64%	Red	6 months
65% to 84%	Amber	12 months
85% to 100%	Green	24 months

Notification of a review will be provided in advance to ensure the correct Senior Staff are available unless there are exceptional circumstances e.g. following a significant incident or subject to programming of an H&S Gap Analysis exercise. The Head of H&S, Head of Occupational Health and Wellbeing or H&S Advisor should be given access to the H&S folder, risk assessments, individual workplace risk assessments, training records, local inductions, H&S audits, inspections and procedures as required. The Corporate OHS Team will be able to access all service areas and discuss safety issues with all staff members and partners as necessary to undertake their duties. The H&S Advisor should be made aware of any particular hazards in the workplace; by the Department in advance. They are required to be appropriately escorted or instructed wearing the appropriate PPE. A report will be submitted to the responsible Manager within two weeks following the site visit, which will include:
- scoring which reflects the level of risk
- a description of the evidence, and
- recommendations for actions against identified risks

The Department should retain a copy of the Review and Action Plan in the H&S Folder for 3 years. The H&S Team will retain a copy of the Review electronically and collate scores into a spreadsheet for analysis and monitoring.

5.3.5 H&S Self-Assessments

All Departments must undertake a H&S Self-Assessment twice per year. The Service Manager is required to identify a designated H&S Champion for their area. The Manager is responsible for providing the H&S Champion with adequate time and resources to undertake the self-assessment review. A copy must be forwarded to the H&S Team. Collated data will be reported back on a six monthly basis to the Strategic OHS Group. H&S Champions are expected to set a schedule for self-assessments within their remit, this requires confirming with their manager who has overall responsibility for H&S and ensure that this is adhered to. The Manager of the Department will return the self-assessment within the timescale against set dates provided by the H&S Department.

5.4 <u>Act-</u> Reporting of Accidents / Incidents

All accidents, incidents and near misses must be reported immediately to a line manager and should be recorded via the Datix Reporting System and actioned where necessary. The Health Board requires its Departmental Managers to investigate all accidents and injuries together with the implementation of controls to mitigate any further accidents or injury. Some incidents may require additional investigation or scrutiny, and where deemed necessary the H&S Advisor for that area may be able to provide managers with support and guidance. The consequences of some accidents may result in the injury being reportable under the Reporting of Injuries, Disease and Dangerous Occurrences Regulations (RIDDOR) to the Health & Safety Executive (HSE).

A Corporate H&S Advisor, following consultation and confirmation with their line manager, is responsible for the reporting of incidents laid down in the RIDDOR Regulations directly to the HSE. Departmental managers will be required to investigate RIDDORs and report on all accidents causing injury or ill health and any potentially dangerous incidents within their departments, which shall be submitted no later than the fourth day from the date of the accident / incident to the Corporate H&S Team. Witness statements should be obtained at the time of the incident; they should also be submitted within 4 working days.

This includes a suitable and sufficient accident investigation using the established Root Cause Analysis system. The Directors of the service areas must ensure a suitable RCA is undertaken for all accidents including RIDDORS. They are also responsible for the immediate reporting of incidents arising from serious defects in medicinal products and other medical supplies and equipment in accordance with recognised standards.

5.4.1 Hazard Notification

The NHS Wales Dangerous Notification Alerts identify hazards and potential hazards arising from accidents with or defects in medicinal products and plant, equipment and other supplies whether medical, or non-medical. The Director of Estates and Facilities is responsible for maintaining and operating arrangements designed to

ensure that the contents of such hazard warning notices are brought to the notice of all officers and departments needing to know of their contents and for ensuring that appropriate action is taken thereon.

5.4.2 In House Hazard Identification

A system of reporting in-house hazards to all service areas is required to ensure that lessons can be learned across BCUHB. The system of reporting and the Divisions taking appropriate action, will be implemented to support the Hazard notification process. This may include issues relating to violent patients, COSHH, Fire or lessons learned from specific Root Cause Analysis (RCA) investigations.

5.4.3 Risk Assessments

Departmental risk assessments within local H&S files are required to describe what work activity is undertaken in the service areas. The risk assessment process identifies the hazards and risks associated with a particular activity and the control measures required to reduce the risk to its lowest acceptable level. Low risk issues would not be included within an action plan unless the department is unable to resolve this issue, it would then be escalated in accordance with Risk Management Strategy and Health Boards governance structure. The risk assessments, as a minimum, require reviewing on an annual basis or more frequently if there is significant change. Risk assessments require review against other pieces of legislation including a COSHH inventory or data sheets.

5.4.4 Duties and Responsibilities for the Management of Occupational Health & Safety

The Health Board recognises its responsibilities for Occupational H&S and as a body corporate and an employer, The Heath Board has a responsibility to conform to the Health and Safety at Work etc. Act 1974 in the interests of its staff and others who may be affected by its operation. The Health Board has a specific responsibility under the Act to prepare a general Policy Statement and all staff shall comply with this policy. Responsibilities for the management of H&S is clearly identified in this Policy and supporting operational procedures.

6. ROLES & RESPONSIBILITIES

6.1 The Health Board of Directors

The Board of Directors has overall accountability for the activities of the organisation. The Health Board shall ensure that they receive appropriate assurances in respect of compliance with the Health and Safety at Work etc. Act 1974 and supporting legislation.

6.2 Chief Executive

The Chief Executive, as the Accountable Officer of the Health Board, has primary overall responsibility for ensuring the formation, review and execution of this Policy. Specifically, the responsibilities of this post are:

- To ensure that adequate Management arrangements exist for the Health Board to comply with the requirements of the H&S Legislation and to maintain and implement BCUHB's H&S Policy.
- To ensure effective communication and co-ordination on matters of H&S at all of its operational facilities.
- To ensure that all senior managers identified within this policy understand their specific H&S responsibilities and to monitor their performance.
- To ensure a Director within each Division is appointed to take overall responsibility for Occupational Health, Safety and Wellbeing matters within their respective Division.

6.3 Occupational Health and Safety-Board Level Executive Director

The Chief Executive has appointed the Executive Director of Workforce and Organisational Development as Board Level Director for Occupational Health and Safety, to lead on H&S issues at board level. The Board Level Director shall be responsible, through a process of nomination, for the development, monitoring and implementation of the Occupational H&S management system. In addition, the Board Level Director shall:

- Ensure that sufficient competent persons are employed to provide advice and guidance to the BCUHB in relation to H&S management.
- Ensure the co-ordination of all H&S activities within the BCUHB.
- Submit an annual report to the Health Board detailing H&S performance.
- Ensure that adequate management arrangements exist within Workforce and Organisational Development Department to comply with the requirements of the H&S legislation and to maintain and implement this policy.
- Ensure that suitable and sufficient resources are available for the provision of an effective Occupational Health, Safety and Wellbeing Service within the BCUHB.
- Chair the Strategic OHS Group to ensure information and governance arrangements for OHS are in place and as necessary escalate issues identified as required.

6.4 Executive Director of Planning and Performance

The Executive Director of Planning and Performance shall, so far as is reasonably practicable, ensure that risks to the H&S of staff and others from workplace environments, in new build and/or refurbished property owned by the Health Board, are eliminated and/or reduced. Ensure that H&S is incorporated at the design stage of any new build, and that H&S communication at operational level is an integral part of the process. They should ensure that the Occupational H&S risks associated with financial constraints do not affect statutory compliance as required by H&S legislation.

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6.5 Executive and Senior Management/Directors

Have professional accountability, in addition to any other specific duties:

- Ensure that management structures and responsibilities are identified and functioning for the effective management of H&S across their areas of responsibility.
- Facilitate effective communications and partnership working with staff in respect of H&S management.
- Provide assurance to the Board Level Director for H&S (Executive Director of Workforce and Organisational Development) that effective management arrangements are in place and functioning across their areas of responsibility.
- Escalate any significant issues identified, that cannot be dealt with locally.
- Support effective implementation of H&S Leads (Champions) within the service area they are responsible for.
- Take appropriate advice and guidance from competent persons for Occupational H&S (Corporate H&S Team) and implement findings of gap analysis, reviews, audits and incidents, accidents or identified trends.

6.6 Director of Facilities/Estates

The Director of Facilities/Estates is responsible for arranging the examination of all Health Board premises whether owned, leased or occupied according to statutory requirements and regulations relating to building and engineering services. They must ensure the safe operation of engineering plant and equipment together with all fire equipment and appliances, fire alarms and associated communication systems and monitoring and maintaining standards of electrical and mechanical safety in accordance with accepted national standards, appropriate Codes of Practice and legislation. They must ensure that the design, construction specifications and maintenance on new and existing buildings and/or leased property within the Health Board conform to the Building Regulations, current Fire Safety legislation and to Department of Health Firecode standards where applicable and ensuring that compliance with the Construction (Design & Management) Regulations is maintained.

It is recommended that the Director of Estates and Facilities consults the Corporate H&S Team when communicating with the HSE Inspectorate and Local Government Officers in respect of specifying and monitoring the standards of safety referred to in the above paragraph and in particular where Licensing and Planning Law and Local by-law is involved together with Building Regulations. Ensuring the availability of competent persons to undertake statutory inspections in respect of gas, electrical installation, water systems, asbestos management etc. Escalating risks in relation to all aspects of the Estate. Ensuring the budget allocated for H&S aspects of the Estate including structural, engineering/electrical plant and equipment is suitably maintained implemented throughout the lifecycle of the project.

6.7 All Divisional Directors

Are responsible to the Chief Executive through the responsible Executive Director to ensure that all reasonably practical steps are in place to maintaining the necessary management arrangements within their Divisions that will allow this policy to be implemented effectively. They will do this by establishing local arrangements to have oversight of H&S through a local group structure that has clear action plans and systems for monitoring H&S performance allowing staff time to attend essential H&S Training and nominating H&S Leads (Champions) who will require additional training to ensure they can support the Divisions in the safe implementation of this Policy. They are responsible for appointing a senior manager to take overall responsibility for Occupational Health, Safety and Welfare matters of each area of responsibility.

6.8 Assistant Directors / Heads of Service / Associate Directors / Hospital/Service Management Teams

Are responsible for and accountable to their Lead for putting in place and maintaining the necessary management arrangements within their Divisions, Services and Departments of responsibility, which will allow this policy to be implemented. This responsibility can only be expedited by developing and maintaining specific H&S policies, which set out local arrangements for underpinning this policy. It is anticipated that these local arrangements will include the mechanics for monitoring, review and audit. The above named staff may choose to delegate some or all of these duties to senior managers, and H&S Leads (Champions) however it is not possible to delegate their responsibility. Specifically, they are responsible for:

- Producing an annual H&S report that gives an assessment of compliance within their service area.
- Creating a regular documented forum for the discussions of H&S matters with staff and managers within the Service.
- Including H&S targets/objectives in manager appraisals.
- Ensuring that responsibilities for H&S are set out clearly in job descriptions for managers and all staff.
- Ensuring that there is a written procedure that details the arrangements for H&S induction, inspections, audits, monitoring etc., which sets out time-scales for the frequency of monitoring and inspection, who undertakes this and to whom reports should be sent. (This should lead to feedback and follow-up action).
- Ensuring that a robust system for carrying out risk assessments are in place.
- Ensuring that there is a regular H&S inspection of premises within their directorates that records of findings are maintained, and actions completed.
- Ensuring that reports from the Strategic OHS Group feed into local Groups or Committees and influence outcomes from such committees.
- Ensuring action is taken in relation to H&S reports, Internal Hazard reports or Wales Department of Health Hazard memoranda and similar guidance.
- Ensure that the recognised H&S Representatives are provided with appropriate facilities and co-operation so that they may properly discharge their legal functions.
- Ensure the appointment of a senior manager to co-ordinate and oversee all matters related to H&S in the workplace.

- Ensuring, through the Leadership Team and named Heads of Department where appropriate, that all new staff within their service area:
  - are given adequate instructions and training to fulfil their duties safely.
  - are provided with correct protective equipment and clothing as appropriate.
  - and are made aware of and comply with relevant safety rules and codes of practice.
  - understand and comply with fire safety arrangements.
- Developing and maintaining service H&S rules and policies within the overall general Statement of Intent supported by the Health Board and Chief Executive Officer
- Administration and operation of safety audits, inspections and assessments (including statutory requirements)
- Ensuring that reports from the HSE relating to their service receive prompt attention and appropriate action.
- Ensuring that all staff attend mandatory training in accordance with current policy.
- Ensuring that all staff receive appropriate H&S instruction.
- Ensure effective accident / incident reporting arrangements are in place and root course analysis investigations of such incidents have appropriate actions that are implemented to prevent a reoccurrence.
- Ensure that robust arrangements are in place for identifying hazards within their departments and risk assessments are undertaken to identify and control risks associated with the hazard.
- Ensure that they have an appropriate level of knowledge to enable them to fulfil their H&S responsibilities.

6.9 Associate Director Health, Safety & Equality

The Associate Director for Health Safety and Equality is one of the key competent persons for the Health Board and provides guidance on the H&S Policy and implementation of the three year Occupational Health and Safety Strategy. The Associate Director Health, Safety and Equality advices the Health Board, Chief Executive, Executive Director of Workforce and Organisational Development and other Senior Staff as appropriate on the implications of the various statutory regulations applying to their area of control and is the contact for the HSE or other relevant enforcing agencies.

The role is to ensure suitable safety systems can be evidenced, that progress against the Strategy improves knowledge and understanding of the management system in all service areas. This will be undertaken by providing a program of work that continually improves the Occupational Health and Safety culture of the Health Board.

6.10 Head of Health and Safety

The Head of Health & Safety advises the Directors/Managers and staff as appropriate on the implications of the various statutory regulations applying to their area of control. Specific responsibilities include:
- Providing a focus for H&S matters and co-ordination of policy, including its formation and review.

- Development of Key Performance Indicators (KPIs) that can be reported to the Health Board.
- Liaising with the Directors and other Senior Managers to ensure that reports from the Strategic OHS Group relating to their areas are properly communicated and that adequate management response is formulated and appropriate action taken.
- Liaising with managers within Divisions to ensure that reports from the HSE receive prompt attention and that appropriate action is taken by relevant Departments.
- Liaise with the Leads on complex Root Cause Analysis investigations where appropriate.
- Ensuring, through the Divisions, effective arrangements for accident/incident reporting and investigation.
- Reporting of incidents laid down in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to the HSE.
- Liaising with the Risk Management Team including Risk H&S Leads in matters relating to escalation of risks through the Governance system.
- The production of a programme of H&S Training to ensure the level and scope is adequate for the Health Board.
- Ensuring that there is an annual H&S audit encompassing all departments within the Health Board.

6.11 Health & Safety Advisors

The Health Safety Advisors are accountable to the Head of Health & Safety with specific responsibilities that include:
- Support the development of policies, procedures and guidance notes to assist management with compliance that are relevant to statutory provisions within BCUHB.
- Assist the Divisions to fully investigate all RIDDOR related incidents and assist in the development of lessons learnt. Supporting recommendations in order to mitigate reoccurrence of similar incidents by those directly responsible.
- Monitor divisional compliance with any recommendations made following an investigation to ensure action plans are in place and reported back to the Strategic OHS Group.
- Identify trends through the monitoring and analysis of data and make recommendations on findings.
- Monitor and develop KPI's that will assist with improved H&S performance and provide reports to relevant groups.
- Effective communication and partnership working.
- Support the development of the Local/BCUHB H&S Risk Profile process.
- Support the development of suitable and sufficient arrangements for the management of H&S within the organisation that will support compliance with Statutory Legislation.
- Provide H&S Courses based on a training needs analysis.
- Undertake audits and inspections of premises.
- Links with partner organisations such as, but not restricted to, the Welsh Government and the HSE.

- Give support to the design and project teams in respect of the H&S requirements for new and existing facilities.

6.12 Manual Handling Manager/Team

The Manual Handling Manager and the Team are responsible for the development and provision of manual handling training to all staff within the Health Board. Specific responsibilities include:

- Ensuring the training meets the needs of the staff through classroom or competency assessments.
- Support clinical areas to provide safer patient care and encourage patients to mobilise through positive manual handling support.
- Deliver non-clinical training and support sedentary workers to keep moving, to reduce ill health in the workforce.
- Providing specialist ergonomic risk assessments and advice.
- Undertake specific audits, inspections and support the development of appropriate risk assessments in all service areas.
- Develop Manual Handling Champions in Service areas to reduce the risks associated with musculoskeletal disorders.
- Provide support to the Head of Health & Safety to ensure the provision of effective training programmes in violence & aggression including de-escalation, personal safety and breakaway techniques to the majority within BCUHB, with the exception of MH&LD directorate.
- The Dementia and Violence & Aggression Link within the Team supports staff with the patient centred behavioural support plan and provides the support needed following training to staff dealing with complex patients or situations.

6.13 Area Risk, Clinical Governance/H&S Managers/Leads

Each Area Division (West, Central and East) may have its own H&S support that has different reporting structures and different roles; however, they are intended to support the effective management of H&S within their designated Area. They review H&S protocol and risk management policies in line with Corporate H&S policies and procedures. Following consultation, they can assist the Corporate H&S team in the delivery of training on health, safety and risk management subjects to all levels of staff within the Area in line with corporate improvement plans and training priorities as defined by the Corporate H&S training needs analysis. Ensure all sites/locations within the Area are fully compliant with policies identified through the gap analysis and legislation, working with key stakeholders to resolve any outstanding issues. Undertake internal audits, inspections and support management on specific and generic risk assessments.

Ensure incident reports are circulated to relevant teams, RIDDORs identified are notified to the Corporate H&S Team for reporting, RCAs undertaken and actions identified to ensure lessons learnt are addressed. Report any contact with the HSE or enforcement agency directly to the Corporate H&S Team prior to meetings being held to ensure a consistent approach is made to the enforcing agencies. Manage the Hazard Warning Alerts ensuring actions are tracked and reported on in a timely manner to the Strategic OHS Group. Respond to issues escalated from local H&S

leads (service champions) and escalate through the governance structure if not actioned.

6.14 Head of Occupational Health and Wellbeing

The Head of Occupational Health and Wellbeing is responsible for the provision of an Occupational Health Service for BCUHB. In particular, providing advice to management about occupational health aspects of the working environment and arrange staff screening programmes as necessary. The following is an example of the type of activities required:

- A pre-employment health assessment service for all potential employees of the BCUHB, as appropriate and to a level relevant to the proposed work of the applicant.
- Health surveillance for relevant occupations that have a recognised disease associated with the work activity e.g. noise, hand arm vibration, skin / respiratory sensitisers.
- Health assessments for night workers in accordance with the European Working Time Directive (EWTD).
- Immunisation programmes for employees.
- Advice / management of diseases and other illnesses that are or could be attributed to occupational hazards e.g. sharps / body fluid contamination incidents / infection related communicable diseases.
- Health and wellbeing initiatives.
- Employee assistant helpline to aid early advice on work or personal aspects / signposting to musculoskeletal / emotional support.
- Advice and support for staff suffering ill health as a result of their occupation, such ill health could involve work with hazardous substances or infective agents.

6.15 Infection Prevention

A Corporate Infection Prevention Team has staff based on each of the three acute sites providing a service across all of BCUHB. This is supported by a clinical microbiology service provided by Public Health Wales. The team provides advice, support and direction on all infection prevention and control issues, training for staff, support for risk assessment, and policy and procedures to protect staff, patients and the public from risks associated with infection. They link closely with the corporate H&S team and directorate managers, and clinical staff to support safe practice.

6.16 Head of Risk Management

The Head of Risk Management is responsible for the development of systems of Good Governance, a dynamic, proactive, integrated and enterprise-wide focus which aims to foster the achievement of its objectives and priority areas. Risk management is a tool to drive continuous improvements in patient care, safety, and experience while improving the quality of decision making. The risk management team is supporting Directorates/Divisions and Corporate services to regularly review and update their risk profiles. The drive to strengthen risk management processes and systems while leveraging sufficient clarity on the governance arrangements. Risk Management is everyone's business across the Health Board, staff engagement

especially from Senior Managers/Directors and capacity building in risk management are key drivers for embedding a positive risk management culture across the Health Board.

6.17 Director /Manager Her Majesty's Prison Service

The prison service will work as an integrated approach to OH&S with combined Policies and procedures, with risks being identified and effectively managed. The risk assessment process requires to be clearly defined with specific cases passed from the prison service to the Health Wing with clear lines of accountability. Those posing significant risks to be highlighted to the Service Leads with clear roles and responsibilities identified. The level of training required by those working in the Prison requires to be at a level that is commensurate with the risks identified by the Head of Healthcare HMP Berwyn.

6.18 Departmental Managers

Departmental Managers are directly responsible for ensuring that rules and procedures in relation to their staff are interpreted correctly and implemented in their entirety. Departmental Managers may choose to delegate some or all of these duties to subordinate staff, however it is not possible to delegate their responsibility. Their specific responsibilities are:

- Undertake site-specific risk assessments, in relation to both physical and mental health hazards.
- Identify potential occupational hazards involved in their operations and the precautions to be taken.
- Ensure that significant risks or risks that are identified and unable to be resolved locally are escalated to the appropriate H&S Group or Committee or equivalent and managed in accordance with the H&S Policy and Risk Management Strategy.
- Produce appropriate departmental guidance, and assessments (including statutory requirements) that relate to the service area.
- Ensure that all relevant rules, procedures and Codes of Practice are brought to the attention of and made available to the staff under their control and that appropriate warning notices and all instructions are prominently displayed.
- Ensure the adequate induction of all new staff emphasising the health, welfare and safety aspects of their duties.
- Ensure that all staff are provided with H&S equipment, protective clothing, etc. ensuring it is always available, properly maintained and used.
- Ensure that all Supervisors understand instructions regarding H&S and monitor staff compliance.
- Investigate all accidents/dangerous incidents within their area of control and ensure that any remedial action is implemented as soon as possible and reporting to their Senior Manager as appropriate. Such remedial action to be recorded on the appropriate accident / incident report form within Datix. Departmental investigations shall be recorded in writing and a copy submitted along with the accident / incident form to the H&S Advisor for the Division if required.
- Ensure that all accidents / dangerous incidents are recorded on the appropriate accident / incident form no later than the fourth day from the

accident / incident date. Major injuries should be reported as soon as reasonably practicable to ensure prompt reporting to HSE.

- Ensure that Witness Statements are taken (and recorded in writing) which shall be enclosed with the accident / incident form when recorded within Datix or at the earliest opportunity if obtained at a later date.
- Ensure that relevant accidents / dangerous occurrences, which occur outside of normal working hours and are listed under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which are required to be reported immediately to the HSE via the H&S Advisor ensuring they are notified as soon as practicable.
- Ensure that equipment used in the Department is safe and adequate for the purpose for which it is intended.
- Ensure that the Estates Department (for non-clinical equipment) / EBME (for clinical equipment) are informed of all new portable electrical equipment so that the statutory tests can be carried out prior to being taken into service and thereafter as appropriate.
- Ensure that all portable electrical equipment shall be visually checked by users at frequent intervals and the results recorded on an appropriate check sheet.
- Ensure that faulty equipment, plant or buildings are reported promptly for repair. Adequate steps are taken to put the relevant unit or area out of use in the interim should this be considered necessary and as appropriate a suitable label attached.
- Ensure all Occupational Health referrals have relevant information and if identified as work related stress are provided with a stress risk assessment with such referrals.
- Liaise with Safety Representatives in accordance with agreed procedures and in particular:
    - Co-operate with safety inspections organised by agreement
    - Maintain a record of all safety inspections
    - Ensure any necessary investigation or action is taken following a safety inspection
    - Disclose such necessary information as may be requested by Safety representatives in accordance with the legislation, on the advice of a Personnel Manager where necessary
- Co-operate with Fire and Safety Officers to ensure that all necessary arrangements are made to protect patients, staff and others against the risk of fire.
- Assist in the investigation and implementation of reports from the HSE.
- Ensure attendance of all staff at mandatory training in accordance with current policy.
- Ensure that appropriate personal protective equipment is issued, readily available and that it is used as appropriate. In appropriate cases, ensure that an assessment of risk is completed using the appropriate form, that any such risk is identified and details what action is to be taken to minimise or remove the risk as required by the Personal Protective Equipment at Work Regulations. Failure of staff to use appropriate issued personal protective equipment in the relevant situations shall be subject to disciplinary procedures.
- Ensure that Work Equipment is assessed for risk on the relevant assessment form and identify the risk level, risk type and clearly indicate recommendations

to remove or reduce the risk to a reasonable and practicable level as required under the Provision and Use of Work Equipment Regulations.

- Ensure that the workplace is assessed for risk on the relevant assessment form and identify the risk level, risk type and clearly indicate recommendations to remove or reduce the risk to a reasonable and practicable level as required under the Workplace (Health, Safety and Welfare) Regulations.
- Action Hazard Notices as directed (internal and external).
- Ensure competent person(s) carry out all appropriate risk assessments as necessary and that such action required to reduce identified risks is carried out. Such assessments shall be recorded in a suitable manner.
- Ensure all departmental employees are informed of the hazards and risks associated with their work, as identified through the risk assessment process and all departmental employees are made aware of any preventative and protective measures they need to adhere to.
- Ensure that all departmental employees have their attention drawn to all Health Board appropriate H&S documentation at least annually or after any review or alteration to such documentation. This shall be recorded in a suitable manner at departmental level for each individual.
- Ensure that they have an appropriate level of knowledge to enable them to fulfil their H&S responsibilities.

All Managers are accountable to the Chief Executive for ensuring that this policy is properly applied in their area of control. In particular, they shall:

- Ensure adequate supervision of all staff and students is provided, commensurate with their skills and competency.
- Ensure that staff receive appropriate training and information necessary for them to carry out their role safely and competently
- Keep detailed local training records of all staff
- Use data from Directorate inspections, Directorate hazard profile, and consultative committees to guide actions to prevent or reduce the risk of serious incidents.
- Undertake stress risk assessments both Departmental and individual as required.

6.19 Health and Safety Directorate/Area Leads (Champions)

The role of the Directorate/Area Lead Champion is as follows:
- Develop systems to co-ordinate /assist in the H&S management processes within the Directorates/Areas and Corporate Functions.
- Assist managers with the completion of risk assessments.
- Assist managers to identify potential hazards and dangerous occurrences and to undertake root cause analysis.
- Investigate complaints in relation to H&S incidents.
- Make representations to their management team, both written and verbal.
- Assist in the arrangement of any H&S review/inspection/audit.
- Disseminate H&S information.
- Attend appropriate meetings and raise relevant matters.

- Provide the Corporate H&S team with copies of inspection reports where appropriate.
- Attend the H&S Area Leads (Champions) meeting organised by corporate H&S.
- Escalate any significant H&S issues.

6.20 Head of Security

The Head of Security is responsible for:

- Providing a focus for H&S matters pertaining to security related incidents including physical assaults, and co-ordination of policy, including its formation and review.
- Liaising with the Directors, Area Directors, assistant Directors and other Senior Managers to ensure that reports from the Security Safety Group relating to their areas are properly communicated and that adequate management response is formulated and appropriate action taken.
- Managing appropriate Security staff including the V&A Case Manager and relevant staff to ensure that the Security Policy is effectively implemented.

6.21 Violence and Aggression Case Manager

The Violence & Aggression (V&A) Case Manager is the lead in the creation of a safe and secure environment for staff and public so that the highest standards of clinical care can be made available to patients. They are responsible for:
- Providing support, information and advice for BCUHB staff victims of work related crime including violence/aggression taking forward prosecutions in partnership with stakeholders within the NHS and external organisations such as the Police and the Crown Prosecution Service.
- Providing support, information and advice for BCUHB victims of work related violence/aggression and untoward workplace security incidents.
- Assist the Head of Health Safety on the development and implementation and review of the Health Board Security Strategy and Policy.
- Development, review and management of the security risk profile process within the Health Board providing assurance, to the Head of Health Safety those security risks within the Health Board being managed in accordance with statutory legislation and national guidance.
- To deputise for the Head of Health & Safety when absent, in relation to Security matters requiring an urgent response.

6.22 Head of Fire Safety/Advisors

The Health Boards lead expert, the Senior Estates Officer responsible for Legislation and Compliance and the Fire Safety Advisors are responsible for the provision of technical expertise to ensure suitable systems are in place to assess the risks associated with the potential risk of fire. Undertake audits and inspections to ensure evacuation procedures are in place and practiced and the structural integrity of buildings is suitable for purpose.

6.23 Employees

All employees have a general duty while at work:
- To take reasonable care for the H&S of themselves and of other persons (including members of the public and patients) who may be foreseeably affected by their acts or omissions at work.
- To co-operate with the BCUHB in the discharge of its statutory duties in relation to the Health and Safety at Work etc. Act 1974.
- Not to intentionally or recklessly interfere or misuse anything provided for the purposes of H&S.
- To report any work situation involving serious and immediate danger to their Line Manager or Supervisor who will escalate it further if appropriate.
- To report any shortcomings in the arrangements provided for H&S at work.
- Undertake any necessary training and instruction provided in the interest of H&S. If the information provided is not adhered to this may lead to disciplinary action being taken in line with relevant Policies and procedures.

6.24 Trade Union Partners and Safety Accredited Representatives

BCUHB recognises the value and importance of pro-active engagement with its employees and its statutory duty in relation to the requirements of the Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996. In so doing the Health Board will work in partnership with its employees through the safety representatives of recognised trade unions and other professional bodies, providing facilities and assistance to these representative groups as required. The focus being to promote a pro-active partnership, working towards ensuring that a healthy and safe environment exists for those who may be affected by the undertakings of the Health Board.

BCUHB accepts that no safety policy is likely to be successful unless it actively involves employees themselves and will therefore co-operate fully with the appointment of Safety Representatives by the recognised Trade Unions, providing them with sufficient facilities and training to carry out their legal functions. Safety Representatives shall be accredited by letter from the Union or Association full time officers, which shall be placed on record in Human Resources. Such accredited Safety Representatives shall be required to produce their accreditation documents on request confirming that they are carrying out functions as a Safety Representative. Safety Representatives, representing the staff in their work place regarding matters of H&S at work, will consult and co-operate with Managers of BCUHB to promote and develop measures to ensure the health, safety and welfare of their colleagues. Specifically they:

- Make representation, in the first instance through their immediate supervisor to the Head of Department or Service Area, on any general or specific matter affecting the H&S of employees in their work place.
- Investigate, in association with the Head of Department or Service, potential hazards and dangerous occurrences at the work place and examine the causes of accidents.

- Carry out inspections together with the Head of Department or Service having given reasonable notice or in accordance with an agreed program and at the agreed intervals - normally no more than once every three months. Such inspections should be recorded in the form recommended under the Safety Representatives and Safety Committee Regulations 1977, which on production to the Head of Department shall be countersigned by them on having received a copy.
- Represent the employees in the work place in consultations with Officers of HSE. It is recommended that the Corporate H&S Team are contacted by Safety Representatives to discuss issues that relate to H&S legislation prior to contacting the HSE; however this is not a specific requirement.
- Receive from the Health Board on request, information relating to the work place or information as to any action the HSE Inspector has taken or proposes to take.

6.25 Non Trade Union Health & Safety Representatives

Where there are no union Representatives appointed under the Safety Representatives and Safety Committee Regulations 1977, the Health and Safety (Consultation with employees) Regulations 1996 allow for the appointment of non-union Safety Representatives, or for direct consultation with all workers on H&S matters. The role of the Trade Union/Non Trade Union H&S Representative is to represent fellow members/employees in consultations on H&S matters with the employer, by carrying out the functions efficiently and using the facilities and assistance provided by the employer. In this way, co-operation on these matters will improve the overall health, safety and welfare of the staff and their workplace.

The functions of a H&S Representative are as follows:

- To represent fellow members/employees in consultation with the employer on H&S related matters.
- To investigate potential hazards and dangerous occurrences and to undertake root cause analysis in conjunction with management.
- To investigate complaints.
- To make representations to the employer, both written and verbal;
- To carry out inspections.
- To receive information from the employer where elected to do so, to attend meetings of safety committees and raise relevant matters.
- To provide employers with copies of inspection reports and to receive responses in respect of inspection reports.

Note: Wherever possible the BCUHB will encourage the nomination of a Trade Union H&S Representative, however when a Union Representative cannot be appointed consideration will be given to availability of a Non Trade Union Representative.

6.26 Primary Care Contractors (PCC)

BCUHB recognises that PCC have a moral and legal duty under H&S legislation to manage H&S risks within their business and this includes the prevention of harm or ill

health to those who are not in their employ. In the case of the relationship with BCUHB this relates to patients/clients who are receiving NHS care in premises not directly under the control of BCUHB.

Through effective partnership and contractual arrangements, BCUHB will provide support, advice and guidance to manage risks associated with H&S via the Primary Care H&S Advisor. This is in conjunction with the Clinical Governance Teams (CGT) which are located within the geographical areas to ensure that the wider NHS community within North Wales benefit from the full range of expertise available.

BCUHB Corporate H&S will agree and facilitate effective monitoring arrangements, in partnership with CGT, to assist with managing and mitigating risks within their environment. This will enable BCUHB and CGT to fulfil the requirements of the Healthcare Standards for Wales in addition to the statutory legislation to ensure good practice. Monitoring arrangements will be undertaken utilising both the Quality Assurance Visiting Programme (QAVP) and H&S Reviews in line with these legislative requirements and the contractual arrangements. These will be reviewed based on a risk based periodic timetable or when contracts change.

6.27 Commissioned Services

When NHS funded care is commissioned outside of the BCUHB, the organisation shall take reasonable steps to ensure that those locations where patient/s are placed are safe and suitable for the needs of the patient/s. The Independent Sector Care Homes have their own responsibilities in respect of compliance with Statutory Legislation; however BCUHB has statutory responsibility for ensuring that patients placed in NHS funded care are cared for in a safe and suitable environment. BCUHB will ensure that this is achieved through evaluation, partnership working with other regulatory agencies including Care Standards Inspectorate Wales, the local authority and the HSE to ensure that effective monitoring arrangements are in place and in line with contractual arrangements with the care providers.

7. ASSURANCE

7.1 Assurance Structure

The Health Board shall gain its assurance in terms of the management of H&S within the Organisation through the Strategic Occupational Health and Safety Group and supporting organisational structures.

7.2 The Health Board

The Health Board will receive regular reports from the Strategic Occupational Health and Safety Group via the Quality Safety and Experience Committee referenced in the Terms of Reference (Appendix 1 & 2). The group has been established to plan, organise and monitor organisational compliance with its statutory H&S obligations and duties, as well as the impact on the organisation of any new and impending legislation. The following will be implemented:
- H&S Gap analysis action plan completed.

- Three year OHS Strategy implemented.
- Directorate/Corporate self-evaluation reports evidenced.
- H&S Team, Manual Handling, Occupational Health and Security audits (annual gap analysis undertaken).
- H&S incidents including trend analysis, lessons learned and actions taken.
- Any enforcement action issued against the BCUHB evidenced and lessons learned.
- Any specific matters regarding H&S for escalation.

7.3 Strategic Occupational Health and Safety Group

The Strategic Occupational Health and Safety Group will provide the means by which management and staff representatives can develop and maintain the H&S management process across the BCUHB and in so doing comply with the requirements of section 2(7) of the Health and Safety at Work etc. Act 1974. The Group will receive activity and performance reports from the Directorates/Areas and Corporate Functions and maintain oversight of the BCUHB H&S risk profile. The Group will send minutes and Issues of Significance to the Quality, Safety and Experience Committee so they can be considered as part of the wider quality and safety issues identified. Significant issues will be escalated to the Health Board. The Strategic OHS Group ensures H&S compliance with external bodies' requirements such as the HSE, The National Health Service Litigation Authority / Department of Health, NHS Wales Dangerous Notification Alerts etc.

The group has delegated authority determined by the Board to take decisions, which enable the group to deliver its main duties and responsibilities. To ensure continued and effective H&S management arrangements, the group will make decisions in respect of all H&S matters including BCUHB Policy. The main duties and responsibilities of this group are to:

- Monitor compliance with statutory H&S requirements.
- Monitor compliance with the HSE H&S action plan and action plans developed to ensure compliance with external bodies.
- Review non-clinical related incidents to identify trends and monitor progress relating to new and outstanding investigations.
- To identify development needs across the organisation, informed by trends in accidents and risk assessment.
- To lead the achievement of a reduction in RIDDOR incidents and related absence, numbers and cost of claims.
- Address matters escalated from Management to Board or equivalent.
- Monitor H&S management and performance.

7.4 Quality, Safety and Experience Committee

The Quality, Safety and Experience Committee shall receive the minutes and any significant issues to be escalated from the Strategic Occupational H&S Group and Quarterly reports on progress of Occupational H&S Plans.

8. Appendix 1

Strategic Occupational Health and Safety Group Terms of Reference

INTRODUCTION

Section 2 (7) of the Health and Safety at Work etc. Act 1974 states that "*In such cases as may be prescribed it shall be the duty of every employer, if requested to do so by the safety representatives mentioned in subsections (4) and (5), to establish, in accordance with regulations made by the Secretary of State, a safety committee having the function of keeping under review the measures taken to ensure the Health and Safety at work of his employees and such other functions as may be prescribed. These arrangements are aligned to the Safety Committees Regulation 1977 and the Health and Safety (Consultation with Employees) Regulations 1996 (as amended).*

The Strategic Occupational Health and Safety Group has been established to provide an effective means of facilitating a partnership approach to the management of Health and Safety risk across the Betsi Cadwaladr University Health Board (BCUHB). Thus providing compliance with the requirements of Statutory Legislation, approved codes of practice and guidance documentation.

The terms of reference and operating arrangements in respect of this Group are set out below.

CONSTITUTION

The purpose of the Strategic Occupational Health and Safety Group is to provide the means by which the management and staff representatives can work in partnership, to develop and maintain health and safety management arrangements across the Health Board.

The Strategic Occupational Health and Safety Group will ensure that an integrated approach to the identification and management of workplace health and safety risk is maintained throughout the organisation. The Strategic Occupational Health and Safety group will support the development of a positive safety culture and safety management system that enhances the organisations ability to identify and manage risks to those affected by their work activity.

SCOPE AND DUTIES

1. To provide assurance in terms of the effective management of Occupational Health and Safety risk across all activities and facilities within the Health Board.
2. To ensure that effective partnership working arrangements are maintained between Management and Staff Health and Safety Representatives.
3. To provide assurance that occupational health and safety management arrangements within the Health Board meet the requirements of the Health and Safety at Work etc. Act 1974, and supporting legislation.

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4. To receive occupational health and safety management reports from all clinical and corporate Departments.
5. To monitor the delivery of the Health Board's risk Health & Safety and performance reporting systems.
6. To monitor actions being taken to address significant occupational health and safety risks within the organisation.
7. To monitor the delivery of the Health Boards health and safety improvement plan in response to identified areas of improvement within the organisation.
8. Continued development of the Occupational Health and Safety Policy and supporting documents and management arrangements.
9. Report on performance in respect of the key health and safety performance indicators within the Health Board.

DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT

The Executive Director of Workforce and Organisational Development has lead responsibility for the Management of Occupational Health and Safety within the Health Board. The specific powers, duties and responsibilities delegated to the Executive Director of Workforce and Organisational Development from the Chief Executive are:

- To chair the Strategic Occupational Health and Safety Group.
- To make recommendations for risk based improvements to the management of occupational health and safety risk across the Health Board.
- To ensure the implementation of relevant policies, procedures and other written control documents that enable the Health Board to meet the requirements of Statutory Health and Safety Legislation.
- Ensure competent health and safety advice and guidance is available.
- Submit regular assurance reports to the Health Board through the Quality, Safety, and Experience Committee for consideration as part of the Integrated Governance through to the Health Board.

AUTHORITY

The Strategic Occupational Health and Safety Group is empowered with the responsibility for:

- The development of a health and safety risk profile and improvement plan.
- Providing Board assurance that health and safety risk is being managed effectively and make recommendations for improvements to the health and safety management systems.
- To monitor the performance of the Health Board in respect of the management of health and safety.
- Implement and review annually the Health Board's Occupational Health and Safety Policy.

- Establishing Sub-Groups to address issues of significance such as but not restricted to, the development of procedures and guidance for the management of Health and Safety e.g. H&S Leads.
- To ratify procedures and guidance in support of the Occupational Health and Safety Policy.
- To review incidents trends across the Health Board which relate to health and safety issues.
- To review serious incidents reported to the HSE.
- Maintain effective partnership working arrangements within the Health Board in relation to the Management of Occupational Health and Safety.
- Develop health and safety performance indicators through the self - assessment audit process.
- To receive and review monitor reports in respect of the Management of Fire Safety and Security, Violence & Aggression and other topics defined by the Group.

MEMBERSHIP

Chair	Executive Director of Workforce and Organisational Development
Vice Chair	Executive Director of Planning & Performance
	Trade Union Health and Safety Representatives (in line with the Local Partnership TOR including representatives of employee safety)
	Associate Director of Health, Safety and Equality
	Executive Director of Nursing and Midwifery
	Medical Director
	Executive Director of Therapies and Health Science
	Associate Director of Quality Assurance
	Medical or Nurse Director Secondary Care
	Area Directors
	Director of Mental Health and Learning Disabilities
	Director of Estates and Facilities
	Fire Safety Lead
	Associate Director HR
	Assistant Director of Infection, Prevention and Control
	Head of Risk Management

	Head of Patient Concerns
	Public Health Wales Representative
	Head of Health & Safety
	Head of Occupational Health and Wellbeing.
Secretary	As determined by the Executive Director of Workforce and Organisational Development
In attendance	The Group may require the attendance of others for advice, support and information routinely at meetings as determined by the Chair.
Deputies	The Group membership is permitted to have named designated deputies.

COMMITTEE MEETINGS

Quorum

At least seven members must be present to ensure the Group is quorate. Of those present, at least three must be Trade Union representatives and 4 "Management " members of which must include the either Chair or Vice Chair and in the absence of the Chair, the Associate Director of Health, Safety and Equality; Divisional representation

Frequency of Meetings

Meetings will be held bi-monthly and otherwise, as the Group Chair deems necessary.

REPORTING AND ASSURANCE ARRANGEMENTS

The Group Chair shall:

- Report formally, regularly and on a timely basis to the Health Board on the Group's activities. Including the presentation of an Annual Report.

- Submit the Group's minutes and issues of significance to the Quality, Safety and Experience Committee for consideration as part of the Integrated Governance Committee through to the Health Board.

- Ensure arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees/Groups of any urgent/critical matters that may affect the safety of staff and others and the operation and/or reputation of the Health Board.

- Provides assurance to the Risk Management Group by raising risks through the governance structure as necessary and providing quarterly and annual reports to the Group.

Governance Sub-Structures

The Group reports to the Risk Management Group chaired by the Chief Executive. The Group also provides assurance reports to the Quality, Safety and Experience Committee of the Board.

The Group will establish sub-groups to support the delivery of effective Occupational Health and Safety management systems. This will include:

Health and Safety Leads (Champions) Group

Operational Occupational Health and Safety Group

Health and Wellbeing Group

Asbestos Management Group

Water Safety Group

Fire Safety Group

Security Management Group

In addition, all Divisional Health and Safety Groups will be accountable to this Strategic Group under its terms of Service

9. Appendix 2: Structure for reporting to Board.

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│   BCUHB Health Board    │
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│   Quality, Safety and   │
│  Experience Committee   │
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│  Strategic Occupational │
│       H&S Group         │
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        │   Executive Director    │
        │ Workforce & Organisational │
        │      Development        │
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                │ All Groups inc: Water Safety │
                │  Asbestos, Fire, Electrical  │
                │   Safety and Security.   │
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                        │ Group Leads (Champion)  │
                        │ Group/Local Q&S Groups, │
                        │  HMT's in Service areas. │
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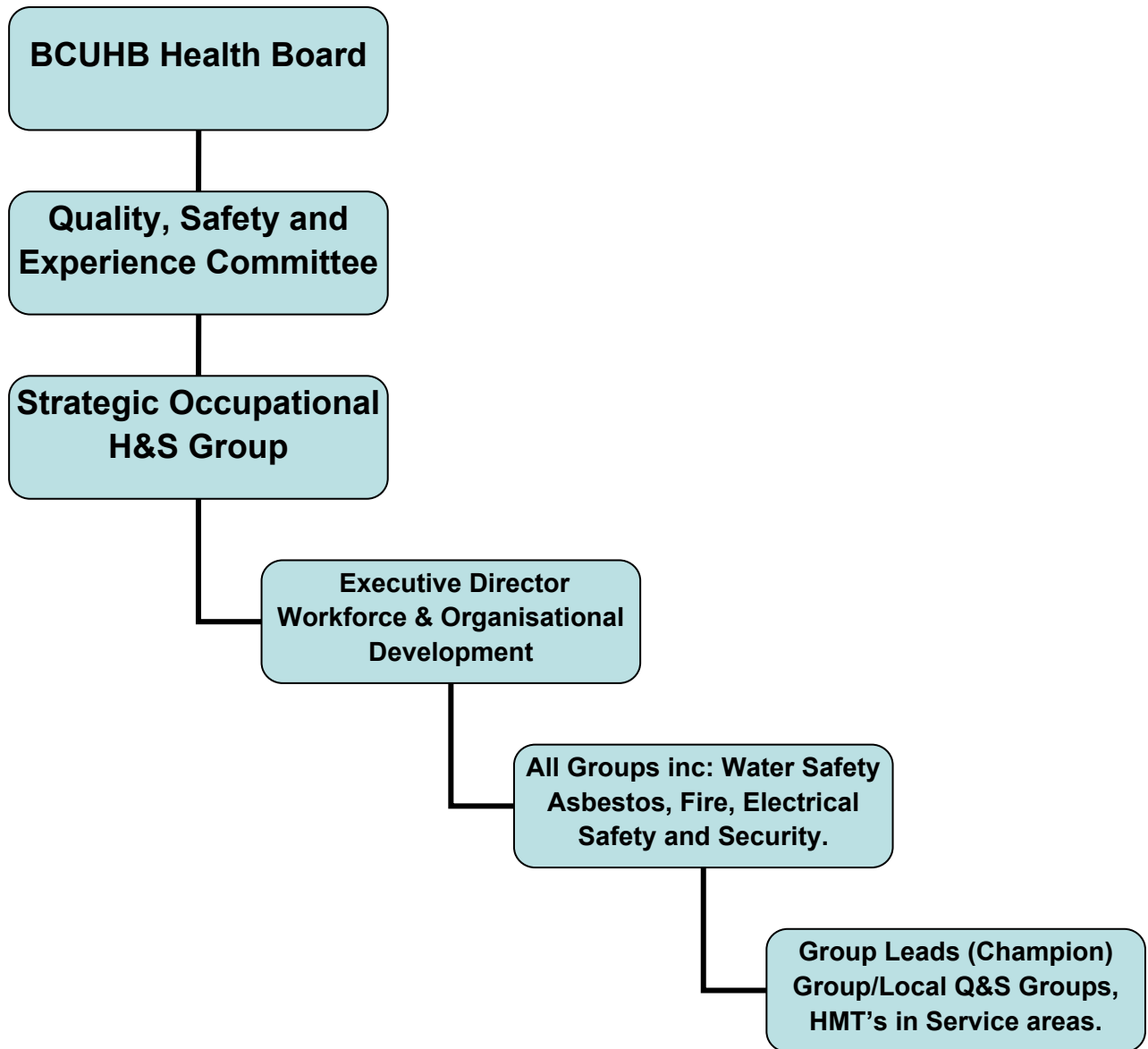
10. References

1. Health and Safety at Work etc. Act 1974
2. Management of Health and Safety at Work Regulations 1999
3. Control of Asbestos Regulations 2012
4. Control of Substances Hazardous to Health Regulations 2002
5. The Work at Height Regulations 2005
6. Control of Vibration at Work Regulations 2005
7. Electricity at Work Regulations 1989
8. Gas Safety (installation & Use) Regulations 1998
9. Control of Noise at Work Regulations 2005
10. Ionising Radiation Regulations 2017
11. Control of Electromagnetic Fields at Work Regulations 2016
12. Control of Artificial Optical Radiation at Work Regulations 2010
13. Confined Spaces Regulations 1997
14. Safety Representatives and Safety Committees Regulations 1977
15. The Health and Safety (Display Screen Equipment) Regulations 1992 amended 2002
16. Manual Handling Operations Regulations 1992
17. The Provision and Use of Work Equipment Regulations (PUWER) 1998
18. Lifting Operations and Lifting Equipment Regulations (LOLER) 1999
19. Personal Protective Equipment at Work Regulations 1992
20. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
21. The Workplace (Health, Safety and Welfare) Regulations 1992
22. Regulatory Reform (Fire Safety Order) 2005
23. Corporate Manslaughter and Homicide Act 2007
24. Health and Safety (First Aid) Regulations 1981
25. The Waste (England and Wales) Regulations 2011
26. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
27. Health & Safety (Safety Signs and Signals) Regulations 1996
28. Construction (Design and Management) Regulations (CDM) 2015
29. Safety Representatives and Safety Committees Regulations 1977
30. The Health and Safety (Consultation with Employees) Regulations 1996
31. HSG65 Successful Health and Safety Management 1997
32. Stress Management Standards
33. Equality Act 2010

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	Health & Safety Policies
Date form completed:	20th October 2019

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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 a disability 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 / 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 / remove these?*

✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / 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

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Betsi Cadwaladr University Health Board (BCUHB), Occupational Health & Safety (OHS) Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The overall aim of the policy is to promote a continual positive culture for OHS Management and to encourage ownership at every level as well as the development and sustainability of high quality support services and systems. This will be achieved through a strong, visible and consistent leadership and be delivered in a timely, efficient, effective and affordable manner. The Policy aims to ensure the organisation meets its legislative obligations to safeguard the health, safety and welfare of patients, staff, visitors, property, as well as the organisation itself. This will enable the Health Board to meet and, where possible, exceed the statutory obligations placed upon the organisation to safeguard everyone who might otherwise be affected by the actions and/or omissions of BCUHB.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	The Chief Executive has the authority to agree and approve any changes necessary to all Occupational Health and Safety (OHS) Policy. The Executive Director of Workforce and Organisational Development has been appointed as the Executive Lead for OHS. The Policy will be formally reviewed and approved by; • Strategic OHS Group • Quality, Safety and Experience Committee. • Board
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	OHS responsibilities are a legal duty and are integral to all BCUHB activities. The Policy is informed by relevant legislation, national guidance and Code of Practices etc. Including, though not limited to a range of legislation which is made under the Health and Safety at work etc. Act 1974 which is provided in the appendix of the Policy of approximately 31 in total. These include the following:- 1. Health and Safety at Work etc. Act 1974 2. Management of Health and Safety at Work Regulations 1999 3. Control of Asbestos Regulations 2012 4. Control of Substances Hazardous to Health Regulations 2002 5. The Work at Height Regulations 2005 6. Control of Vibration at Work Regulations 2005 7. Electricity at Work Regulations 1989

		8. Gas Safety (installation & Use) Regulations 1998 9. Control of Noise at Work Regulations 2005 10. Ionising Radiation Regulations 2017 11. Control of Electromagnetic Fields at Work Regulations 2016 12. Control of Artificial Optical Radiation at Work Regulations 2010 13. Confined Spaces Regulations 1997 14. Safety Representatives and Safety Committees Regulations 1977 15. The Health and Safety (Display Screen Equipment) Regulations 1992 amended 2002 16. Manual Handling Operations Regulations 1992 17. The Provision and Use of Work Equipment Regulations (PUWER) 1998 18. Lifting Operations and Lifting Equipment Regulations (LOLER) 1999 19. Personal Protective Equipment at Work Regulations 1992 20. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 21. The Workplace (Health, Safety and Welfare) Regulations 1992 22. Regulatory Reform (Fire Safety Order) 2005 23. Corporate Manslaughter and Homicide Act 2007 24. Health and Safety (First Aid) Regulations 1981 25. The Waste (England and Wales) Regulations 2011 26. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 27. Health & Safety (Safety Signs and Signals) Regulations 1996 28. Construction (Design and Management) Regulations (CDM) 2015 29. Safety Representatives and Safety Committees Regulations 1977 30. The Health and Safety (Consultation with Employees) Regulations 1996 31. HSG65 Successful Health and Safety Management 1997 32. Stress Management Standards The Policies relate to work activities within all BCUHB, Divisions, Departments and Specialities. The standard procedures in operation will require cross referencing with the Policy to ensure work is carried out in a safe manner. The procedures in place will require modifying to ensure they are compliant with the Policy.

Part A   Form 1: Preparation

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The policy will apply to all premises and undertakings of BCUHB. Stakeholders will include all staff, contractors, visitors, Trade Union Partners and volunteers. The draft version of the Policy will be uploaded to the staff intranet for review/consultation. This will be accompanied by a message to all users in the Corporate Bulletin advising of the review. Targeted emails will be distributed to relevant areas (Estates & Facilities, Hospital/Area Directors, and Mental Health & Learning Disability etc.) to ensure successful dissemination and increase awareness. Following ratification and implementation of the Policy, a number of forums including a Safety Leads Group, Security Group, Fire Safety, Water Safety and Asbestos Group will provide feedback to the Strategic OHS Group which has organisational wide representation including Nursing Unions, Radiation, Estates and Facilities etc. and clear Terms of Reference. As the Strategic three year plan progresses and the revised Policy is embedded, communications and programs of work will be further reviewed/developed as informed by the feedback from relevant parties/groups. Staff will receive training on induction and specific learning dependant on the requirements of a training needs analysis.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	The extent of training and capacity to deliver the changes will be challenging. A twelve month action plan has been developed to support the Policy implementation plan. Culture and some working practices may hinder the drive for change. However we have senior level commitment to the changes from the Board and this will make a significant difference to the program plans. The financial situation is a risk that funds will be removed from some statutory inspections that are required to comply with statutory inspections.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers regardless of age, disability, gender, transgender, marriage or civil partnership, pregnancy or maternity, race, religion and belief or non-belief, or sexual orientation. The Policy will have a positive effect on staff wellbeing identifying areas of concern such as noise, vibration, radiation, fire, slips trips falls, manual handling etc. alongside the best practice for management. The Policy will recognise the specific needs of protected characteristics as prescribed by the Equality Act 2010. For example, pregnancy or maternity and disability thus reducing inequality and/or disadvantage.

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

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. *(Please refer to the Step by Step guidance for more information)* 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? i.e. 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 3: Record of Potential Impacts – Human Rights and Welsh Language

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)				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?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of age group. The Policy is considered to have a positive effect on particular age groups. The legislation is there to protect the workforce and therefore does not negatively affect or hinder the individuals of any age. Legislation enacted to enforce OHS employer duties has been legally and ethically reviewed by Parliament to ensure non-discrimination and compliance with the Human Rights under the European Convention of Human Rights (incorporated into domestic legislation via the Human Rights Act 1998). The Policy will promote healthy working practices that reduce the risks associated with an ageing workforce such as manual handling training to reduce the risks of musculoskeletal disorders. The overarching Policy will acknowledge and best endeavour to meet the specific needs of the Young Worker whilst ensuring specific associated risks are recorded and reviewed appropriately via prescribed risk assessments (the specific guidance will be recorded as a subordinate Procedure)	

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

Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of disability. The Policy is considered to have a positive effect on disability. The overall legislative framework will support, through Health surveillance, a pro-active approach to identification of ill health conditions as a result of work activity. This may include preventative inoculations, noise assessments for hearing loss, vibration monitoring of equipment processes and staff health surveillance. In addition to the above, the Policy recognises the legal requirements around considering reasonable adjustments for disabled staff in accordance with our WP11 NHS Wales Managing Attendance at Work Policy. Health and Safety information is not automatically published in braille or languages other than Welsh and English. The primary source of circulation is via the Policies, Procedures and other written control documentation page on the BCUHB intranet. Software that will read the policy for the reader is now very common therefore documents should generally be accessible to people with a visual impairment or requiring translation. In addition, the Intranet must adhere to the Public Sector Bodies (Websites and Mobile Applications) (No.2) Accessibility Regulations 2018 which promotes a standard approach for website development that aids accessibility for those with an imparment.	
Gender Reassignment (sometimes referred to as 'Gender	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of gender identity. The Policy is considered to have a positive effect on gender identity. Where staff have identified as Transgender / disclosed their status or may be undergoing/have undergone gender	

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

Identity' or transgender)					reassignment, they may be more susceptible to stress in the workplace. The Policy includes a commitment to ensure that suitable and sufficient resources are available for the provision of an effective OHs and Wellbeing Service within BCUHB. This will include Confidential counselling for staff members who feel they are suffering ill health as a result of stress caused by factors at work or elsewhere.	
Pregnancy and maternity	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of pregnancy or maternity. The Policy is considered to have a positive effect on race. The Policy will be supportive of identification through suitable and sufficient risk assessments to identify hazards associated with pregnant workers. This is supported by Pregnancy and Maternity Policy with appropriate work place assessment and reasonable adjustment as required.	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of race. The Policy is considered to have a positive effect on pregnancy and maternity. Being visibly of a different race/ethnicity may make individuals more vulnerable to abuse/harassment and stress in the workplace. The Policy includes a commitment to ensure that suitable and sufficient resources are available for the provision of an effective OHs and Wellbeing Service within BCUHB. This will include Confidential counselling for staff members who feel they are suffering ill health as a result of stress caused by factors at work or elsewhere. Health and Safety information is not automatically published in languages other than Welsh and English. Software that will	

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

					translate the policy for the reader is now very common therefore documents should generally be accessible to people requiring translation.	
Religion, belief and non-belief	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of religion, belief or non-belief. The Policy is considered to have a positive effect on religion, belief or non-belief. Assumptions made about or knowledge of a person's religion may make them more vulnerable to abuse/harassment and stress in the workplace. The Policy includes a commitment to ensure that suitable and sufficient resources are available for the provision of an effective OHs and Wellbeing Service within BCUHB. This will include Confidential counselling for staff members who feel they are suffering ill health as a result of stress caused by factors at work or elsewhere.	
Sex (men and women)	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of sex. The Policy is considered to have a positive effect on sex.The Policy will create a process through which risk assessments are undertaken in areas such as the stress assessment or pregnant workers assessment. This will clearly identify actions required and may identify opportunities to explore flexible working arrangements where the proposed changes impact upon personal circumstances, for example, where the proposals impact upon childcare responsibilities. The proposal is then referred to existing HR Policies such as leave policies, including flexible working etc.	
Sexual orientation	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of sexual	

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

(Lesbian, Gay and Bisexual)					orientation. The Policy is considered to have a positive effect on sexual orientation. Assumptions made about or knowledge of a person's sexual orientation may make them more vulnerable to abuse/harassment and stress in the workplace. The Policy includes a commitment to ensure that suitable and sufficient resources are available for the provision of an effective OHs and Wellbeing Service within BCUHB. This will include confidential counselling for staff members who feel they are suffering ill health as a result of stress caused by factors at work or elsewhere.	
Marriage and civil Partnership (Marital status)		x			The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of marital status. The Policy is considered to have a neutral effect on marital status. There is no evidence to suggest the H&S policies will have an impact on Marriage and Civil Partnerships.	
Low-income households	x		x		The Policy will apply to all staff, contractors, visitors, Trade Union Partners and volunteers equally regardless of level of income. The Policy is considered to have a positive effect on all household income brackets. The policies are supportive of staff in all service areas for example the Personal Protective Equipment Regulations provide equipment to protect staff free of charge. This supports people on low income households. Uniforms are also provided to staff as appropriate.	

Human Rights:

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

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
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

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)			
x		x			Human rights will not be adversely affected. The Policy's aim is to have a positive impact on maintaining health and wellbeing as well as mitigating the occurrence of accidents that may cause death. This supports BCUHBs positive obligation under Article 2, Right to life. By supporting individuals that may be experiencing assumptions made about or knowledge of any of the protected characteristics that may make them more vulnerable to abuse/harassment and stress in the workplace, the Policy reinforces Articles 3, 8 and 9.	None identified

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

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	☐		☐		The Policy will be submitted to the Welsh Language Portal for translation.	
Treating the Welsh language no less favourably than the English language		☐			The Policy will available in both Welsh and English.	

Part A Form 4: Record of Engagement and Consultation

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.

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.	- We engaged with all staff groups who attend the Strategic OHS Group including leaders in Celtic Pride, Equality Leads, 1:1 meetings with key stakeholders such as Trade Union Partners. - A systematic review of 117 site inspections with 169 questions based on the 31 pieces of legislation has informed the Policy development with direct feedback from operational stakeholders on the ground. - OH&S Website provides support and advice on the law and how policies are being implemented. - Trade Union Partners attended numerous site visits in support of staff concerns raised. - Consultation on BCUHB staff intranet.	
Have any themes emerged? Describe them here.	We have identified that further work is necessary on musculoskeletal disorders that affect the older worker. Additional work on risk assessments for pregnant workers and adequate health surveillance to protect staff from having a disability as a result of their work activity such as Vibration White Finger. There are a number of ways to improve the structure for Occupational Health and Safety in many service areas. This Policy will support the building of an effective infrastructure.	

Part A Form 4: Record of Engagement and Consultation

If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	The Policy places clear responsibilities on Assistant Directors and Line managers to undertake suitable and sufficient risk assessments which need to be specific about the work activities and risks identified. The Policy is guided by the gaps identified throughout the safety management system a 12 month action plan including developing Policy, procedure and guidance is being implemented.	

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.

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

1. What has been assessed? (Copy from Form 1)	BCUHB Occupational Health & Safety Policy

2. Brief Aims and Objectives: (Copy from Form 1)	The overall aim of the policy is to promote a continual positive culture and to encourage ownership at every level as well as the development and sustainability of high quality support services and systems. This will be achieved through a strong, visible and consistent leadership and be delivered in a timely, efficient, effective and affordable manner. This will ensure the organisation meets its legislative obligations to safeguard the health, safety and welfare of patients, staff, visitors, property, as well as the organisation itself. This will enable the Health Board to meet and, where possible, exceed the statutory obligations placed upon the organisation to safeguard everyone who might otherwise be affected by the actions and/or omissions of BCUHB.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes		No	x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes		No	x
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?	Yes	x	No	

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		No	✓
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The H&S Management system will have a positive impact on wellbeing. This includes risk assessments in all areas of BCUHB and appropriate adjustments would be made for staff to return to work safely or adjustments whilst in work. The sole purpose of the legislation is to protect staff and others from ill health affects injury or death as a result of a workplace accident or long term ill health condition. The overall assessment is considered to be positive.				
5. If you answered 'no'	Yes			✓

Part B Form 5: Summary of Key Findings and Actions

above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	The document will be translated into Welsh.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes ✓	No	
	How is it being monitored?	Strategic OHS meetings, audits, reviews Quarterly reports on activity and escalated to QSE as required.	
	Who is responsible?	Associate Director of Health, Safety and Equality	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? The information will be generated by H&S Leads, H&S Advisors, Head of Occupational Health and Wellbeing, Manual Handling Manager, Head of H&S, Security Manager, risk registers and incidents etc.	
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	When the Policies is reviewed in line with Policies on Policies.	

7. Where will your policy or proposal be forwarded for approval?	The Strategic Occupational Health and Safety Group Quality, Safety & Experience Committee Board

8. Names of all parties involved in undertaking this Equality Impact	Name	Title/Role
	Steven Roscoe	Head of Health and Safety

Part B Form 5: Summary of Key Findings and Actions

Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Mike Towson	Senior Equalities Manager
	Peter Bohan	Associate Director Health Safety and Equality
	Sue Green	Executive Director Human Resources and Organisational Development
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	None identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None identified		
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?	None identified		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	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.	None applicable		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Regular review of policy which will be informed from relevant group's feedback as well as comments from the consultation.		

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Committee Annual Report 2019-20
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: Prior Scrutiny:	The Committee Annual Report has been scrutinized by the Committee Chair and Lead Executive
Atodiadau Appendices:	1. Committee Annual Report (which itself has three accompanying appendices)

Argymhelliad / Recommendation:

The Committee is asked to:
1. Review the draft Annual Report for 2019-20
2. Provide comments and feedback as necessary
3. Agree that Chair's Action can be taken if necessary before submission to Audit Committee

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	Ar gyfer sicrwydd For Assurance	Er gwybodaeth For Information	
	√				

Sefyllfa / Situation:

Committee input to the Annual Report for 2019-20 is sought.

Cefndir / Background:

The Annual Report has been prepared on a BCU-wide template for all Committees and Advisory Groups. The report will require further amendment to incorporate themes from the March 2020 meeting, and will be submitted to a workshop meeting of the Audit Committee to be held on the 12th May 2020.

Asesiad / Assessment & Analysis

Risk Analysis

The report contains references to risks identified throughout the year.

Legal and Compliance

The Committee is required to produce an annual report which forms part of a composite report to the full Health Board.

There are no relevant matters to highlight relating to strategy, finance, and impact assessment

Quality, Safety & Experience Committee
Annual Report 2019-20

1. Title of Committee

Quality, Safety & Experience Committee (QSE)

2. Name and role of person submitting this report:

Mrs Gill Harris, Executive Director of Nursing and Midwifery

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the Committee met during this period:

The QSE **Committee** was routinely scheduled to meet six times and otherwise as the Chair deemed necessary. During the reporting period, it met formally on six occasions plus two additional workshops were held. Attendance at formal meetings is detailed within the table below. It is confirmed that all formal meetings were quorate.

Independent Members of the Committee	21.5.19	16.7.19	24.9.19	19.11.19	28.1.20	17.3.20
Lucy Reid (Chair)	P	P	P	P	P	
Cheryl Carlisle	P*	A	P	P*	P*	
Jackie Hughes	A	P	P	P	P	
Lyn Meadows	P	P	P	A	P	

Directors and Officers - formally In attendance (as per Terms of Reference)	21.5.19	16.7.19	24.9.19	19.11.19	28.1.20	17.3.20
Deborah Carter Associate Director of Quality Assurance (NB was acting Exec Director of Nursing & Midwifery from April to Aug 2019)	P	P	P*	P	P	
Gareth Evans Chair of Healthcare Professionals Forum	A	A	A	X	A	
Sue Green Executive Director of Workforce & OD	P	A	P	P*	P	
Gill Harris Executive Director of Nursing & Midwifery	A	A	A	A	P*	
David Fearnley Executive Medical Director	◆	◆	P	P	P	
Melanie Maxwell Senior Associate Medical Director / 1000 Lives Clinical Lead	A	A	P*	P*	P	
Evan Moore Executive Medical Director	P	A	◆	◆	◆	◆
Jill Newman Director of Performance	P*	P	P*	P*	P	
Teresa Owen Executive Director of Public Health	P*	P	A	P*	P*	
Chris Stockport Executive Director of Primary & Community Services	P*	P	A	P*	P	
Andy Roach Director of Mental Health & Learning Disabilities	X	P	A	A	A	
Lesley Singleton Acting Director of Mental Health & Learning Disabilities	◆	◆	◆	P*	P	
Adrian Thomas Executive Director of Therapies & Health Sciences	P	P	P	P	P	

Key:

P - Present   P* **-** Present for part meeting

A - Apologies submitted   X - Not present

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. Other independent members may also attend on a co-opted basis. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

- Ensure the adequacy of safeguarding and infection, prevention and control arrangements;

- Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

- Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

- Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

  o Sources of internal assurance (including clinical audit) are reliable
  o Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
  o Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

- Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

- Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised

Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

- Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

- Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

- Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

- Receive periodic updates in respect of the workforce flu vaccination.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference. V5.0 were operative up until July 2019 and V6.0 for the remainder of the year. Copies are provided at Appendices 1 and 2.

The work programmes, cycles of business and overall performance of the Committee are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 3 breaches of this nature in terms of a range of individual papers not being available 7 days before the meeting.

6. Overall *RAG status against Committee's annual objectives / plan: AMBER

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	Assurance Status (RAG)*	Supporting narrative *(Please provide narrative against all red and amber including the rationale for the assurance status)*
Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;	Amber	Good evidence in parts of the organisation but not consistently pan-BCU wide. Occasions where committee not being sighted on key risks in a timely fashion. Need to strengthen organisational learning.

Ensure the adequacy of safeguarding and infection, prevention and control arrangements;	Green	
Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;	Red	Some improvements in patient feedback and access to PALS. In year the impact of the centralisation of vascular services has reduced patient confidence in the Health Board. Further work around patient experience and complaints required. More robust data is available but Board needs to use it more effectively to improve experience.
Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;	Amber	Greater level of assurance around H&S across the organisation and actions in place to mitigate risks.
Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that: • Sources of internal assurance (including clinical audit) are reliable • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis • Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.	Amber	Committee is better informed but there are actions outstanding.
Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;	Amber	Partially assured but more consistency required.
Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee	Amber	In year the Committee have reduced the risk score re care homes. Reports received regarding women's services in England (eg; Shrewsbury). WHSCC Quality & Patient

(WHSSC); Emergency Ambulance Services Committee (EASC).		Safety Committee minutes are shared. Further actions to improve assurances around Board's own externally commissioned services.
Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;	Amber	Lack of confidence that the Committee are seeing all appropriate indicators. Concern that the narrative within the IQPR is variable.
Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.	Amber	Review liaison between QSE and SPPH. QSE has confirmed the sustainability of safe services – eg; endoscopy, but sustainability from a financial or performance perspective is not within remit.
Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;	Red	Some progress has been made in Q4 to better recognise that a more risk based approach will help inform these discussions.
Receive periodic updates in respect of the workforce flu vaccination.	Green	

Key:

Red	= the Committee did not receive assurance against the objective
Amber	= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed
Green	= the Committee received adequate assurance against the objective

7. Main tasks completed / evidence considered by the Committee during this reporting period:

7.1 The Committee received a range of standing and regular items as per its cycle of business (see Appendix 3). The agenda setting process also allows for flexibility to bring ad-hoc papers to the Committee usually these relate to providing assurance against a current risk or issue, an all Wales issue requiring local consideration, or to ensure governance and scrutiny of an issue ahead of a forthcoming Health Board meeting. A summary of such reports in 2019-20 is as follows:-

- A comprehensive response to the recommendations arising from the Welsh Government's Review of maternity services at Cwm Taf. Of the 70 recommendations, 6 were rated as ongoing improvement required. The

actions would be monitored by the QSE Committee and a briefing provided to the Board;

- An update on the management of risk for the handover of patients between the Ambulance Service and the Emergency Departments. Measures being taken included a regular review of corridor congestion within the Emergency Department and handover delays.
- The Medicines Management Report identified key risks being managed by the service. The lack of pharmacy support for Mental Health services in the East was discussed and the plans to address this. There was also discussion around the implications for patients of recent changes to repeat prescribing services in community pharmacy.
- An inspection report of HMP Berwyn's health services undertaken by HM Inspectorate for Prisons and Healthcare Inspectorate Wales. The findings were positive overall but identified the main area for improvement was dental services. This service has been constrained by estates issues that have resulted in difficulties being able to provide additional dental services resulting in long waiting times for prisoners.
- The Committee received an update on an extraordinary meeting of the Local Partnership Forum to discuss the nurse rota changes and there was a commitment to move forward in partnership with the changes.
- An update was provided on a joint venture between WAST and the Health Board to develop the advanced paramedics multi-disciplinary team working programme. This is operational across 5 cluster areas and initial reports of its impact are very positive;
- The Health Board's response to HIW's Thematic review of Children's Services was received providing details of how the Health Board will be implementing learning arising from the findings;
- The externally commissioned follow up Infection Control and Prevention Report by Jan Stevens was received and highlighted significant improvements across the Health Board as part of the Safe Clean Care work.
- Monitoring of HASCAS / Ockenden recommendations with end of year position that 19 of the 35 recommendations have been closed, with 14 of the remaining open ones being assessed as 'green' and 2 reporting as 'amber'. Claire Brennan to provide figures
- An update report on dementia services which demonstrated significant progress in improving dementia support for patients and detailed the work of the Dementia Strategy Group.
- The Committee were sighted on significant waiting times for psychological therapy services and were informed that a review had been identified as a key piece of work as part of the annual plan. Following this review, a Task and Finish Group would oversee the implementation of the recommendations with progress to be monitored by the QSE Committee.
- The Self Assessment of Quality Governance Arrangements was formally received and the Committee would receive an action plan at the next meeting to monitor progress;

7.2   Patient stories provide a patient, carer or relative with an opportunity to tell us about their lived experiences of using our services; what was good about the experience,

what was bad and what could be improved. Within 2019/2020 the QSE Committee ratified revised Patient Stories Guidelines (ISUE01) which provided a renewed emphasis on using patient feedback as the basis for quality assuring our services in line with our Patient Experience Strategy (BCUHB, June 2019), and our mandatory responsibilities in the following key policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)
- Wellbeing of Future Generations (Wales) Act (WG, 2014a)
- Social Services and Wellbeing (Wales) Act (WG, 2014b)
- Parliamentary review of Health & Social Care in Wales (2018)

The following patient stores have been presented to the QSE Committee in 2019/2020.

Helen's Story - I am not a service user; the role of ICAN within ED

Key Themes;	Learning/Actions;
• Patient voice not being listened to • Terminology used to label patient • Needs of the individual not being recognised due to demand on the service • Different service received after 7pm. • Training for external agencies	• Ensure people are listened to and respected, whilst having their individual needs understood • Promote and develop the ICAN service it changes and saves lives. • Further training and information for external agencies. • Include increased awareness of the ICAN services within the PALS operational model.

Arthur's Story - Importance of Welsh Language Service Provision – Acute Care

Key Themes;	Learning/Actions;
• *Receiving sufficient Information* such that patient and family members can be fully, informed and involved in decisions made in relation to Arthur's care. • *Welsh Language/Communication in Welsh* – clear failure to respect Arthur's communication needs resulting in lack of information about, and involvement in decision concerning ongoing care • *Informed Consent* • Staff Attitude/Knowledge & Skills; there was a complete lack of empathy and response to Arthur's stated communication needs	• The ability to provide care through the medium of Welsh is essential for the provision of clinically effective care and is an essential for involvement and the provision of information and a prerequisite of informed consent. • Reminder to staff of how to contact the relevant interpretation services if no Welsh speaker available to ensure compliance with the Welsh Language Measure 2011 (WG, 2011). • Included questions relating to satisfaction with ability to 'speak Welsh to staff if you wanted to' within our real-time feedback questionnaire. • Recruited to ensure the bilingual provision of the Patient Advice and Liaison Service (PALS). • Incorporate guidance on the (Welsh Language Measure (Wales), WG 2011) within Customer Care Training.

Importance of Developing Dementia Services – Linda's Story told by Ben

Key Themes;	Learning/Actions;
• .Lack of adequate Dementia Care within Acute and Community Hospitals	Since Linda's admission to hospital the following improvements have been made to enhance patients care: • Patient activities have been increased • Dementia Care Worker has been appointed August 2019. • Occupational Therapist is doing daily activities in the Day Room. Some patients are being encouraged to prepare their own breakfast to promote independence –this is known as 'Functional Friday' • Physiotherapist is supporting physical therapy with patients of all abilities • New Dementia friendly flooring and cutlery tare to be purchased.

Community Care Collaborative Hub - East

Key Themes;	Learning/Actions;
• Service users do have a mistrust of "authority". • The hospital set up as a whole presents multiple barriers, ie appointment letters are sent but patient is homeless. • Because of their lifestyle they may not attend appointments, they are then removed from the waiting lists • Appointment times can be difficult to adhere too. • Patients feel the experience in hospital is negative, they are treated differently.	• Development of 'one stop' interdisciplinary health care in a socially welcoming environment, ensures access to health care services in a non-judgemental manner for service users who would otherwise find it difficult to access traditional health services which involve multiple access points.

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
21.5.19	The Committee were provided with a summary proposal on the Clinical Audit function including a realignment to the Office of the Medical Director. The paper included recommendations on the role of the Audit Committee and QSE Committee going forwards in relation to clinical audit reporting and the approval/monitoring of the plan. The Committee agreed that further clarification of this was required and noted that the paper was due to be discussed at Audit Committee in the near future.

	A Quality Assurance report detailing concerns, claims, incidents and Healthcare Inspectorate Wales recommendations was received for the period January to March 2019. The Committee noted that whilst this report was still developing, further work was required in relation to the quality of thematic reporting and lessons learnt to provide the Committee with assurance. The Reducing Avoidable Mortality Report did not provide the Committee with the clarity required on progress in reducing avoidable mortality across the Health Board. It was noted that there are a number of areas not meeting the expected improvement and the actions planned to address this were unclear. The Committee have asked that this be addressed and a further update provided at a future meeting. The Committee agreed to receive regular updates on the endoscopy review and outpatients follow up backlogs as standing agenda items until further notice. The Committee reviewed the risks currently assigned to it and noted concerns about the target risk scores and whether they were achievable in the timescale documented. It was noted that the risk register is currently being reviewed across the Health Board and should address this issue. The Committee did not agree to the suggested reduction in the risk score for mental health as insufficient assurance had been provided in light of recent reports and the current performance indicators. The quality and content of reporting to the Committee and the associated impact upon the level of assurance that the Committee can take from these reports. A renewed commitment from operational leads was required to ensure that this was addressed.
16.7.19	The Committee noted a number of issues reported across the Health Board with regard to water safety including legionella incidents. The resulting need to close clinical areas due to these issues have a direct impact upon the provision of services for patients. The Director of Estates and Facilities highlighted the operational challenges and that the associated risk of legionella had been escalated appropriately with an action to review and refresh the policy to clarify responsibility. The Committee noted the current risk of non-compliance with Health and Safety legislation which was being addressed through a detailed gap analysis reporting to the Strategic Health and Safety Group. The Committee received a Quality and Safety report from MHLDS which provided some quantitative data relating to performance indicators and initiatives across the division. The

	Committee has requested a further report to be provided at the next meeting in September to include data analysis on lessons learnt, areas for improvement and key performance indicators in order to provide assurance on organisational learning and the implementation of the Quality Improvement Governance Plan. The Children's Services update report identified a number of areas of risk including an increase in waiting times for neuro-development services and the lack of 24/7 provision of the Tier 4 inpatient services for acutely ill high-risk young people. The Committee will receive the organisational response to the recent HIW thematic review of Children's and Young People's Services across Wales at the next meeting.
24.9.19	The Annual Plan Monitoring Report and progress against key actions was reviewed and the Committee noted that there were quality assurance issues with the report. In particular, there were milestones recorded as Red with no accompanying narrative and incorrect colour coding which made it difficult to be assured of progress. There were discussions over the progress against the plans for the provision of diagnostic services and overall productivity. The Committee requested an up to date report to be submitted to members in between meetings. The Committee noted, in the Integrated Quality and Performance Report for August, the high numbers of postponed procedures for non-clinical reasons and there was discussion around the actions being taken to address this. It was also noted that a recent Wales Audit Office report had been discussed at Audit Committee and the recommendations were being worked on. The Committee were informed about concerns with the sustainability of the breast radiology service with limited cover being provided by other areas. A radiologist had recently been appointed but recruitment has been challenging. The Committee were apprised of a shortage in resources within the paediatric ophthalmology service resulting in interim arrangements being made with other sites. The Committee queried the proposed closure of some of the actions in the HASCAS and Ockenden Improvement Group report on the basis of the narrative and other ongoing workstreams. The Occupational Health and Safety Gap Analysis Report was received which identified significant areas of non-compliance against health and safety legislation across the Health Board. The report also highlighted the need to improve the risk management structure and the robustness of previous self-assessments undertaken. The report included a comprehensive

	improvement plan with timescales, but it was noted that some of the requirements may involve significant resources which the Committee were not in a position to consider. The Committee were concerned with the lack of progress with the Follow Up Backlog Clearance. Although the report was inconsistent in part, the size of the backlog has increased and the trajectories for improvement were unclear
19.11.19	Long waits were identified for psychological therapies in the East and a report has been commissioned to review the model in place. Significant pressures were noted within the oncology service as a result of recruitment challenges, which is being reviewed; The Committee were supportive of improving infection prevention and control measures by staff no longer using lanyards. Alternatives are available and these should be used by both clinical and non-clinical staff going forwards; The Committee agreed to escalate the Mortality report to the Board as a result of inadequate assurance being provided. It was agreed that the matter would be discussed further with the Executive Medical Director as the Committee's feedback on the last report had not been actioned;
28.1.20	The level of postponed procedures for non-clinical reasons was discussed and the Committee noted that it had not received the report that had been previously agreed. The Committee requested that due to the numbers reported and the previous audit report, a detailed analysis should be provided to the next Committee meeting. The GMC had placed the junior doctor training service in Wrexham Maelor into Enhanced Monitoring following concerns raised by Health Education and Improvement Wales (HEIW). The Hospital Management Team had developed an action plan to address the concerns and a follow up visit was expected in 2020. The Committee were concerned that the failure to address the issues could result in the withdrawal of training posts and undertook to bring the matter to the attention of the Board;
17.3.20	TO BE ADDED

9. Focus for the year ahead:

The primary focus of the QSE Committee over the next twelve months will be:

- Develop reporting arrangements to enable better scrutiny at Executive-led groups across the areas of quality and safety; health and safety; patient experience and effectiveness.

- Ensure better informed Committee agendas structured around the Risk Management and Quality Improvement Strategies.
- Undertake review of cycle of business and terms of reference to ensure closer alignment and strengthened focus.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 3.

V0.3

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

1 INTRODUCTION

1.1   The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E).** The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2 PURPOSE

2.1   The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

3 DELEGATED POWERS

3.1   The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

> 3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;
>
> 3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;
>
> 3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;
>
> 3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;
>
> 3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:
>
> - Sources of internal assurance (including clinical audit) are reliable
> - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11   to receive periodic updates in respect of the workforce flu vaccination.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6 MEMBERSHIP

6.1 Members

Four Independent Members of the Board.

6.2 In attendance

Executive Director of Nursing and Midwifery (Lead Executive)
Executive Medical Director
Executive Director of Therapies and Health Sciences
Executive Director of Primary Care & Community Services
Director of Performance
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Associate Director of Quality Assurance
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council
Trade Union Partners

6.2.1   Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. The Mental Health & Learning Disabilities Division will attend as per scheduled items on the cycle of business.

6.3 Member Appointments

6.3.1   The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2   Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7 COMMITTEE MEETINGS

7.1   Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2   Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3   Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8   RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1   Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3   The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1   joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4   The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5   Receive assurance and exception reports from the Quality and Safety Group (QSG)

9.   REPORTING AND ASSURANCE ARRANGEMENTS

9.1   The Committee Chair shall:
9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;
9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2   The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1   The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

Quorum 11. REVIEW

11.1   These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval:
QSE Committee 29.11.18
Board 24.1.19

V5.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

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3) DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11   to receive periodic updates in respect of the workforce flu vaccination.

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4.1   The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2   It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3   It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

5) SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

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Director of Performance
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Associate Director of Quality Assurance
Director of Mental Health & Learning Disabilities
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.2.2 Trade Union Partners are welcome to attend the public session of the Committee

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by

the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

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6.4.1 Secretary: as determined by the Board Secretary.

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6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7) COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8) RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5 Receive assurance and exception reports from the Quality and Safety Group (QSG)

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10) APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11) REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval:
Audit Committee 30.5.19
Health Board 25.7.19

V6.0

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 03/03/2020 10:46

Part 1 – Annual Recurring Business

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Accessible Healthcare Standards Annual Report incorporating WITS report	*Peter Morris Eleri Hughes-Jones*					X	
Annual Quality Statement	*Di Read*		X draft	X final			
Children's Services	*Teresa Owen Alison Cowell*			X			X
Patient Safety Report (formerly CLICH)	*Matt Joyce*	X		X		X	
Clinical Audit – monitoring of outcomes from clinical audit plan	*Adrian Thomas*		X Approval of plan				Via JAQS meeting
Committee Annual Report (inc Review of Terms of Reference and Approval of Cycle of Business)	*Kate Dunn*		X final				
Continuing Health Care (By exception only – main aspects to be brought within primary & community care assurance reports)	*Chris Stockport*						
Corporate Risk Assurance Framework (QSE Risks) EACH MEETING FROM APRIL 2020 ONWARDS (AGREED BY AC WORKSHOP)	*Peter Barry*			X			X
Executive Quality & Safety Updates **In Committee** (To sight the Committee on current issues around complex complaints, never events, key risks, Regulation 28s and any significant quality & safety issues	*All Execs*	X	X	X	X	X	X
Healthcare Inspectorate Wales Annual Report					X		

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Health & Safety (including HSE Reports and Corporate Health at Work updates)	Sue Green	X	X	X	X annual report	X	X
Health Protection (PHW Report)	Teresa Owen	X					
Improvement Group (HASCAS & Ockenden) Chair's Assurance Report	Gill Harris	X	X	X	X	X	X
Incidents (High Risk SUIs) – to focus on organisational learning	Deborah Carter Matt Joyes	X	X	X	X	X	X
Infection Prevention & Control	Amanda Miskell	IQPR slides only	Q3 report	IQPR slides only	Q4 report	Q1 and annual report	Q2 report
Integrated Quality Performance Report	Ed Williams Jill Newman	X	X	X	X	X	X
Learning Disability Strategy – monitoring of implementation Frequency to be determined							
Medicines Management	Berwyn Owen		X ann rep			X key risks	
Mental Health Services – Quality & Performance Assurance report on the implementation of T4MH Strategy	Steve Forsythe		X		X		X
Mortality & Morbidity (inc lessons learnt from casenote reviews)	Melanie Maxwell			X			X
Nurse Staffing Report (as required by Wales Act 2016)	Debra Hickman			X Annual report			X mid year update
Patient Stories		X	X	X	X	X	X

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Patient Experience Report (focusing on patient experience and what has changed or is planned as a result of their feedback)	*Carolyn Owen Matthew Joyes*		X		X		X
Policies for Review (as required)	*Varies*	X	X	X	X	X	X
Primary & Community Care Quality Assurance Report incorporating care homes	*Chris Stockport*		X		X		X
Prison Health	*Chris Stockport*		X			X	
PSOW Annual Letter	*PSOW*					X	
Putting Things Right Annual Report (inc link to PSOW Annual Report)				X			
Quality Improvement Strategy 2017-2020 (inc Dementia Strategy)	*Deborah Carter*			X draft	X final		
Quality/Safety Awards and Achievements (added by LR Oct 19. Verbal updates)		X	X	X	X	X	X
Quality Safety Group – assurance report	*Deborah Carter Caroline Williams*	X	X	X	X	X	X
Safeguarding	*Michelle Denwood*			X Ann Rep			X
Standing Items – Opening Business (apologies, declarations of interest, minutes)		X	X	X	X	X	X
Standing Items – Closing Business (items discussed in committee, documents circulated, issues of significance, any other business, date of next meeting)		X	X	X	X	X	X
Tissue & Organ Donation Annual Report	*David Southern*	X					

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Welsh Health Specialised Services Committee – Quality & Patient Safety Committee Minutes and/or Chair's Reports (held in public) *obtained from WHSCC website*	*Cathie Steele WHSCC*	X	X	X	X	X	X
Welsh Risk Pool Services and Legal & Risk Services Annual Review	*Anne Louise Ferguson*				X		

In addition a "Part 2" Rolling Plan of Ad-Hoc Business is maintained by the corporate secretariat

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 17.3.20
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:					
The Committee is asked to note the report					

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	✓

Sefyllfa / Situation:
To report in public session on matters previously considered in private session

Cefndir / Background:
Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment
The Committee considered the following matters in private session on 28.1.20: • Approval of previous minutes • Harms Review • Urology Service Update • Executive Briefings

Minutes of the Welsh Health Specialised Services Committee
Quality and Patient Safety Committee
held on 29 October 2019 at
WHSSC, Unit G1, Treforest Industrial Estate, Pontypridd

Committee Members Present

Delyth Raynsford	(DR)	Independent Member (acting Chair)
Trish Buchan	(TB)	Independent Member
Dilys Jouvenat	(DJ)	Independent Member

Apologies from Members

Lyn Meadows	(LM)	Independent Member
Martyn Waygood	(MW)	Independent Member

Apologies from Attendees

Claire Appleton	(CA)	Quality Lead (WHSSC)
Iolo Doull	(ID)	Deputy Medical Director, WHSSC
Ashraf Mikhail	(AM)	Renal Consultant (SBUHB)
Karen Preece	(KP)	Director of Planning, WHSSC
Adele Roberts	(AR)	Head of Quality, WHSSC
Susan Spence	(SS)	WRCN Manager, WHSSC
Jennifer Thomas	(JT)	Medical Director, WHSSC
Helen Tyler	(HT)	Corporate Governance Manager, WHSSC

In Attendance

Andrea Richards	(AR)	Specialised Services Planning Manager, WHSSC (part meeting)
Liz Kenward	(LK)	Specialised Services Planning Manager, WHSSC (part meeting)
Carole Bell	(CB)	Director of Nursing & Quality, WHSSC
Jemma McHale	(JM)	CHC Representative
Claire Richards	(CR)	Neonatal Network, Transport Manager (part meeting)
Sunil Reddy	(SR)	Neonatal Transport, Clinical Lead (part meeting)
Claire Nelson	(CN)	Assistant Director of Planning, WHSSC (part meeting)
Georgia Matthews	(GM)	Quality Lead, WHSSC

Minutes

Robert Ellis	(RE)	Business Support Officer, WHSSC

The meeting opened at 13:30hrs.

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QPS19/034	**Welcome, Introductions and Apologies**
	Delyth Raynsford (DR), acting Chair of the Quality and Safety Committee opened the meeting.
	Apologies were noted as above.
QPS19/035	**Action Log and Matters Arising**
	QPS19/023: KS provided members with an updated position regarding a replacement Chair for the committee. Whilst discussions had progressed a firm replacement could not be announced at this stage.
	ACTION: Q&PS Development Day and self-assessment to be arranged once new Chair is appointed.
	Members agreed that when scheduling meetings, including the Development Day, school holidays should be avoided. Members would also be given the opportunity to contribute to the agenda which would concentrate on the revised Quality Assurance Framework before sharing with the Joint Committee.
QPS19/036	**Minutes of the meeting of 13 August 2019**
	The minutes of the meeting held on 13 August 2019 were approved as a true and accurate record subject to the following amendments:
	Spelling amendment to the acting chair's name
	Minutes would be altered to reflect that **QPS19/024** (Update Report from the Welsh Renal Clinical Network, P4) referred to the collection of provider data around transportation and timing of service delivery and that its collection was outside the remit of the Q&PS Committee.
	It was suggested than the wording of the minute **QPS19/025** (Update Report – Mental Health, P5) would be revised to 'children with dysregulated behaviour'.
QPS19/037	**Action Log and Matters Arising**
	The action log was considered by the members and updated accordingly.
	QPS19/021: An update had been received from the Medical Director at SBUHB that the review of the two sarcoma cases (QPS19/006) were nearing completion. They would be shared with WHSSC once they had gone through the Health Board system.
	QPS19/024: Welsh Renal Clinical Network

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Members noted that CB had fed back comments to the Renal Network following the last meeting.

QPS19/025: Update on Tier 4 CAMHS
Members noted that service will remain in escalation level 3 until the completion of the coroner's inquest which had been postponed until the New Year.

Members noted that the letter sent to one of the Health Boards re the provision of CAMHS Tier 4 had been shared and circulated to members as agreed.

QPS19/025: Neurosciences – Regulation 28
Members noted that the Regulation 28 briefing had been circulated and noted that the final response had been submitted to the coroner.

QPS19/025: Commissioning Team Risk Register Update
Members noted that a copy of the Commissioning Team Risk Register had been circulated to members on 12 September 2019.

QPS19/038	**Patient Story** Members received a 'Patient Story' presented by GM from a patient with Congenital Heart Disease (CHD) who had undergone surgery with a commissioned provider. Consent had been received from the patient to share the story Members provided positive feedback and requested that the patient was thanked. The story generated a good discussion around a lifespan approach and the interface between local and specialised services. It was agreed that GM would provide feedback to the patient and to ensure that the committee comments were fed into the audit and outcome day in terms of the need for review of patient information and adequate preparation of others prior to and after surgery. It was also noted that the expansion of an All Wales Post Traumatic Stress Disease (PTSD) service was currently being considered. **ACTION:** GM to feed back to patient and thank her on behalf of Q&PS Committee members for agreeing to share her story.
QPS19/039	**Items for Discussion and consideration** **Update Report from the Welsh Renal Clinical Network** Members received the Update Report from the Welsh Renal Clinical Network (WRCN), the purpose of which was to provide a briefing on quality and patient safety issues within the service.

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	Members resolved to: • Note the information presented in the report. **ACTION**: Members requested clarity around set criteria used for placing services in escalation. CB to link with WRCN and report back to members.
QPS19/040	**Update from Neonatal Network** Representatives from the neonatal network were welcomed to the meeting and provided the committee with their first neonatal network report. The report generated a good discussion and provided the committee with changes to the governance structure and reporting arrangements in the network. Members noted that the Report data (from south Wales only) should be used to inform the ongoing review of a 24hr service. Member expressed concern that no north Wales Neonatal data was made available to the Network by BCUHB despite being requested. As WHSSC also commissioned transport services for North Wales it was agreed that the chair should write formally to BCUHB expressing their concern re the lack of data and this needed to be addressed. Whilst the WHSSC commissioned independent review had not been published concern had been raised re the provision of a standardised equipment. There was an action plan in place with the network and CB agreed to discuss some issues highlighted in the report on her return from leave. Members resolved to: • Note the information presented in the report. **ACTION**: QPS Chair would write to BCUHB and include in the chairs report to the Joint Committee. **ACTION**: CB to discuss the ongoing issue re non-standardisation of infusion pumps in the south Wales service with KP
QPS19/041	**Update Reports from the Programmes** **a) Cancer and Blood** Members received the report the purpose of which was to provide a briefing on quality patient safety issues within the services in the Cancer and Blood Commissioning Team Portfolio. A summary of escalated services and current risk scores was received.

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It was noted that there was ongoing concern in relation to the organisation and attendance at the MDT despite additional investment in the service. Assurance was given that this was being monitored with monthly performance meetings with the service and the level of escalation was currently being reviewed by the WHSSC Clinical Directors Group (CDG).

In addition to the report CN updated the committee with regards to the current suspension of children sarcoma services at Birmingham Children's Hospital. A view would be taken by WHSSC CDG and an agreed level of escalation considered. In the meantime WHSSC were in discussion with both the provider and NHS England to ensure that appropriate actions were being taken to reinstate the service.

Members resolved to:

- Note the information presented in the report.

b) Neurosciences
Members received the report the purpose of which was to provide a briefing on quality patient safety issues within the services in the Neurosciences Commissioning Team Portfolio. A summary of escalated services and current risk scores was received. As part of the discussions one of the independent members requested clarification on the definitions of the risk scoring.

An update was provided on the national Home Parental Nutrition Callea position. It was noted that the company had written to patients apologising for the disruption to services.

Members resolved to:

- **Note** the information presented in the report.

ACTION: CN to circulate to members a clear definition of the meaning of 'Effective' as used in risk ratings.

c) Cardiac
Members received the report the purpose of which was to provide a briefing on quality patient safety issues within the services in the Cardiac Commissioning Team Portfolio. A summary of escalated services and current risk scores was received.

It was noted that Cardiac Surgery performance in South Wales remains a concern, particularly in regards to the service provided by C&VUHB. Monthly performance meetings with C&V and an action plan has been put in place following a Commissioning Quality Visit in February. Despite this performance has not improved.

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Performance meetings have been held bi-monthly with SBUHB and whilst improvement had been sustained from September 2018 with 0 breaches being reported, since May 2019 performance has deteriorated with low number of breaches being reported each month.

On 16 October 2019 the WHSSC Team held a follow up joint meeting with cardiac surgery colleagues from SBUHB and CAVUHB to discuss alternative options for improving the long waiting times for patients, particularly at C&VUHB. It had previously been proposed that SBUHB would support a cohort of patients from Cardiff to mitigate the risks and reduce the numbers of 36 week breaches. This is no longer a viable option due to a recent deterioration in the waiting times in SBUHB. A number of other options were in the process of being explored including outsourcing.

It is noted that very late referrals from Health Board cardiology services to cardiac surgery is having a significant impact on the waiting times and this needed to be addressed. Both Health Boards have agreed to shadow report component waiting times to WHSSC to gain a better understanding of the waits.

The Delivery Unit also reported that whilst improvements had been made in Health Boards applying the Pathway Start Date there is still limited assurance regarding the accuracy of these dates at some Health Boards. The Delivery Unit has also reported that whilst the Pathway Start Date at C&VUHB was 100% accurate, they had less assurance at SBUHB due to the number of missing Pathway Start Date from HDUHB. There is a risk that the current waiting times at SBUHB are understated and may result in a greater number of breaches than are currently being reported.

Members were notified that two water heater cooler units for the cardiac bypass machines at Alder Hey Cardiothoracic unit had grown the environmental mycobacteria *Mycobacterium chimaera.* Both machines were immediately withdrawn from service and replacement machines procured and monthly water testing put in place. No further evidence of contamination has been reported. Alderhey had been part of the national exercise in 2017 following the MHRA safety alerts and NHS England had been assured that all the necessary patient information and consent was being adhered to and that all processes had been followed.

As a result of the above a notification exercise for all patients who underwent cardiac surgery with cardiac bypass between November 2015 and January 2019 is being undertaken. Patient and GP letters will be sent. Directors of Nursing and Medical Directors from the

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affected Health Boards have been notified. A quality visit is scheduled for the 18th November.

Members resolved to:

- **Note** the information presented in the report.

d) Mental Health

Members received a summary the purpose of which was to provide a briefing on quality patient safety issues within the services in the Mental Health Commissioning Team Portfolio. A summary of escalated services and current risk scores was received.

An updated position was provided in relation to both CAMHS services. Members were made aware that a revised Tier 4 Service Specification has been published for consultation. It was also noted that the Coroner's Inquest relating to a death in Ty Llidiard had been postponed until the New year.

It was reported that following a discussion with Regis, QAIS, HIW and NHS England in August, WHSSC have agreed that until the provider is able to join the framework next April off framework placements will be considered on an individual basis. Whist they are a service that remains a concern with HIW WHSSC were advised that they have made significant changes to their governance structures and have been granted registration to reopen the second ward. The WHSSC Quality Lead for Mental Health is working closely with the Health Board Care coordinator to oversee any placements from a quality perspective and participating in the quarterly oversight meetings in place.

Members resolved to:

- **Note** the information presented in the summary.

e) Women & Children's

The planner for Women & Children's presented the report to the committee. An update was provided on the commissioned services within the portfolio and a summary of escalated and current risk scores received.

In particular the report highlighted that the Cochlear Service in CTMUHB had been escalated to level 4 and temporarily suspended whilst further investigation work took place. This was as a result of concerns raised by CVUHB following a transfer of services to them following the loss of audiology support on the PoW site. WHSSC were working closely with both services to ensure that the delivery of the RTT times by 31st March 2020.

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QPS19/042	**CAMHS Themes Presentation** As requested at the last meeting, members received a presentation from CB on CAMHS themes which they found extremely informative and generated a wider discussion. CB agreed to circulate the presentation and offered committee members to receive an update on the work being undertaken on Vulnerable Groups. This was welcomed and agreed by members. **ACTION**: CB to circulate presentation to members with acronyms expanded. **ACTION**: CB to request K Hallewell to attend next Q&PS meeting and present on ongoing Vulnerable Groups work.
QPS19/043	**Concerns and SUI report** In addition to the individual SUI's and complaints reported in the commissioning team reports, members received a summary and overview of the data and compliance of handling times. The committee noted that there were no outstanding complaints and that WHSSC were reliant on Health Boards to undertake the investigation in a timely fashion as well as the need for them to go through Health Board processes prior to their release. Members resolved to: • **Note** the information presented in the report.

QPS19/044	**Report from the WHSSC Policy Group** Members received the report of the WHSSC Policy Group. They also felt that it would be helpful if a member of the policy team presented the report in the future to answer any queries that were raised. They also requested that where policies were out of date a supporting narrative in terms of actions being taken would be helpful for assurance purposes. Members resolved to: • Note the information presented in the report. **ACTION**: Member of the policy team to be asked to attend future Q&PS Committee to present the report.
QPS19/045	**CQC/HIW Summary Update** Members received the CQC/HIW summary report. They agreed that this was a very helpful report which could be used by each of the Health Boards a point of reference for each of their own commissioned services.

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	Members resolved to: • Receive the report for information.
QPS19/046	**Summary of Services in Escalation** Members received the report of services in escalation. Once again members provided positive comments in terms of the usefulness of the summary opposition and agreed that the summary position should continue to be presented to Joint Committee members for reference back into Local Health Boards. Members resolved to: • Note the information presented in the report.
QPS19/047	**Any Other Business** **Safeguarding:** CB made members aware of three recent potential safeguarding issues that had arisen in relation to services commissioned by WHHSC and explained that in all cases the provider safeguarding teams were made aware of the issues and dealt with them locally. Notwithstanding this, the WHSS Team would be reporting these incidents to the CTMUHB Executive Safeguarding group (in CTMUHB's capacity of host organisation to WHSSC) as WHSSC doesn't have its own safeguarding team.
QPS19/048	**Agenda Items for next meeting** CB summarised the items that had been agreed for consideration at the next meeting in addition to the routine reports. • Neonatal Network update to include equipment provision • Presentation on Vulnerable Groups work • Full update on Sarcoma Services • Full update on Cardiac Surgery In addition members were also asked if there was anything additional that they would want discussed.
QPS19/049	**Key Issues for Health Board Quality and Safety Committees** CB explained that reports from the Chair of Q&PS go to the subsequent Joint Committee meeting together with the table of services in escalation. Following Joint Committee these are shared with Q&PS members, Health Board Q&PS Chairs and also Quality leads from each of the Health Boards. Everyone agreed that this was vital in order for the Health Board Q&PS Committees to be sighted

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	on matters considered at WHSSC Q&PS meetings. Members agreed that it would be helpful to raise the profile of specialised services and each HB to gain assurance they should consider ensuring that there was a specific slot on each Health Board Q&PS meeting agenda focusing on 'Specialised Services'. **ACTION:** RE to confirm details of all Health Board Q&PS Chairs and Executive leads to ensure accuracy of distribution. Members commented on the quality of the reports and the level of detail and assurance received and wanted this feedback to all staff who had prepared and presented the reports. CB agreed to action on behalf of the committee . **ACTION:** CB to feedback to Commissioning Teams acknowledging the work done in improving reporting to Q&PS and to thank the Teams on behalf of the Q&PS members.
QPS19/051	**Date and Time of next meeting** It was confirmed that the next meeting was scheduled to be held on 21 January 2020 at the WHSSC offices, Unit G1, The Willowford, Treforest, Pontypridd, CF37 5UR

The meeting closed at 16:45hrs

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Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 17th March 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Inspection reports
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Deputy Chief Executive / Executive Director of Nursing
Awdur yr Adroddiad Report Author:	Deborah Carter Director of Operations / Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Bi-monthly meetings submitted to the Quality Safety Group (QSG) and QSG/QSE at a local level
Atodiadau Appendices:	**Appendix A** Corporate Nursing HIW Tracker Tool; actions from recent inspections (Appendix B & C) **Appendix B** Hospital Inspection (Unannounced), Ysbyty Gwynedd, BCUHB, Maternity Services **Appendix C** HIW & CIW: Joint Community mental Health Team Inspection (Announced), Ty Derbyn **Appendix D** BCUHB internal Standard Operating Procedure for Healthcare Inspectorate Wales (for information)

Argymhelliad / Recommendation:

The Board/Committee is asked to note the following reports;

- BCUHB / HIW Position Statement
- Appendix A – Corporate Nursing HIW Tracker Tool; actions from recent inspections (Appendices B & C)
- Appendix B – Hospital Inspection (Unannounced), Ysbyty Gwynedd, BCUHB, Maternity Services
- Appendix C – HIW & CIW: Joint Community mental Health Team Inspection (Announced), Ty Derbyn
- Appendix D – BCUHB internal Standard Operating Procedure for Healthcare Inspectorate Wales (for information)

In addition, the Board/Committee are asked to approve the new Corporate Nursing Tracker Tool for improvement actions and the revised approach to monitoring the implementation of the actions.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)				
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	**Ar gyfer Trafodaeth** **For Discussion**	**Ar gyfer sicrwydd** **For Assurance**	**Er gwybodaeth** **For Information**	✓

Sefyllfa / Situation:

The purpose of this paper is to provide assurance to the Committee in relation to the capturing of HIW actions. In addition, the Committee are asked to note the following two recent Healthcare Inspectorate Wales inspection reports;

1. Hospital Inspection (Unannounced), Ysbyty Gwynedd, BCUHB, Maternity Services
   Inspection date: 25th and 27th November 2019
   Publication date: 28th February 2020
   Appendix B

2. HIW & CIW: Joint Community mental Health Team Inspection (Announced), Ty Derbyn, Wrexham, BCUHB and Wrexham County Borough Council
   Inspection date: 15th to 16th October 2019
   Publication date: 7th February 2020
   Appendix C

Prior to publication of both recent reports, HIW issued the Health Board with any immediate concerns and/or improvement plans for completion. These are HIW recommendations, based on the findings from the inspections and are incorporated into the Corporate Nursing Tracker Tool, **Appendix A**. These completed plans by the Health Board can be found at the end of each report.

The inspection relating to **Appendix B,** forms part of the wider thematic review of Maternity Services across Wales. The review is in its final stages; phase two. This will look at the Health Board's governance arrangements. To do this, interviews will be held on 18th and 19th March with various staff to look at how the Health Board's governance arrangements promote safe and effective care covering areas such as;

- Issues and themes arising from the inspections of maternity services within the health board
- Reporting and management of concerns
- Risk management
- Workforce
- Quality governance arrangements (ward-to-board) for maternity services

<div align="center">New Corporate Nursing Tracker Tool</div>

The list of actions detailed in **Appendix A** represents the new reporting format following the Corporate Nursing proposal to review and re-design the tracker to incorporate specific themes that will further enable lessons to be learned and to ensure wider learning across the organisation. Furthermore, the new tracker captures any further review of actions for assurance purposes.

This has been developed to ensure that it is consistent with other forms of reporting. As you can see from the column headings found at **Appendix A**, the tracker now includes the following;

- Each improvement plan has its own unique reference code i.e. "HIW-IP-015". This enables us to locate the exact improvement plan.
- Each plan is also coded; "IA" (Immediate Assurance Plan) and "IP" (Improvement Plan). Whilst the improvement plans incorporate any immediate assurances, it is important to distinguish between the two as an immediate assurance means that HIW have immediate concerns

regarding patient safety where they require the service to inform HIW of the urgent actions the service are taking.

- Establishes the Directorate, Area and Speciality which will assist with specific information searches and more precise location of Health and Care Standard Themes.
- Provides a status update of either "In Progress"; the service are working towards the agreed implementation date for each action. There is also a column for any revised implementation dates and number of revisions. "Implemented"; the service have implemented the action. A column has been added for planned follow up reviews, and review findings. These actions will only be "Closed", once the reviews have been undertaken and the findings shared for assurance to QSG bi-monthly, and also to QSE when required. This helps to ensure any actions requiring a review either by the service or by corporate, are built into the cycle of business.

The diagram below provides an overview of the total amount of actions in progress and implemented since 2017. There are 2 actions from 2017 still open. The Business Manager is working with the operational leads to clarify these actions urgently. Any actions prior to 2014 are not included on the new Corporate Nursing Tracker Tool as they are all closed and as such, they have been archived on the Corporate Nursing Quality Assurance shared drive.

Count of BCUHB Response (as per action plan sent to HIW)	Column Labels			
Row Labels	Implemented	In Progress	(blank)	Grand Total
2017	15	2		17
2018	141	13		154
2019	61	71		132
(blank)				
Grand Total	217	86		303

Work around the theming of all HIW actions in line with the Health & Care Standards is underway. This will support learning, assurance and forms part of the work of the Learning for Improvement Workgroup which is chaired by the Assistant Director Of Patient Safety And Experience. The Terms of Reference for the group were discussed during the 30th January 2020 meeting and will be finalised at the next meeting on 14th April 2020. The main objective of the group is, the learning to inform quality improvement. It is the joining up of learning from HIW, Patient Safety and Quality Improvement work such as the Ward Accreditation, with a "This is what we did next…" approach.

To ensure an integrated approach, a representative from HIW (Senior HIW Inspector) recently joined the group.

Cefndir / Background:

HIW inspect the NHS in Wales, from general practices to hospitals. HIW assess compliance based on the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation.

As shown in **Appendix D**, there is an agreed internal Standard Operating Procedure (SOP) for HIW along with a timeline which confirms the HIW timescales for issuing the Health Board with any immediate concerns and/or improvement plans for completion, based on the findings from the inspections.

Corporate Nursing is responsible for;

1. Managing all HIW correspondence
2. Quality Assuring all HIW correspondence
3. Managing the corporate HIW Tracker Tool and expediting actions / updates from Divisions
4. Act as the conduit between the Health Board and HIW
5. Preparing monthly exception reports for Quality & Safety Group

For each of the two reports enclosed at **Appendix B** and **C**, the Corporate Nursing Tracker Tool at **Appendix A**, intends to provide the committee with an update on progress against each action and **Appendix E** provides a response from Corporate Nursing.

Asesiad / Assesent & Analysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board's Quality Improvement Strategy (QIS), and Living Healthier Staying Well. These are part of our overall key objectives.

Financial Implications

Costs will be incurred in each service / area and will differ depending on HIW recommendation / Health Board action, and some costs will be part of the maintenance / refurbishment programme. Failure to provide safe care, can result in a complaint, claim and compensation of which there can be significant financial implications.

Risk Analysis

There is a risk of harm to staff if the estate or facilities is not fit for purpose. If staff are unable to provide suitable care, there is a risk of harm to the patient. There is also a reputational risk, particularly in terms of the press following any negative reports and immediate concerns.

Financial risk is associated with costs of any claims.

There is a risk of non-compliance with regulations. When standards are not met, HIW make recommendations for improvement, these feed into the NHS Wales Escalation and Intervention Arrangements.

In addition, if HIW do not receive sufficient assurance that action has been taken to address issues, they can take enforcement action.

Members are asked to note, that one of the matters raised in the HIW inspection report for Midwifery & Women's Services (ensuring that policies and procedures are reviewed and updated within appropriate timescales), are reflected on the corporate risk register under risk ID 2052, Tier 2, with a current score of 12 (High) and a target score of 4 (Moderate). Mitigating actions currently in place include;

1. Full list of Clinical written control documents (WCDs) have been compiled and sent to Compliance and Assurance Manager on 5 December 2019.
2. Compliance and Assurance Manager will review and input into the main database format developed.
3. New list to be cross referenced against existing database and cascade extraction to identify duplicates/omissions (Office of the Board Secretary).
4. Final list to be reviewed and segmented into priority/area for submission to QSG prior to moving into newly developed intranet site (Office of the Board Secretary).
5. Stratification of list in progress in preparation for migration onto internet by Office of Board Secretary identified gaps will be presented to QSG by the Office of Board Secretary this will form part of the Office of the Board Secretary work plan.

Further actions are in place to help achieve our target score.

Legal and Compliance

There is a risk of non-compliance with regulations as per the risk analysis

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required.

Midwifery & Women's Services, West, Ysbyty Gwynedd

Line Ref	Imp Plan Ref	Imp Plan Code	Date of Inspection	Directorate	Area	Speciality	Status	H& C Standards	Ward / Unit	Report /Immediate Action letter	HIW Recommendation	BCUHB Management Response	Imp Date	No. Revisions	Rev. Imp Date	Actual Imp. Date	Status Updates	Owner	Planned Follow up Review	Actual Follow up Review	Finding of Review
304	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that resource and availability of perinatal support is reviewed.	The Directorate is working in partnership with the Perinatal Mental Health Service to ensure that all relevant information and support is available to all women.	31/11/2019				This work has commenced and is ongoing. Progress will be monitored by the service and a follow up date has been set to review progress	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
305	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Perinatal Mental Health Service is located on the Glan Clwyd Hospital site. North Wales has a full complement of Perinatal Mental Health practitioners and therefore all six Counties have a named professional.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services			
306	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		The Perinatal Mental Health Service has a robust training programme for 2020 which commenced in January. The training includes 'Training the trainer' for *Infant and Health Visiting Perinatal Mental Health* . The Women's Professional Development Midwife attended the training in January 2020, with a plan to identify midwife champions in all clinical areas and cascade this specialist knowledge.	01/04/2020				The 'Maternal Mental Health Guideline' has been reviewed and updated and will be submitted to all Women's, Mental Health and Corporate Governance meetings for approval in February 2020	Fiona Giraud Director Of Midwifery & Womens Services			
307	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.5		Improvement Plan	The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	All pregnant women are given a copy of the Betsi Cadwaladr University Health Board Birth Choices Leaflet to facilitate discussion regarding options for birth.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services			
308	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		All staff have been reminded to document Birth Choice discussions within the Hand Held Notes. This will be monitored at the Clinical Supervisors for Midwives monthly notes audit.	31/11/2019				This action was completed immediately following the inspection. Follow up date has been set to review compliance	Fiona Giraud Director Of Midwifery & Womens Services	31/05/2020		
309	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Birth Choice Clinics commenced within the maternity unit in Ysbyty Gwynedd in January 2020. Feedback from women on this service introduction will be collated and presented to the Women's Quality Safety and Experience (QSE) sub group on a quarterly basis. This will then feed up to the Board through the Corporate Quality safety Group (QSG).	31/11/2019				This work has commenced and is ongoing. Progress will be monitored by the service and a follow up date has been set to review progress	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
310	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	1.1		Improvement Plan	The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support	The contact details for the Community Health Council are displayed and available in all clinical areas. This compliance is monitored on the Matron daily walkabout on the unit.	31/11/2019				Compliance is to be monitored by the service via daily walkabouts and a follow up date has been set to review compliance	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
311	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	2.1		Improvement Plan	The health board must ensure that hand sanitiser gels are available for use	Fully operational hand sanitiser-dispensing pumps available at every bed space and throughout the unit. Compliance with this will be checked by the housekeeper and Health Care Support Worker on a daily basis.	31/11/2019				Compliance is to be monitored by the service via daily checks by the Housekeeper and Health care Support Worker, and a follow up date has been set to review compliance	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
312	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	1.1		Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	All midwives receive an annual update on breast-feeding and are available to support women on an individual basis when required. There is also a dedicated page on the Health Board's website	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services			
313	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Infant Feeding Co-ordinator is available to support staff to provide care to women and babies presenting with cases that are more complex.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services			
314	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		A business case has been developed with options of how we can improve and further support breast-feeding support workers as part of a Quality Improvement Project. Awaiting a response from Finance	31/11/2019				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
315	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		Pending approval from Finance the Directorate will be recruiting in March 2020 and staff will commence in May 2020	01/05/2020				In progress with the service; The Breast feeding Business Case was presented at the Secondary Care Service Development meeting on 26 February 2020 and will be considered at a Health Board 2020/21 Priorities Meeting on 27 February 2020 and at a Finance Recovery Meeting on 3 March 2020, which is Chaired by the Chief Executive Officer	Fiona Giraud Director Of Midwifery & Womens Services			
316	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.4		Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates.	31/11/2019				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
317	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		All policy/guideline authors are approached by the appropriate Forums within Women's Services when policy review is required.	31/11/2019				Progress will be reported through usual governance route. No follow up required	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
318	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		Authors of all outstanding policies are regularly reminded to submit their updated versions to the relevant governance group for approval in a timely manner. A tracker has been developed to support the monitoring of this action	31/05/2020				In progress as per BCUHB Management Response; The monitoring of all WCD updates is being maintained via bi-weekly meetings, the next meeting is scheduled for 28 February 2020	Fiona Giraud Director Of Midwifery & Womens Services			
319	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services			
320	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Agreement was reached at the Women's Quality, Safety & Experience Sub-Group (QSE), that a list of policies, authors and due dates should be shared with the site triumvirate leadership teams, to enforce and support lines of accountability	31/11/2019				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		
321	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support	31/03/2020				In progress as per BCUHB Management Response; The monitoring of all WCD updates is being maintained via bi-weekly meetings, the next meeting is scheduled for 28 February 2020	Fiona Giraud Director Of Midwifery & Womens Services			
322	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Health Board have developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner	31/03/2020				The Health Bpard request that all policies developed are ratified by the Corporate Quality & Safety Group moving forward. No follow up review date required	Fiona Giraud Director Of Midwifery & Womens Services			
323	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	31/11/2019				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020		

324	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Bi-weekly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan	31/11/2019			Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020
325	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		A Written Controlled Documents progress report is reviewed at the Women's QSE Sub-Group on a quarterly basis	31/11/2019			Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud Director Of Midwifery & Womens Services	31/03/2020
326	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.5		Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	Clinical Supervisors for Midwives discuss documentation standards, which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff.	31/11/2019			As per BCUHB Management Response, sessions are delivered every two years. Initial review date set	Fiona Giraud Director Of Midwifery & Womens Services	31/05/2020
327	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also presented to Women's QSE sub group annually	31/11/2019			As per BCUHB Management Response, monthly audit note sessions take place with staff and progress reported via governance route. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
328	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Each midwife is required to audit two sets of their own records from the previous year to discuss at a group Supervision session on an annual basis	31/11/2019			As per BCUHB Management Response, audit takes place on an annual basis and is monitored by the service. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
329	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation	31/11/2019			As per BCUHB Management Response, audit takes place on an annual basis and is monitored by the service. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
330	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes	31/11/2019			This action was completed immediately following the inspection. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
331	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	Governance, Leadership and Accountability		Improvement Plan	The health board must ensure that CTG training is reviewed to cover the introduction of new processes	All new documentation is made available for staff consultation prior to implementation	31/11/2019			This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
332	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		Clinical Supervisors for Midwives also post information with regards to the introduction of new documentation on the midwifery hub	31/11/2019			This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud Director Of Midwifery & Womens Services	
333	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan		All midwives and obstetricians are required to complete six hours of face-to-face CTG training per annum. Training sessions include interpretation of a CTG using the antenatal and intrapartum CTG stickers implemented across the Women's Directorate	31/11/2019			Follow up review date set to check compliance.	Fiona Giraud Director Of Midwifery & Womens Services	31/05/2020
334	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		Midwifery CTG champions have been identified in each maternity unit. Midwifery CTG champions are in the process of completing a training programme that includes attending an RCOG study day and working with other CTG national champions. Following completion of the training, the champions will be responsible for delivering the training to midwives and obstetricians within the Directorate	01/04/2020			This action is in progress with the service as per BCUHB Management Response. As at February 2020, training has commenced and remains in progress until April 2020	Fiona Giraud Director Of Midwifery & Womens Services	
335	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	7.1		Improvement Plan	The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times	An external independent review of medical rotas has been completed, as part of the health board's medical workforce review strategy	31/11/2019			As per BCUHB Management Response, this has been completed and subject to governance. Follow up review date set to ensure implementation	Fiona Giraud Director Of Midwifery & Womens Services	30/04/2020
336	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan		An independent review of job plans is scheduled for 7 February 2020	01/04/2020			This action is in progress with the service as per BCUHB Management Response. As at February 2020, The independent review of job plans has taken place and is on target for completion in March 2020	Fiona Giraud Director Of Midwifery & Womens Services	

Progress against actions- Midwifery & Women's Services- West

18%

82%

■ Implemented ■ In Progress
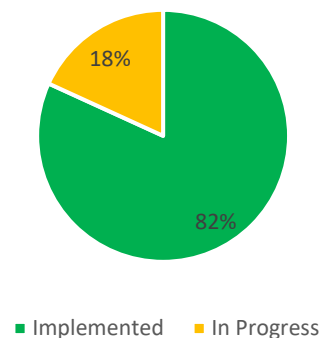
Community Mental Health Team, East, Ty Derbyn, Wrexham

Line Ref	Imp Plan Ref	Imp Plan Code	Date of Inspection	Directorate	Area	Speciality	Status	H& C Standards	Ward / Unit	Report /Immediate Action letter	HIW Recommendation	BCUHB Management Response	Imp Date	No. Revisions	Rev. Imp Date	Actual Imp. Date	Status Updates	Owner	Planned Follow up Review	Actual Follow up Review	Finding of Review
337	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.2	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all service users are afforded enough time to discuss their needs and treatment with staff	Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers	01/04/2020				The Clinical Operatoinal Manager has met with the Mental Health Measure Lead to discuss development of a Duty Standard Operating Pprcedure, based on the Flintshire model. This is to be shared with the team for comments and will be trialled once agreed. Imp date remains as April 20.	Hilary Owen Head Of Governance And Compliance, MHLD			
338	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	5.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that delays, from point of referral to when service users are assessed, are reduced	Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers	01/04/2020				The Clinical Operatoinal Manager has met with the Mental Health Measure Lead to discuss development of a Duty Standard Operating Pprcedure, based on the Flintshire model. This is to be shared with the team for comments and will be trialled once agreed. Imp date remains as April 20.	Hilary Owen Head Of Governance And Compliance, MHLD			
339	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	5.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that the current duty system is reviewed, and that adequate staff cover is secured	Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers	01/04/2020				The Clinical Operatoinal Manager has met with the Mental Health Measure Lead to discuss development of a Duty Standard Operating Pprcedure, based on the Flintshire model. This is to be shared with the team for comments and will be trialled once agreed. Imp date remains as April 20.	Hilary Owen Head Of Governance And Compliance, MHLD			
340	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	5.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that sufficient resources are secured in order to improve access to psychology, psychotherapy, Occupational Therapy and healthcare support workers' services	Internal processes are to be reviewed to improve access to Occupational Therapy	31/03/2020				This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD			
341	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Business case to be developed for additional Psychological Therapies staff which will explore the opportunity to introduce Band 4 Assistant Psychologists to the teams	01/07/2020				This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD			
342	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Review the current Health Care Support Worker provision allocated to the teams based on demand and if there is a need for additional support, review what resource is available that can be moved to support the team on a short/medium/long term basis	01/07/2020				This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD			
343	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	5.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all service users are aware of how to contact the CMHT out of hours service	All Service Users are to receive a copy of their Care & Treatment Plan which includes details of contact details out of hours	31/03/2020				An email has been circulated to all Managers (evidence provided) to ask that Practitioners review their case load and audit their client files to clarify the patients who need to receive their CTP. Case note audits are also being undertaken within Supervision to ensure that patients are routinely offered their CTP and that this is clearly documented within the patient file.	Hilary Owen Head Of Governance And Compliance, MHLD			
344	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details	31/03/2020				Posters, grab cards and leaflets have all been updated and are available in the CMHT. We are awaiting Welsh translation of these.	Hilary Owen Head Of Governance And Compliance, MHLD			
345	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away	31/03/2020				Posters, grab cards and leaflets have all been updated and are available in the CMHT. We are awaiting Welsh translation of these.	Hilary Owen Head Of Governance And Compliance, MHLD			
346	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	5.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all service users are aware of who to contact in the CMHT if they have a crisis and that they receive timely support	All Service Users are to receive a copy of their Care & Treatment Plan which includes details of contact details out of hours	31/03/2020				An email has been circulated to all Managers (evidence provided) to ask that Practitioners review their case load and audit their client files to clarify the patients who need to receive their CTP. Case note audits are also being undertaken within Supervision to ensure that patients are routinely offered their CTP and that this is clearly documented within the patient file	Hilary Owen Head Of Governance And Compliance, MHLD			
347	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details	31/03/2020				Posters, grab cards and leaflets have all been updated and are available in the CMHT. We are awaiting Welsh translation of these	Hilary Owen Head Of Governance And Compliance, MHLD			
348	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away	31/03/2020				Posters, grab cards and leaflets have all been updated and are available in the CMHT. We are awaiting Welsh translation of these	Hilary Owen Head Of Governance And Compliance, MHLD			
349	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	2.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that the ligature point risk assessment is reviewed and updated in order to reflect all risks and to highlight actions to be taken to reduce risks	Review anti-ligature assessments, update current risks and ensure these are included at the Local Health & Safety Group Meeting for review	28/02/2020		31/03/2020		The current ligature assessments are included and are due to be reviewed at the next H&S Meeting in March as there was no meeting in February. As such, revised implementation date set for March 2020.	Hilary Owen Head Of Governance And Compliance, MHLD			
350	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Agree routine reviews of the risk assessments	28/02/2020		31/03/2020		Anti-ligature risk assessments are a standing agenda item on the local Health & Safety Meeting. (agenda provided as evidence). The next meeting is to be held on the 10.03.2020. As such, revised implentation date set for March 2020	Hilary Owen Head Of Governance And Compliance, MHLD			
351	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	2.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that individual service users' risk assessments are reviewed and updated in line with specified timescales	Raise staff awareness through an immediate memo and Team Meetings	28/02/2020				An email has been circulated to all staff (evidence provided) to remind staff that risk assessments are reviewed and updated and the Care & Treatement Planning Process has been shared. No follow up date required for this action	Hilary Owen Head Of Governance And Compliance, MHLD			
352	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Carry out an audit of case notes as part of supervision and discuss with staff the importance of timely reviews and to update paperwork accordingly- update required	01/05/2020				This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD			
353	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	3.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that care plans are regularly reviewed and updated to reflect the changes in service users' condition	Raise staff awareness through an immediate memo and Team Meetings	28/02/2020				An email has been circulated to all staff (evidence provided) to remind staff that risk assessments are reviewed and updated and the Care & Treatement Planning Process has been shared. No follow up date required for this action	Hilary Owen Head Of Governance And Compliance, MHLD			
354	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Carry out an audit of case notes as part of Supervision and discuss with staff the importance of timely reviews and to update paperwork accordingly	01/06/2020				This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD			

#	Ref			Date	Service	Location	Team	Status			Site	Plan	Requirement	Action	Target Date			Update	Owner		Review Date
355	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all service users are able to access support from the CMHT when they need it	Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details	28/02/2020			Posters and grab cards have been updated and are available in the CMHT. We are awaiting Welsh translation of these. No follow up requried for this action	Hilary Owen Head Of Governance And Compliance, MHLD		
356	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	3.1		Ty Derbyn	Improvement Plan	The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed	Ensure that the process in place to scrutinise and check Mental Health Act papers is followed	28/02/2020			The MHA Manager carried out an audit of section papers during w/c 17.02.20 and there is clear evidence that these are being scrutinised by AMHPs and Medics as per Policy MHLD 0026. Follow up review date set to ensure this approach is consistent	Hilary Owen Head Of Governance And Compliance, MHLD		31/05/2020
357	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Ensure that all staff are up to date with their Mental Health Act mandatory training	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
358	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Ensure that staff utilise the expertise of the Approved Mental Health Practitioner Team that is co-located in the CMHT and also that of the Mental Health Act Team	28/02/2020			This action is in progress with the service- update required	Hilary Owen Head Of Governance And Compliance, MHLD		
359	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all staff complete all aspects of mandatory training. Also, that all staff are familiar with the requirements of the Social Services and Well Being (Wales) Act 2014	Review mandatory training during supervision to ensure compliance of all staff	01/04/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
360	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented			Ty Derbyn	Improvement Plan		Ensure that there is specific focus around the Social Services and Well Being (Wales) Act within Team Meetings and share guidance with all staff	28/02/2020			Documentation in relation to the Act have been shared with staff and evidence provided- 4 documents shared which includes; 'The Essentials', Part 3 code of practice assessing needs, part 4 code of practice meeting needs and part 10 code of practice advocacy. No follow up date required for this action.	Hilary Owen Head Of Governance And Compliance, MHLD		
361	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Training and Development Officer to meet with Local Authority Staff to ensure that staff know how to access the learning hub and community care inform	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
362	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Training opportunities to be shared with staff by Team Managers	28/02/2020			This action is in progress with the service- update required	Hilary Owen Head Of Governance And Compliance, MHLD		
363	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that relevant staff receive CBT and DBT training	Review staff training and development needs through supervision and Performance Appraisal Development Review (PADR) and encourage staff to apply for CBT/DBT training if this is relevant to their role	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
364	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that staff are able to meet all the conflicting demands on their time	Ensure that discussions are held in supervision and team meetings and clearly documented and that staff are encouraged to manage their time appropriately	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
365	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that staff are able to make suggestions to improve the work of the team and that they are involved in deciding on changes introduced that affect their work	Senior Leadership Team to attend regular Team Meetings to share developments and receive suggestions for service improvements and staff to be encouraged to be involved in local communication programmes such as Listening Leads or the Be Proud campaign	01/04/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
366	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that a culture of openness and learning is encouraged and supported with the team	Staff are to be encouraged to attend and participate in local meetings and feed back to their teams the learning from such meetings	28/02/2020			Email circulated to all managers on the 25.02.2020 to ask that staff are encouraged to attend local meetings. Follow up review date set to ensure that this is consistent	Hilary Owen Head Of Governance And Compliance, MHLD		31/05/2020
367	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented			Ty Derbyn	Improvement Plan		Continue to share the Strategy, Service & Re-Design (SSRD) Monthly Update with Teams and ensure this is being discussed in Team Meetings	31/03/2020			The Strategy, Service & Re-Design (SSRD) update is circulated regularly. The next meeting is on the 03.03.2020 but the update from December 2019 have been provided as evidence. Follow up review date set to ensure that this is consistent	Hilary Owen Head Of Governance And Compliance, MHLD		31/05/2020
368	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Ensure that learning from Serious Untoward Incidents are shared with	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
369	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that positive action is taken in respect of staff health and well-being	Staff are to be encouraged to complete Wellbeing Action Plans as part of their supervision	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
370	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Managers to discuss individual staff requirements during supervision and make any reasonable adjustments to support individuals.	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
371	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1		Ty Derbyn	Improvement Plan	The health board and local authority must ensure that all errors, near misses and incidents are treated confidentially	Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed to assure staff that these are treated confidentially	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
372	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan	The health board and local authority must ensure that staff involved in errors, near misses and incidences are treated fairly	Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed and individual staff involved in such incidents, etc. are supported by Managers utilising the systems and services that are in place	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		
373	HIW-IP-016	IP		Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress			Ty Derbyn	Improvement Plan		Set up a peer support system for staff	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD		

374	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that appropriate action is taken as a result of errors, near misses and incidences and staff are kept informed about changes made in response to reported errors, near misses and incidents	Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD
375	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Share Lessons Learned Bulletin and ensure this is clearly displayed and discussed within Team Meetings	31/03/2020			This action is in progress with the service	Hilary Owen Head Of Governance And Compliance, MHLD
376	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress	3.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that staff feel secure in raising concerns about unsafe clinical practice and that they feel confident that management would address their concerns once reported	Ensure that raising concerns is a standing item at Team Meetings and that staff are encouraged to raise concerns as this is the process for learning and improving our service	28/02/2020	31/03/2020		The Community Service Manager has confirmed that this will feature on the wider Team Meeting . Confirmation that this has been included on the agenda is outstanding. As such, this action remains in progress. Implementation revised date entered for March 2020	Hilary Owen Head Of Governance And Compliance, MHLD
377	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented		Ty Derbyn	Improvement Plan		Ensure that staff are aware of how to raise concerns through their Line Management and Senior Managers	28/02/2020			A Memo has been circulated to all staff informing them of the importance of raising concerns and the process to do this (evidence provided). No follow up review date required	Hilary Owen Head Of Governance And Compliance, MHLD
378	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented		Ty Derbyn	Improvement Plan		Ensure that staff are aware of the Safe Haven process	28/02/2020			A Memo has been circulated to all staff which included details of the Safe Haven process (evidence provided). No follow up review date required	Hilary Owen Head Of Governance And Compliance, MHLD
379	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented	3.1	Ty Derbyn	Improvement Plan	The health board and local authority must ensure that staff are not subjected to discrimination	Staff are to be made aware of the process for raising concerns if they feel discriminated against	28/02/2020			A Memo has been circulated to all staff informing them of the importance of raising concerns and the process to do this (evidence provided). No follow up review date required	Hilary Owen Head Of Governance And Compliance, MHLD
380	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	In Progress		Ty Derbyn	Improvement Plan		Staff to attend Equalities Training and Dignity at Work Training	28/02/2020	31/03/2020		This action is in progress with the service; HR Manager for MH&LD has agreed to provide some training sessions for staff in Ty Derbyn. These are to be arranged over the next month. Revised imlementation date set to March 2020	Hilary Owen Head Of Governance And Compliance, MHLD
381	HIW-IP-016	IP	Oct-19	Mental Health & Learning Disabilities	East Wrexham	Community Mental Health Team (CMHT)	Implemented		Ty Derbyn	Improvement Plan		Signage to be developed in the waiting area in relation to there being a zero tolerance for discriminatory abuse on staff	28/02/2020			Zero Tolerance poster is displayed within all areas of the building (evidence provided). No follow up review date required	Hilary Owen Head Of Governance And Compliance, MHLD

Progress against actions- Community Mental Health Team- East
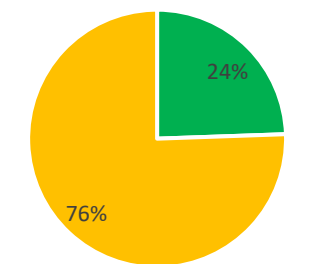
- 24% Implemented
- 76% In Progress

Hospital Inspection (Unannounced)

Ysbyty Gwynedd – Maternity Services,
Betsi Cadwaladr University Health Board

Inspection date: 25 – 27 November 2019

Publication date: 28 February 2020

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of maternity services at Ysbyty Gwynedd within Betsi Cadwaladr University Health Board on 25, 26 and 27 November 2019. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Llifon ward - antenatal ward (before delivery) and postnatal ward (following delivery) with a capacity of 28 beds

- Midwifery led unit - with a capacity of two delivery rooms and one birthing pool

- Labour ward - (during labour) with a capacity of seven delivery rooms and one birthing pool

- Triage assessment area and a waiting room

- One operating theatres.

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

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[1] https://hiw.org.uk/national-review-maternity-services

2. Summary of our inspection

Whilst we identified some areas for improvement, overall we found evidence that the service provided respectful, dignified, safe and effective care to patients.

There were some good arrangements in place to support the delivery of safe and effective care and positive multidisciplinary team working.

This is what we found the service did well:

- Women and their families were positive about the care and treatment provided during their time in the unit

- We observed professional, kind and dignified interactions between staff and patients

- There was a good range of health promotion information displayed

- There were good arrangements in place to provide women and families with bereavement support

- Good governance of daily clinical activities

- Strong midwifery and medical leadership was evident and there was good support offered to staff.

This is what we recommend the service could improve:

- Review of medical job plans

- Review of policies and procedures

- Some areas of patient record keeping

- Review of access to perinatal mental health support.

3. What we found

Background of the service

Betsi Cadwaladr University Health Board is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham). The health board has a workforce of approximately 16,500 staff.

There are three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital), along with a network of community hospitals, health centres, clinics, mental health units and community based teams.

Ysbyty Gwynedd is the district general hospital for the west area of North Wales, situated in Bangor. The hospital serves a population of over 200,000 people. The acute hospital service has a total of 684 beds, with a full range of specialties.

Maternity services are managed as a North Wales networked service supported by a neonatal network. Services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages around 6,224 births per year, with around 1,770 of these at Ysbyty Gwynedd.

Women who birth within the health board have the choice of four birth settings. These include home, freestanding midwifery led units, alongside midwifery led units and obstetric units.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients were positive about their overall experience of the service. Most patients told us they were happy with the care and support provided to them. Without exception, patients told us they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients.

We found perinatal resource required review to increase support availability.

Health promotion was clearly displayed throughout the unit.

We identified improvements regarding birth choices discussed and appropriate documentation.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided. A total of 10 questionnaires were completed. We also spoke with 10 patients during the inspection.

The majority of patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent (scores were detailed as nine out of ten and above). Patients and their families who we spoke with also said they had a good experience in the whole of the unit. Patient comments included:

> *"Help always available – baby taken away overnight so that I could get some sleep".*

> *"Staff approachable and always felt welcome".*

The majority of the patients confirmed their postnatal stay had been more than 24 hours.

Staying healthy

We found there were good amounts of health promotion information displayed in relation to breastfeeding, skin to skin advice, post-natal mental health and general advice on keeping healthy before, during and after pregnancy.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes, we saw information in relation to smoking cessation throughout the unit.

Dignified care

During the course of our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of patients who completed our questionnaires were very positive about their experience of care.

We also saw staff promoting privacy and dignity when helping patients with their personal care. We reviewed care documentation and did not find any areas of concern regarding dignified care.

There were en-suite facilities within some of the birthing and postnatal rooms to help support dignity during the patient's stay. Where en-suites facilities were not available, shared toilet facilities were located nearby.

Four of the patients who completed questionnaires, said they saw the same midwife in the birthing unit as they did at their antenatal appointments. Half of the patients were six to 12 weeks pregnant when they had their booking appointment. All patients said they were asked by the midwife about how they were feeling and coping emotionally in the antenatal period.

All of the staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies and support, to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit, known as the 'Angel Suite'. We saw this provided a comfortable environment for patients and families to use. If this room was in use, we were told that an unoccupied postnatal room would be made suitably available. However, we felt that its location, adjacent to the assessment unit was not suitable due to sound and visibility of expectant mothers being assessed from the doorway. There had been sound proofing measures put in place to reduce outside sound and there were also plans seen in redesigning the room to maintain dignity and respect of patients and families. We were told that plans had been recently approved but had not yet progressed at the time of our

visit. We were told that a bereavement lead who worked across the three sites within the health board was available through core working hours to offer support and advice. Staff also told us that the on-call matron for the maternity service would be the first point of contact if guidance was required outside of core hours. However, staff also said they felt there was a lack of perinatal support for patients due to the limited resources of the dedicated mental health team which some senior staff also confirmed to be a concern.

> Improvement needed
>
> The health board must ensure that resource and availability of perinatal support is reviewed.

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care. Visiting times were clearly displayed within the unit and staff told us there would be flexibility around this if requested.

Daily staffing details were displayed within in the unit to inform patients of who would be caring for them.

Information was available in both English and Welsh and staff we spoke with were aware of the translation services within the health board and how to access these. Welsh speaking midwives were also identifiable by the Welsh speaker logo[2] on uniform.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire said they felt

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2 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers on your team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

confident to ask for help or advice when required. The majority of patients also said they had been listened to by midwifery and medical staff during their stay. However, the majority of patients we spoke to and those who had completed questionnaires said they were not always spoken to regarding their birth choices. There was also little evidence of discussions around this seen within the case notes we reviewed.

We saw that staff maintained patient privacy when communicating information. We noticed that it was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

We saw that staff within the unit met twice daily, at shift change-over time. Midwifery and medical handovers were held separately due to midwifery and medical shifts not following the same working pattern. The handover meetings we were able to attend, displayed effective communication in discussing patient needs and plans with the intention of maintaining continuity of care. These meetings were well-structured and evidence based which the inspection team felt to be of noteworthy practice.

Each ward had a patient safety at a glance board[3] which was used on a daily basis by multidisciplinary teams. These boards clearly communicated patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements.

We were also told by staff that active learning was seen through vibrant maternity voices[4] and birth afterthoughts groups [5], which are chaired by a service users. They had been created for mums-to-be and new mums to meet and discuss

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[3] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

[4] Vibrant Maternity Voices – User engagement group which holds engagement events with a key focus on encouraging normality – ensuring that women's voices are heard.

[5] Birth Afterthoughts is a listening service, co-ordinated by the consultant midwife, available to any women and their partner who have give birth in BCUHB. It is confidential and provides an opportunity to discuss and understand what happened during labour and birth.

services, care and improvements. There was also a Facebook page seen for anyone wishing to learn more regarding maternity services within North Wales.

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Improvement needed

The health board must ensure that discussions regarding birth choices take place and are documented accordingly.

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Timely care

The patients we spoke with told us that staff were very helpful and would always attend to their needs in a timely manner. Staff explained they would always ensure that patients are regularly checked for personal, nutritional and comfort needs. This was also seen within the patient's records we reviewed. We also saw that call bells were easily accessible and answered in a timely manner.

We saw that patient observations were recorded on a recognised national chart to identify patients who may becoming unwell or developing sepsis. Staff were aware of the screening tool and reporting system for sepsis, which enabled appropriate and timely action to be taken.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit.

We looked at a sample of patient records within the unit and found evidence that patient's personal beliefs and religious choices were captured during antenatal appointments. This was to help ensure they were upheld throughout their pregnancy, labour and postnatal care. We saw that care plans also promoted people's independence based on their assessed abilities.

Birthing partner support was promoted and all of the birthing rooms were well equipped. Two of the birthing rooms within the unit also had a plumbed in birthing pool which patients could use during labour.

We were told by staff and patients that local parent craft groups such as breastfeeding and health promotion before and after delivery, were very beneficial for new mothers and fathers. Parent classes were also offered to families in their own homes. These sessions are organised and delivered by midwifery support workers and were seen by the inspection team to be good practice in promoting independence.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes to ensure that all members of the team were informed of patient preferences.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit between 9.00am and 8.00pm. Staff also told us that birthing partners could stay with the patient during labour.

The hospital provided a chaplaincy service and there was a hospital chapel. We were also told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Listening and learning from feedback

Information was available on the health board's website relating to the process for patients to follow should they have concerns they wish to raise, there was also information available on the unit. We were told by the senior management team that ward managers within the unit were fully aware of the NHS Wales Putting Things Right[6] process and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints. However, staff did not routinely provide patients with details of the Community Health Council (CHC)[7] who could provide advocacy and support to raise a concern about their care.

We were told that following an informal complaint, lead matrons would contact a patient offering to discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explained that this was used as a way of addressing concerns, but also with a view to highlight any practice issues that may need resolving. Staff told us that communication was maintained with patients and families throughout any concern received and they were also given the opportunity to meet with senior members of staff to discuss their concerns further.

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[6] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

[7] http://www.wales.nhs.uk/sitesplus/899/home

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Staff told us that they regularly seek patient feedback through feedback forms or questionnaires, one of which is the birth afterthoughts information card which was given to all women following birth. We were told these are acted upon by the senior management team and shared with staff during lessons learnt meetings and appraisals.

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Improvement needed

The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

</div>

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall there were good processes in place within the unit to support the delivery of safe and effective care.

We found that there were robust processes in place for the management of medicines, pain assessment and clinical incidents, ensuring that information and learning is shared across the service.

We identified areas for improvement regarding breastfeeding support and provision within the unit.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed, however inconsistencies in medical record completion was evident.

The service described good arrangements for safeguarding procedures, including the provision of staff training.

Safe care

Managing risk and promoting health and safety

The unit appeared to be very clean, appropriately lit, well ventilated and clutter free. Clinical rooms such as clean utility and sluice were also seen to be very well organised.

We considered the unit environment and found sufficient security measures in place to ensure that babies were safe and secure within the unit. We noted that access to the birthing unit was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. We were also assured that abduction drills and fire drills regularly take place to ensure safety is maintained in an emergency.

We looked at the arrangements within the unit for accessing assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate

equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley and we were assured that regular stock, date and maintenance checks were taking place on this equipment.

Emergency evacuation equipment was seen within the birth pool rooms, which could be used in the event of complications during a water birth. We were also assured that all staff had received appropriate training in their appropriate use in the case of emergency.

Falls prevention

We saw there was a risk assessment in place for patients admitted onto the unit and those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the unit were clean and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[8] and saw good hand hygiene techniques. We found hand washing and drying facilities were available. We also saw information displayed to promote the correct hand washing procedure for staff to follow. However, we saw some hand sanitiser gel dispensers within the unit empty or not working.

We were told that an infection control audit had been carried out by the health board recently and we were shown the results of this. We found that cleaning schedules for the unit were in place and up-to-date and we saw designated labels on equipment to signify that it was clean and ready for use.

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[8] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

We saw high compliance with infection prevention and control training. Staff explained that any concerns raised regarding infection prevention and control would be escalated to senior members of staff.

Some side rooms within the unit were available for patients use should there be a requirement to reduce the risk of infection and help prevent infections being transferred to other patients.

We were told that the birthing pools were cleaned daily and evidence of this was seen.

> Improvement needed
>
> The health board must ensure that hand sanitiser gels are available for use.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met throughout the day and night.

Within the unit there were facilities available to purchase drinks if required. We saw patients being offered hot and cold drinks and water jugs were within easy reach. Staff on the unit had access to facilities to make toast and drinks for patients outside of core hours. Patients also told us that the food and drinks available were to a good standard.

In the patient care records we reviewed, we found that patient nutritional requirements were well documented.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. We found that medication cupboards were securely locked to maintain safety.

There were daily checks of the temperature at which medication was stored. We found there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We also noted that medication prescribing and administering was in line with the health board policy.

We looked at a sample of medication records and saw these had been completed appropriately. Pharmacy support was available to the unit and an out-of-hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in

patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was mandatory and all staff we spoke to confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. Formal safeguarding supervision had been recently introduced and was mandatory for staff to attend two sessions per year. The health board recently started to roll-out the process to community based midwives, with the intention of expanding this across the rest of the service over the year.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We found the checks on the neo-natal resuscitaire[9] to be consistently recorded demonstrating that they had been carried out on a daily basis.

We found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

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[9] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

Effective care

Safe and clinically effective care

Staff who we spoke with told us that they were happy with the quality of care they were able to give to their patients. We were told by staff and patients that those in the birthing unit would always be kept comfortable and well cared for, with pain relief available during labour. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed. We observed staff effectively prioritising clinical need and patient care within the unit. From the patient records reviewed, it was evident that clinical need prioritisation was forefront in care planning.

The inspection team saw that the midwifery led unit had admission criteria that facilitated birth for low risk women with group B strep or who required induction of labour for a postdates pregnancy, thus encouraging normality. This was seen to be good practice as it promoted birth choice continuation.

We were also told that the unit had dedicated theatre staff coverage from the general theatres in the hospital, for caesarean sections or other surgical procedures. Two operating theatres were seen and midwives we spoke with confirmed that unless they were trained to do so, they were never expected to practice as a scrub nurse[10] and perform scrub duties. They also told us that maternity and theatre staff worked well together as a team.

Although we saw that a breastfeeding coordinator was appointed, staff and senior managers told us that the substantial workload covered meant that visibility on the unit to promote breastfeeding was greatly reduced. The inspection team felt that more support in breastfeeding was needed within the unit.

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[10] Scrub nurses are registered nurses who assist in surgical procedures by setting up the room before the operation, working with the surgeon during surgery and preparing the patient for the move to the recovery room.

> **Improvement needed**
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> The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board. We were told that projects to support education in growth assessment protocol (GAP) and gestational related optimal weight (GROW)[11], epilepsy in patients, and the full review of documentation and the creation of care pathways across the unit had been recent projects completed. We were told that further work was planned to implement the use of innovation champion midwives across the service, who would be encouraged to become involved in innovation and research projects to support the team.

The health board maternity practice development midwife was also seen to carry out the inspirational work of Practical Obstetric and Multi-Professional Training (PROMPT)[12].

Information governance and communications technology

We found secure measures in place to store patient information to uphold patient confidentiality and to prevent unauthorised access.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. However, we found a number were out-of-date and requiring review.

We found that a monthly maternity dashboard was produced which included information in relation to each hospital and across the health board. This provided

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[11] GAP – Growth assessment protocol - GROW – Gestation related optimal weight (A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[12] PROMPT - Practical Obstetric and Multi-Professional Training. The course teaches attendees how deal with obstetric emergencies.

information with regards to the clinical activity, induction of labour, clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of associated risk.

We saw that data was collated from birth registers manually by two labour ward midwives. However, Welsh Government receive all maternity data via electronic information systems as well as other national bodies when benchmarking outcomes of birth. Maternity data is captured electronically following birth, therefore we suggested that the department consider moving from manual to electronic data collection for greater efficiency.

> **Improvement needed**
>
> The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.

Record keeping

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. We saw appropriate observations charts, care pathways and bundles being used. However, whilst we saw that preventative measures had been put in place to prevent venous thromboembolism[13] for patients on the unit, risk assessments had not been documented to support the reason why.

We also saw inconsistencies across the medical health records reviewed with gaps in areas such as medical signatures and General Medical Council registration number completion.

> **Improvement needed**
>
> The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.

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[13] https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#risk-assessment

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Staff were striving to deliver a good quality, safe and effective care to patients within the unit.

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

Staff reported that there was good multidisciplinary team working and we saw evidence to support this.

We found evidence of supportive leadership and management. Staff who we spoke with were positive regarding the support they received from senior staff.

We however recommended improvements in medical job planning to maintain continuity of care.

Governance, leadership and accountability

We saw a number of regular meetings were held to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meetings and obstetric clinical review of incident meetings. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums and weekly

multidisciplinary meetings such as Cardiotocography (CTG)[14] reviews. We found there was good overall monitoring and governance of the staffing levels of the service.

We also found there was internal audit activity taking place, which was being monitored and presented in appropriate quality, safety and risk meetings and forums. Staff also told us that active learning and follow-up on audit actions were always carried out.

The senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE)[15] and Each Baby Counts[16] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies such as MBBRACE and ongoing work takes place to ensure the unit is in line with the recommendations made.

We have seen evidence of a newly formed focus group with an aim of reducing caesarean section rates as well as PPH which is led by a labour ward consultant lead. There is a clear plan in place to review the notes and highlight the good practice and areas of improvements. The clinical director is overseeing this project.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report

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[14] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

[15] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[16] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

errors, near misses or incidents and that these were never dealt with in a punitive manner.

Monthly risk meetings are held at Ysbyty Gwynedd where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. We were assured that the internal risk register was monitored and acted upon when required.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife presented themes and trends to this meeting, with the view of highlighting any areas of practice improvements required across the heath board. Lessons learnt are shared and circulated to all staff within a monthly feedback newsletter, summarising the month's issues which staff told us was very useful.

Staff felt the daily leadership within the unit to be excellent. Staff said they felt supported by the senior team and there is always an 'open door' to speak to them. We were also told by staff that the senior team members would hold monthly visits to all sites which gave staff the opportunity to gain feedback and support if required.

We also saw good work carried out by the consultant midwife to achieve expert practice. This included the development of the new Vaginal Birth After Caesarean Section (VBAC)[17] protocol, user engagement in service development, and creation of many training initiatives to increase learning and development.

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[17] VBAC - Vaginal Birth After Caesarean Section – Where many women who have had one previous caesarean section can safely have a vaginal birth in a subsequent pregnancy, or they can choose to have a caesarean section.

Staff and resources

Workforce

All staff we spoke with felt they received excellent leadership and support, personally and professionally. Strong team working was seen to be encouraged by all senior managers. This was confirmed by staff we spoke with and those who completed our questionnaires. A number of staff said they considered their working environment to be positive and they were happy to work within Ysbyty Gwynedd. Some of the comments from staff included the following:

> *"I've been well supported by all staff at Betsi and appreciate this"*

> *"Very supportive, kind and welcoming staff both acute and community".*

Senior staff we interviewed shared with us the success of support given to the maternity services from Deloitte Risk Advisory UK[18]. This support mechanism was introduced into the health board four years ago when the health board was placed into special measures[19]. Effective outcomes have been seen in relation to working practices, working relationships and operational risk management.

We were told by all staff that midwifery rotas were managed well within the unit. If there were any shortages of staff cover, the newly introduced midwife on-call system would be used. The system was developed to place midwives (currently working within the acute site) onto a rota to cover staffing shortages, rather than using community midwives. Positive feedback had already been received regarding this change and an increase in homebirths was reported due to community midwives being able to perform community based care instead of being called in to the acute site to cover shortages.

We saw there were departmental escalation processes in place and all staff we spoke with were aware of where to locate the policy and how to escalate issues

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[18] Delloite Risk Advisory UK – an organisation who supported the HB to enable business to understand and manage their risks more effectively, allowing them to create and protect their values for all of their stakeholders.

[19] Special measures refer to a range of actions which can be taken to improve health boards, trusts or specific NHS services in exceptional circumstances.

such as staffing shortages. Senior staff also told us that if required, clinically trained office staff would cover shortages where required.

Medical staff we spoke felt medical rotas were being managed well. However, we learned that on occasion some medical staff can be pulled away from the delivery unit to cover workload on the early pregnancy assessment and obstetric emergency unit. This meant the delivery unit would be left with only registrar cover. This was seen to have a detrimental effect on continuity of care. We spoke to the senior medical team and they acknowledged that this was an area for improvement and advised that work plans would be reviewed imminently. The clinical director of the unit confirmed that the job planning of consultant obstetrician and gynaecologists is under review in the view of allocating a nominated dedicated consultant obstetrician to be present on labour ward during working hours. This would maintain continuity of care and improving senior medical cover within the unit.

Some medical staff also felt the service needs to implement the role of a fetal medical consultant within the maternity outpatients, to deliver care to women requiring support in the antenatal period. We were advised that a review of fetal medicine services in North Wales is underway and will be completed mid 2020. Staff also explained that a fetal medicine task and finish group is duly considering the addition of a fetal medicine component in the vacant consultant post.

We saw evidence of robust induction programmes for both midwifery and medical staff and staff felt these were of benefit when commencing their role. We also saw that the training and mentorship arrangements for medical staff was very positive. Medical staff we spoke with confirmed that the training, support and guidance is of a high standard. Medical and midwifery staff also said the organisation encourages and supports good teamwork.

We found there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and control and safeguarding, is predominately completed on-line and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is PROMPT training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that

regular training was taking place. This was also confirmed in the staff questionnaires received.

The health board had a lead midwife for practice education/practice facilitation who monitor compliance with training across the year. Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

We saw evidence of training in CTG, however staff we spoke to told us that the recently introduced CTG monitoring stickers (method of improving continuity of care) were confusing due to the information required and more training in the completion of theses was required.

Clinical supervisors for midwives were in place across the health board. The supervisors are responsible for ensuring compliance with the national standard that all midwives access four hours of contact with a clinical supervisor for midwives, inclusive of two hours of group supervision. The health board monitor compliance with this target during the previous financial year and are continuing this on an ongoing basis.

We confirmed that within the unit all appraisals were up-to-date. Staff we spoke with told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development. We were also told that continuous professional development and training time is given to all staff within their working hours.

We found there was a good level of support in place from the specialist lead midwives, who were knowledgeable about their specialist roles. These leads provide support and guidance through study days, supervision sessions and meetings with staff, as and when required. We also saw a good range of skill mix throughout the unit.

Although we were told there were no nursery nurses employed within the services, we saw that maternity support workers were encouraged to develop their skills to the next level in qualification. This would mean more support could be given to the midwives and new mothers in areas, such as breastfeeding, bathing and general care needs.

> **Improvement needed**
>
> The health board must ensure that:
>
> - CTG training is reviewed to cover the introduction of new processes e.g. CTG assessment stickers
>
> - Medical work plans are reviewed to ensure adequate medical cover is in place at all times.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection

- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking

- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed

- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation

- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward

- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital

- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 2019

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
N/A			

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
N/A				N/A

Appendix C – Improvement plan

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that resource and availability of perinatal support is reviewed.		The Directorate is working in partnership with the Perinatal Mental Health Service to ensure that all relevant information and support is available to all women.	Perinatal Mental Health Specialist Midwife	Commenced and ongoing
		The Perinatal Mental Health Service is located on the Glan Clwyd Hospital site. North Wales has a full complement of Perinatal Mental Health practitioners and	Perinatal Mental Health Specialist Team	Complete

		therefore all six Counties have a named professional.	Perinatal Mental Health Specialist Team	Complete
		The Perinatal Mental Health Service has a robust training programme for 2020 which commenced in January. The training includes 'Training the trainer' for *Infant and Health Visiting Perinatal Mental Health*. The Women's Professional Development Midwife attended the training in January 2020, with a plan to identify midwife champions in all clinical areas and cascade this specialist knowledge.	Professional Development Midwife	Commenced To be completed by April 2020
The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	3.5 Record keeping.	All pregnant women are given a copy of the Betsi Cadwaladr University Health Board Birth Choices Leaflet to facilitate discussion regarding options for birth.	Community midwives	Complete
		All staff have been reminded to document Birth Choice discussions within the Hand Held Notes. This will be monitored at the Clinical Supervisors for Midwives monthly notes audit.	Operational lead manager	Complete

		Birth Choice Clinics commenced within the maternity unit in Ysbyty Gwynedd in January 2020.	Midwifery Led Unit lead midwife	Complete
		Feedback from women on this service introduction will be collated and presented to the Women's Quality Safety and Experience (QSE) sub group on a quarterly basis. This will then feed up to the Board through the Corporate Quality safety Group (QSG).		
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	1.1 Health promotion, Projection and Improvement	The contact details for the Community Health Council are displayed and available in all clinical areas. This compliance is monitored on the Matron daily walkabout on the unit.	Inpatient Matron	Complete
Delivery of safe and effective care				
The health board must ensure that hand sanitiser gels are available for use.	2.1	Fully operational hand sanitiser-dispensing pumps available at every bed space and throughout the unit. Compliance with this will be checked by the housekeeper and Health Care Support Worker on a daily basis.	Ward manager	Complete

The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	1.1 Health promotion, Projection and Improvement	All midwives receive an annual update on breast-feeding and are available to support women on an individual basis when required. There is also a dedicated page on the Health Board's website.	Ward manager	Complete
		The Infant Feeding Co-ordinator is available to support staff to provide care to women and babies presenting with cases that are more complex.	Infant Feeding co-ordinator	Complete
		A business case has been developed with options of how we can improve and further support breast-feeding support workers as part of a Quality Improvement Project. Awaiting a response from Finance.	North Wales Strategic Infant Feeding Group	Complete
		Pending approval from Finance the Directorate will be recruiting in March and staff will commence in May 2020.		May 2020
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	3.4 Information Governance	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates.	Written Control Document Group	Complete

		All policy/guideline authors are approached by the appropriate Forums within Women's Services when policy review is required.	Forum Chair	Complete
		Authors of all outstanding policies are regularly reminded to submit their updated versions to the relevant governance group for approval in a timely manner. A tracker has been developed to support the monitoring of this action.	Written Control Document Group	Ongoing
		A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates.	Director of Midwifery & Women's Services North Wales Clinical Lead	Complete
		Agreement was reached at the Women's Quality, Safety & Experience Sub-Group (QSE), that a list of policies, authors and due dates should be shared with the site triumvirate leadership teams, to enforce and support lines of accountability.	QSE Group members	Complete

		Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support.	Written Control Document Group	March 2020
		The Health Board have developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner.	Written Control Document Group	Commenced and ongoing
		The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	The Director of Midwifery and Women's Services	Complete
		Bi-weekly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan.	North Wales Clinical Lead	Complete and on-going
				Complete and on-going

		A Written Controlled Documents progress report is reviewed at the Women's QSE Sub-Group on a quarterly basis.	Written Control Document Group	
The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.	3.5 Record Keeping	Clinical Supervisors for Midwives discuss documentation standards, which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff.	Clinical Supervisors for Midwives	Ongoing
		The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also	Clinical Supervisors for Midwives	Ongoing

		presented to Women's QSE sub group annually.	Clinical Supervisors for Midwives	Complete
		Each midwife is required to audit two sets of their own records from the previous year to discuss at a group Supervision session on an annual basis.	Clinical Supervisors for Midwives	Complete
		The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation.	Women's Operational Team	Complete
		Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes.		

Quality of management and leadership

The health board must ensure that CTG training is reviewed to cover the introduction of new processes e.g. CTG assessment stickers.		All new documentation is made available for staff consultation prior to implementation. Clinical Supervisors for Midwives also post information with regards to the	Senior Management Team Site Management Teams	Commenced and on-going

		introduction of new documentation on the midwifery hub.	Clinical Supervisors for Midwives	Complete
		All midwives and obstetricians are required to complete six hours of face-to-face CTG training per annum. Training sessions include interpretation of a CTG using the antenatal and intrapartum CTG stickers implemented across the Women's Directorate.	CTG champion midwives. Professional Development Midwife. Consultant Obstetricians	Commenced and on-going
		Midwifery CTG champions have been identified in each maternity unit. Midwifery CTG champions are in the process of completing a training programme that includes attending an RCOG study day and working with other CTG national champions. Following completion of the training, the champions will be responsible for delivering the training to midwives and obstetricians within the Directorate.	CTG champion midwives. Professional Development Midwife. Consultant Obstetricians	Commenced and with completion date of April 2020

The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times.	7.1 Workforce	An external independent review of medical rotas has been completed, as part of the health board's medical workforce review strategy. An independent review of job plans is scheduled for 7 February 2020.	Executive Medical Director Executive Medical Director	Completed Commenced and completion date March 2020.

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):   Fiona G Giraud

Job role: Director of Midwifery and Women's Services

Date: 17-1-2020

HIW & CIW: Joint Community Mental Health Team Inspection (Announced)

Wrexham Community Mental Health Team, Betsi Cadwaladr University Health Board and Wrexham County Borough Council

Inspection date: 15 and 16 October 2019

Publication date: 7 February 2020

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales

Our values

Our Core values ensure people are at the heart of everything we do and aspire to be as an organisation.

- Integrity: we are honest and trustworthy

- Respect: we listen, value and support others

- Caring: we are compassionate and approachable

- Fair: we are consistent, impartial and inclusive

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction the next three years. These are:

- To consistently deliver a high quality service

- To be highly skilled, capable and responsive

- To be an expert voice to influence and drive improvement

- To effectively implement legislation

1. What we did

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health team inspection (CMHT) of Wrexham CMHT within Betsi Cadwaladr University Health Board and Wrexham County Borough Council on 15 and 16 October 2019.

Our team, for the inspection comprised of two HIW inspectors, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and two Care Inspectorate Wales (CIW) inspectors. The CIW inspectors were only present for the first day of the inspection. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the Act.

HIW and CIW explored how the service met the Health and Care Standards (2015) and the Social Services and Well-being (Wales) Act 2014. HIW also consider how services comply with the Mental Health Act 1983, Mental Health Measure (2010), Mental Capacity Act (2005).

Further details about how we conduct CMHT inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all Health and Care Standards (2015), Mental Health Act 1983 and the Social Services and Well-being (Wales) Act 2014.

We found the quality of service user care and engagement to be generally good and service users were mainly positive about the support they received.

All referrals received by the team are screened through the Single Point of Access (SPoA) process. We found that information shared between professionals was responded to in a timely manner.

We found that a multidisciplinary, person centred approach was in place for the assessment, care planning and review and that service users and their families were involved, where appropriate, in the process.

We found discharge arrangements to be satisfactory, in general, and tailored to the wishes and needs of service users.

Staff feedback in relation to workload and the quality of management and leadership was mixed, and this requires further exploration by the management team.

This is what we found the service did well:

- Staff engagement

- Information for patients and carers

- Physical environment was clean and welcoming

- Person centred care planning and provision

- Multidisciplinary approach to provision of care

- General record keeping

- Medication management

- Physical health overview for patients

- Management overview and governance

- Auditing, reporting and review

- Support and supervision for staff.

This is what we recommend the service could improve:

- Update risk assessments and link to care plans

- Mental Health Act Administration

- Access to psychology, occupational therapy and healthcare assistants

- Duty arrangements

- Ligature risk assessment

- Some aspects of staff training

- Staff involvement in decision making.

3. What we found

Background of the service

Wrexham Community Mental Health Team (CMHT) provides community mental health services at Ty Derbyn, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD, within Betsi Cadwaladr University Health Board and Wrexham County Borough Council.

Wrexham CMHT provides community and recovery focussed mental health and social care in line with the statutory Welsh Government legislative framework led by the Welsh Mental Health Measure. Services within Wrexham are principally primary care (Tier 1), and the CMHT (Tier 2). The joint service providers are Betsi Cadwaladr University Health Board (BCUHB) and Wrexham County Borough Council Local Authority (LA). The team currently operates during daytime core hours of nine to five, from Ty Derbyn which is located on the site of Wrexham Maelor Hospital.

The team deals with a high referral rate of over 5,500 referrals per annum.

Services are community and recovery focused for adults with mental health needs, providing evidence based care within defined localities. There is full integration of nurses, social workers, support workers, psychiatrists, psychologists and occupational therapists. Although psychology and occupational therapy are line managed separately, they are co-located and work across the county. The line management for psychology is through to the Director of Psychological Therapies within the Mental Health & Learning Disabilities (MHLD) Division, BCUHB. The line management for Occupational Therapy (OT) is through to the Therapies Division, at BCUHB but there is close working across BCUHB. Ty Derbyn houses Local Primary Mental Health Support Services, psychological therapies, community mental health teams and Caniad[1], alongside accompanying administration support. The team has established links with local services such as home treatment, liaison team, and acute care services. All services attend, and play an active part in the weekly multi-disciplinary team meeting. Local authority staff, in the Initial Response Team, also work alongside

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[1] https://caniad.org.uk/wrexham/

the team to share appropriate information regarding concerns received from North Wales Police and/or other social care agencies.

The team operates within the confines of the Welsh Mental Health Measure (WMHM) alongside the Social Services Well-being Act (SSWBA).

A county based approach for service delivery was in operation, with Tier 1 services, also based at Ty Derbyn, integrated within the whole county team. This has resulted in an expansion of the service to include new staff and a redistribution of the skill mix into front line Local Primary Care Mental Health Support Services. Medical support is also a key factor of the service, and Ty Derbyn has been instrumental in piloting a different model of working to allocate planned medical sessions to deliver accessible, direct comprehensive mental health services at the earliest point of referral. This was in the process of being evaluated to ensure that staff are supported appropriately to work alongside primary care services to offer a high standard of client care at the nearest point of entry to services in line with Part 1a and 1b of the WMHM.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

> Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all standards in all areas.
>
> The service users who contributed to the inspection were generally positive about the services they received. Service users, in the main, felt included and respected by the choices they were given.

During the inspection we distributed HIW questionnaires to service users to obtain their views on the standard of care provided by the CMHT. A total of 39 questionnaires were completed.

Most of the service users who completed the questionnaire rated the service provided by the CMHT as either excellent or very good, and nearly all said that staff treat them with dignity and respect.

Care, engagement and advocacy

Based on the service users' responses to the questionnaire, we determined the quality of care and engagement to be adequate.

Nearly all service users who completed a questionnaire said that their preferred language was English, and that they were always able to speak to staff in their preferred language.

Most respondents said that staff usually give them enough time to discuss their needs and treatment and few said they did not. Most respondents said that staff usually listen to them carefully when they meet.

We were told that service users were able to access Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA). Around half of the service users who completed a questionnaire said they had been offered the support of an advocate. Most respondents said they knew how to contact this person if they have a concern about their care.

The majority of service users who completed a questionnaire said the service provided completely met their needs.

Access to services

Ty Derbyn was accessible to people with mobility problems, with limited, designated disabled parking spaces located near the main entrance, and lowered curbs   leading to the electronically operated door at the main entrance. There were adapted toilet facilities available within the waiting area.

The whole of the accommodation was in a good state of repair both externally and internally. The furniture and fixtures throughout the building were also in a good state of repair.

The waiting area and consulting rooms were clean and tidy. Health promotion leaflets and posters were available within the waiting area together with magazines for people to read whilst waiting to be seen.

We found access to the service and the referral process to be adequate. Referrals were, in the main, dealt with appropriately. However, staff told us that they often struggled to limit delays in addressing service users' needs due to the high demand.

We found that referrals were, in the main, received via general practitioners (GPs). However, referrals were also accepted from various sources such as other health or social care professionals or police.

A majority of respondents said they were referred to the CMHT by their GP, a few referred themselves following discharge from an inpatient ward, and around a quarter said that they were referred to the service by other means.

Around a quarter of respondents said it took them up to two weeks to be seen by the CMHT following their referral, around half said it took three to four weeks, and around a quarter said that they did not know or could not remember how they were referred. Comments included:

> *"I have been asking for help since 2016, but I feel I only started to get the correct help, help I needed since 2019, under the treatment of Doctor. Why does a person have to get to crisis point to get the help they need. Doctor and his team have been superb".*

"It takes too long to get help when there is a person in crisis who doesn't recognise or accept that they are suffering from mental ill health. Only when the crisis reaches a dangerous level and families are strong enough to fight the system to face CMHT to help is it put in place."

All referrals to the team are screened through the Single Point of Access process (SPoA). There was a very high demand on the service with up to 30 referrals being considered at SPoA meetings each day. Multi-disciplinary meetings, held to review referrals, were taking place regularly and were attended by members of the multidisciplinary team. We observed these meetings during the inspection and found that information was shared and responded to within the constraints of the pressures on the service.

Urgent referrals are dealt with through the duty system. Service users were usually seen on the same day by a duty officer. If, after relevant enquiries, the referral was not judged to be as urgent as first thought, then the service user would be offered an appointment, within 28 days with the primary mental health care team as required under the Mental Health Measure. There was high demand on the duty system and we were told that demand often outweighs capacity. This was being reviewed at the time of the inspection. Service users expressed mixed experiences of the duty system with some telling us that they had received a prompt response whilst one service user told us that they had to wait for four hours to be seen. Some staff also expressed concerns about the duty system stating that arrangements were not always well planned and that there was not always adequate cover in place. Comments included:

"Inefficiency in planning rotas - often on duty and clinic at same time. Numbers are priority not complexity and man hours spent. No reward for hard work and development of good practices."

"Duty system needs to be looked at, however, I am aware that this is in place."

"Some days on duty there is only one member of staff on the rota due to shortages. It is a regular occurrence not having anything to eat or drink when on duty as it is so busy."

"One duty system work is a free for all that severely impacts on duty and CMHT clients."

"Duty arrangements in our team have made the duty system unsafe, and unworkable. Managers have not come up with any sensible solution to this."

Referrals that require an assessment under the Mental Health Act are passed to one of the Approved Mental Health Professionals (AMHP) for action. The AMHP provide a designated service and do not act as care co-ordinators and are therefore able to respond to referrals in a timely way.

Where appropriate, and if service users do not meet the threshold for secondary health care, they are referred to other services better placed to meet their needs.

Where appropriate, people with caring responsibilities were offered carer assessments under the requirements of the Social Service Well-being (Wales) Act and were referred to Hafal[2], for additional support and advice.

Staff and managers told us that there was a delay of up to four years in service users being able access psychology and psychotherapy services after they were assessed as requiring them. The impact of this delay for service users was at best to hamper their recovery and could lead to service users' relapse. The health board should review the availability of psychology and psychotherapy support and look at ways of reducing waiting times, and how service users should be actively supported during the waiting period. It is concerning that the delay in accessing psychology support was highlighted as an area for improvement during inspections of other CMHT managed by the health board. There were also some delays in accessing Occupational Therapy and Health Care Support Worker services.

The team was experiencing some challenges with allocation of care co-ordinators due to the volume of referrals. However, staff told us that every effort was being made to ensure that this was being managed appropriately, with the most appropriate team member being allocated to work with particular service users.

All clinical staff had access to the BCUHB based IT network. Work was under way to develop a joint electronic case management system across Wales.

Out of hours emergency access to mental health services was provided by Wrexham Local Authority Emergency Duty Team (EDT). EDT consisted of AMHP provision, for assessments under the Mental Health Act. There was clear

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[2] Hafal is a charitable organisation managed by the people they support: individuals whose lives have been affected by serious mental illness.

guidance in place to ensure safe and effective hand over of work from daytime to out of hours.

In addition, the Psychiatric Liaison Team offered access to 24 hour services for mental health assessments via the emergency department at Wrexham Maelor Hospital. We were told that there was good communication and joint working between the CMHT and the Psychiatric Liaison Team.

The majority of service users who completed a questionnaire said they knew how to contact the CMHT out of hours service, although nearly a third said they did not. Of those who said they had felt the need to contact the CMHT out of hours service in the last 12 months, around half said they got the help they needed.

Most respondents said they knew who to contact in the CMHT if they have a crisis, although a quarter said they did not. Of those who needed to contact the CMHT in a crisis in the last 12 months, around half said they got the help they needed.

Improvement needed

The health board and local authority must ensure that:

- Delays, from point of referral to when service users are assessed, are reduced

- The current duty system is reviewed, and that adequate staff cover is secured

- Sufficient resources are secured in order to improve access to psychology, psychotherapy, Occupational Therapy and healthcare support workers' services

- All service users are aware of how to contact the CMHT out of hours service

- All service users are aware of who to contact in the CMHT if they have a crisis and that they receive timely support.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate.

The service had a system in place to enable patients to raise concerns/complaints and the service was able to demonstrate that they considered patient feedback to improve services.

The medication management processes were safe and robust.

We found the ligature point risk assessment required reviewing and updating in order to reflect all risks and to highlight actions to be taken.

Record keeping was generally good and care notes were easy to navigate. However, action is required to ensure that the service is compliant with the requirements of the Mental Health Act 1983.

Managing risk and promoting health and safety

The environment was found to be free of any obvious risk to health and safety. However, a service user spoken with during the inspection told us that they sometimes feel vulnerable when sitting in the waiting area, particularly when there are other, sometimes distressed service users waiting to be seen by staff.

General and more specific environmental risk assessments were undertaken and any areas identified as requiring attention were actioned. There was a ligature point risk assessment in place. However, we found that this required reviewing and updating in order to reflect all risks and to highlight actions to be taken.

From inspection of care files, we found that individual service users' risk assessments had been undertaken. However, these were not always being reviewed and updated in line with specified timescales.

Quarterly health and safety meetings were being held at Ty Derbyn to review any concerns and risks which are then escalated to the East area health and safety meeting and the Mental Health and Learning Disability divisional meeting. Key information relating to risk was shared with all staff electronically and at team meetings.

Staff told us that positive risk management was part of service planning and delivery. All staff are trained in the Wales Applied Risk Research Network (WARRN)[3] risk management framework. This training was considered mandatory for all clinical staff.

Staff told us that the weekly multidisciplinary meetings afforded them the opportunity to discuss and escalate any concerns. In addition, regular discussions between consultant medical staff and care coordinators promoted the escalation and documented of identified risks. Monthly supervision sessions, led by the team managers also enabled discussions around risk and escalation if required.

> **Improvement needed**
>
> The health board and local authority must ensure that:
>
> - The ligature point risk assessment is reviewed and updated in order to reflect all risks and to highlight actions to be taken to reduce risks
>
> - Individual service users' risk assessments are reviewed and updated in line with specified timescales.

Medicines Management

We found the management processes to be safe and robust.

We observed that the clinic room was clean and tidy with all cupboards kept locked. Stocks were kept in good supply.

Ty Derbyn had a high volume of clients who need ongoing support with their medication. Clozapine was monitored and depot injections were administered

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[3] http://www.warrn.co.uk/

through the nurse led clinic service which also provided physical health care monitoring.

Assessment, care planning and review

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate.

The care files we viewed were generally well managed and easy to navigate. However, some care plans had not been reviewed and updated to reflect the changes in service users' condition, as highlighted in the progress notes which were generally comprehensive.

Most service users who completed a questionnaire said that they were seen by the CMHT staff about the right amount of times, though nearly a quarter of respondents said they were not seen enough when needed.

Most service users who completed a questionnaire told us that they felt involved in the development of their care plan and that they received, or were given an opportunity, to have a copy of their care plan.

Around half of the service users who completed a questionnaire said that they had a formal meeting or review with their care coordinator to discuss their care in the last 12 months, with most adding that they felt involved in the discussions and decisions made about their care and support during their formal meeting or review.

A majority of respondents said they were given the opportunity to challenge any aspect of their care and treatment plan that they disagreed with during their formal meeting or review.

The majority of service users who completed a questionnaire said it was easy to access support from the CMHT when they need it, a few said it was not very easy. Comments included:

> *"Telephone numbers to communicate with them not through Ty Derbyn. Reception desk which has not good service at all. Too much anxiety by waiting on line every time, then you leave a message and no one comes back to you".*

> *"Very understanding people".*

We found that there were good systems in place to manage service users' physical health with monthly wellness, drop in clinics being held at Ty Derbyn.

This is open to all service users, whether open or closed to the CMHT. This enables third sector agencies to come together, to offer advice and support, in one location, and includes welfare rights, housing and voluntary agencies.

A quarter of service users who completed a questionnaire said they had needed support for physical health needs in the last 12 months, and most confirmed that they had received help.

Improvement needed

The health board and local authority must ensure that:

- Care plans are regularly reviewed and updated to reflect the changes in service users' condition

- All service users are able to access support from the CMHT when they need it.

Patient discharge arrangements

Following our inspection of case files, and discussions with staff, we found discharge arrangements to be generally satisfactory. This is because the process, in the main, was service user-led and managed in accordance with service users' requirements.

The majority of service users who completed a questionnaire said their accommodation needs have been met and around half said that their employment needs have been met by the services provided through the CMHT.

Around half of respondents said that their education needs have been met by the services provided through the CMHT.

The majority of respondents said that their social needs (such as being able to go out when they want), have been met by the services provided through the CMHT.

Around a third said that the option to receive direct payments to help meet their care and support needs had been discussed with them, around a third said it had not and a further third didn't know or couldn't remember.

Around half of the service users who completed the questionnaire said that the CMHT involved a member of their family, or someone else close to them, as much as they would have liked.

Around two thirds of respondents said they had been given information about other support services (including written) by the CMHT, and around a quarter said they had not. The remainder said they did not want any information.

Safeguarding

Staff we spoke with were clear about their responsibilities in relation to safeguarding adults and children and were able to describe the reporting processes.

There were clear policies and procedures in place for staff to follow and the training information provided confirmed that staff had received adult and child safeguarding training.

The team has key link workers for both Multi Agency Risk Assessment Conference (MARAC)[4], and multi-agency public protection arrangements (MAPPA)[5] within the safeguarding arrangements.

Compliance with specific standards and regulations

Mental Health Act Monitoring

We reviewed the statutory documents of six service users who were the subject of Community Treatment Orders (CTO)[6] being cared for by Wrexham CMHT, and spoke with members of the Mental Health Act Administration team. We highlighted a number of areas for improvement in respect of documentation relating to the detention of patients under the Mental Health Act. Issues highlighted included:

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[4] A Multi Agency Risk Assessment Conference (MARAC) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

[5] MAPPA stands for Multi-Agency Public Protection Arrangements and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

[6] Patients who have been detained in hospital under the Mental Health Act, may be discharged on to a community treatment order (CTO). A CTO is an order made by a responsible clinician to enable supervised treatment in the community.

- Non-compliance with Section 11 of the Act, in that medical examinations were not reviewed within the required five day time frame. This invalidated the Section 3 order and also the Community Treatment Order.

- A date on Part 3 of Form CP3 on one file had been altered from a 12 to a 13. This may have invalidated the detention.

- Form CO8, to authorise treatment for mental disorder on one file was completed before the commencement of the Community Treatment Order which is not reflective of Chapter 25.42 of the Code of Practice.

- Form CP2, variation of conditions under section 17(B)(2), on one file, did not evidence that the patient, or nearest relative, had been informed of a change, or that the patient had received a copy of Form CP2 in accordance with chapter 4.11 and 29.29 of the Code of Practice.

- Form CO6 for ECT treatment, on one file, did not contain any evidence of statutory consultation with the Second Opinion Appointed Doctor (SOAD)[7], in accordance with Chapter 25.62 of the Code of Practice, or a record that the responsible clinician has communicated the results of the SOAD visit, in accordance with Chapter 25.69 of the Code of Practice.

- On one file inspected there was no evidence that the responsible clinician had shared the SOAD decision with the patient following the completion of Form CO7, in accordance with chapter 25.69 of the Code of Practice.

- Old treatment certificates, which were no longer in force, and no longer authorise treatment, were not clearly marked as such, in accordance with chapter 25.87 of the Code of Practice.

- Statutory consultee records were not always completed following a visit by the SOAD, in accordance with chapter 25.62 of the Code of Practice.

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[7] The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting.

- There was no evidence on any files inspected of the non-statutory form being used to record that the patients has been explained their rights under section 132A of the Act in accordance with Chapter 4.3 of the Code of Practice, which states that patients should be informed of their rights both verbally and in writing.

- Some correspondence still referring to SCT (supervised community treatment), this term is no longer to be used effective from the Revised Code of Practice in October 2016.

- Expired Section 17[8] leave forms were not clearly marked as no longer valid, in accordance with chapter 27.17 of the Code of Practice.

> **Improvement needed**
>
> The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the Care and Treatment Plans (CTP) of a total of 11 service users.

We found some consistency in the tool used to assess service users' needs and found this addressed the dimensions of life as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being (Wales) Act, in most cases.

Overall, we found that the assessment of service users' needs was proportionate and appropriate.

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[8] Section 17 leave can be used in respect of patients who have been treated in hospital under the Mental Health Act, and are being discharged or allowed out of the hospital on short-term leave, and may be put under a Community Treatment Order (CTO). Under Section 17 of the Act, patients can be recalled to hospital if, for example, they stop taking required medication or their condition gets worse.

Care plans were generally well structured and person centred and reflected service users' emotional, psychological and general health and well-being needs.

Entries within the case files were contemporaneous with all members of the team documenting their involvement/interventions within one file. However, as previously mentioned, care plans did not always reflect changes in service users' care needs which were reported in the progress notes.

We found the process of identifying, assessing and managing risk to be adequate with some files demonstrating a higher calibre of recording than others. We found that risk assessments mostly informed the interventions identified in the service user's care plan. However, as previously mentioned, these were not being reviewed and updated in line with specified timescales.

Compliance with Social Services and Well-being Act

It was evident from the care documentation seen, and from service users' responses to the questionnaire, that their views and wishes were the main focus of the work conducted by the CMHT. Service users told us that they felt involved, included and consulted in the planning of the support services. We saw examples where some service users had positively engaged in 'what matters'[9] conversations.

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[9] A structured conversation between professionals and service users to determine what they value most and how they wish to be cared for.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards and the Social Services and Well-being Act.

We found that there were adequate links and communication between the management within the health board and local authority, with adequate overview of the service by both authorities.

Staff gave mixed comments in relation to management and leadership and suggested communication between managers and staff could be improved. This requires further exploration by the management team.

Leadership, management and governance arrangements

The integrated working of Health Staff and Local Authority Staff, within the CMHT, has been in place for over 15 years. The team was based in BCUHB accommodation. The team was managed by a county manager, whose substantive post was within the health board.

There was a partnership agreement in place to ensure appropriate integration of both local authority and health board functions. BCUHB and Wrexham LA hold budgets separately. The Community Service Manager has a responsibility and delegated accountability for both, working closely with Wrexham Local Authority Head of Service.

Weekly performance reports were being presented to the local authority and health board senior managers.

Team meetings were taking place on a weekly basis. These meetings were minuted and copies shared with team members. The senior leadership team also met on a regular basis and make themselves available to team members through visits to the office.

We were told that there have been some early discussions between BCUHB and Wrexham LA relating to the governance and management arrangements for social care staff. Wrexham LA is looking to strengthen social care roles and ensure the implementation of the Social Services and Well-being Act (Wales

2014), within mental health, whilst maintaining the level of integrated working delivered by the current arrangement.

There was a formal complaints procedure in place which was compliant with Putting Things Right[10] and the local authority's formal complaint process. Information about how to make a complaint was posted in the reception area.

Staff told us that emphasis was placed on dealing with complaints at the source in order for matters to be resolved as quickly as possible, as well as to avoid any further discomfort to the complainant and any need for escalation. All complaints are brought to the attention of the county manager who addresses them in line with relevant local authority and health board policy. Although there were two separate complaints processes in place, there was evidence of joint complaint investigation and reporting. Staff also told us that serious untoward incidents and concerns were recorded on the Datix[11] system, and discussed at weekly meetings and any learning disseminated to the team through the health board's quality, safety and experience group.

We confirmed that there was a formal staff recruitment process in place with evidence of required background checks being undertaken. The staff interviewing process was competency based with record of the interview retained on staff files. Formal contracts and job descriptions were issued to staff by the health board or the local authority respectively. Newly appointed staff followed a formal induction process and were supported by more experienced colleagues and their line manager.

We reviewed a sample of eight staff files (four employed by the health board and four employed by the local authority). We saw that there was a formal staff recruitment process in place with all necessary pre-employment checks undertaken. We saw that there was a formal staff support and supervision process in place with regular one to one meetings being held between staff and

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[10] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

[11] Datix is a web-based incident reporting and risk management software for healthcare and social care organizations.

their line managers. In addition to one-to-one meetings, staff told us that they received day to day, informal support from their line managers who were reported as being very accessible.

There were formal annual appraisals in place, managed under respective health board or local authority systems.

Professional support and supervision was accessible, both individually and as part of groups with staff able to access training from both the health board and local authority although there are challenges around electronic recording of training due to being employed by separate agencies. Staff also have separate electronic recording systems for annual leave and time sheets. However, local processes had been set up to keep this to a minimum with managers working across both governance arrangements to ensuring that training and staff ratios were actively managed.

Staff we spoke with told us that they were able to access mandatory and other service specific training and the training record we viewed confirmed this. Mandatory training completion figures were at 80% for clinical staff which is slightly below the target of 85%.

We distributed HIW questionnaires to staff during the inspection to obtain their views on the standard of care and working conditions. We received 22 completed questionnaires from a full range of staff. Respondents said they had been in their current role from two to over 30 years. The majority of respondents had been in post six years or more.

All staff who completed a questionnaire said that they had undertaken training in Health and Safety, the Mental Capacity Act 2005, Mental Health Act 1983, Deprivation of Liberty Safeguards, the Mental Health (Wales) Measure 2010, safeguarding adults and fire safety. Most said they had undertaken training in risk assessment and management and in safeguarding children.

A minority of staff said that they had undertaken training in Cognitive Behavioural Therapy (CBT)[12] and Dialectical Behaviour Therapy (DBT)[13], and most had received it more than 12 months ago.

Very few staff members who competed a questionnaire said that they had undertaken training in Family Therapy, with half saying that they had received other training relating to specialist care provided in their area of work.

Most staff members who completed a questionnaire said training, or learning and development helped them to do their job more effectively and said that it helped them to stay up to date with professional requirements. A majority said the training helped them to deliver a better experience for service users.

Half of the staff who completed a questionnaire said they had undertaken joint social services / health board training in the last 12 months.

Nearly all staff who completed a questionnaire told us that they had an appraisal, annual review or development review of their work in the last 12 months, and that their learning and development needs were identified.

Half of the staff who completed a questionnaire told us that they are often unable to meet all the conflicting demands on their time at work with around half saying that there was never enough staff within the CMHT to enable them to do their job properly. Comments from staff included:

> *"Whilst I always try to give my job 100%, it is becoming increasingly difficult due to poor management and staff shortages. It is unsafe to work due to lack of staff and no support from senior management."*

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[12] Cognitive behavioural therapy (CBT) is a talking therapy that can help service users manage problems by changing the way they think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

[13] Dialectical behavior therapy (DBT) is a type of talking treatment. It's based on cognitive behavioral therapy (CBT), but has been adapted to help people who experience emotions very intensely.

> *"Staff shortages has put added pressure on remaining staff - support very lacking."*

> *"Not enough time, resources to give the service user the care they need, and as I have been in this team for many years this saddens me. Although I attempted to give my best care this is not always possible and I have to be the bearer of bad news and be open and honest with the patient about lack of resources".*

A minority of respondents said they were able to make suggestions to improve the work of their CMHT with around half saying that they never felt involved in deciding on changes introduced that affect their work.

The majority of staff members who completed a questionnaire told us that were satisfied with the quality of care they are able to give to service users and service users informed and involved in decisions about their care.

Nearly half the staff who completed a questionnaire told us that the organisation encourages teamwork.

A minority of staff told us that there was, generally, a culture of openness and learning with the organisation that supports staff to identify and solve problems.

Around half the staff said that partnership working with other organisations was effective.

The majority of staff said that they were able to access the electronic records management system and databases in order to support the provision of good care and support for service users.

The majority of staff members who completed a questionnaire told us that that their manager encourages them to work as a team and that they could be counted on to help them with a difficult task at work. Comments included:

> *"Easily accessible and approachable."*

> *"Despite change in management, I still feel that we are very much supported".*

The majority of staff who completed a questionnaire told us that they know who the senior managers were and that there is generally effective communication between senior management and staff.

Around half agreed that their immediate manager takes a positive interest in their health and well-being and a minority disagreed. Around half did not agree their manager takes positive action on health and well-being. Around half agreed that

their current working pattern/off duty allows for a good work life balance and few disagreed.

> *"Managers do not listen to the staff, there have been a few serious incidents in the team, including a member of the team violently attacked. Managers have not made any changes since and staff are still at risk of being attacked."*

> *"Although I do know my senior management, I do not feel supported by them. I find they ignore staff concerns around safe staffing levels and lack of services available to patients."*

> *"Due to low staff levels, and not being supported after a serious incident this led to myself and other members of the team having to take a period of on work related stress."*

> *"I was off work with work related stress - I was harassed so much by a manager that I ended up even more stressed - and nothing got done."*

> *"Staff feel not supported by managers if an error, near incidents, feel they are blamed. Staff member was treated badly over a [recent incident.]"*

A minority of staff who completed the questionnaire said that they had seen errors, near misses or incidents in the last month that could have hurt staff or service users. Most staff who had seen an error said they had reported it.

Around half of respondents did not agree that the CMHT treats staff who are involved in an error, near miss or incident fairly, with a minority of respondents stating that the CMHT encourages them to report errors, near misses or incidents.

A minority of respondents agreed that the CMHT would treat reports of an error, near miss or incident confidentially and slightly more disagreed.

Half of respondents stated that the organisation would blame or punish the people who are involved in such incidents. Around half disagreed that action would be taken on incidents identified.

> *"Culture of blame rather than support."*

> *"There is a culture of blame within the service."*

> *"Manager are too easy to blame staff and do not treat staff fairly."*

"Staff have been seriously injured nothing has been done."

Around half of the staff members who completed the questionnaire said that they were not always informed about errors, near misses and incidents that happen in the team and a minority said they were given feedback about changes made in response to reported errors, near misses and incidents.

Most of the staff who completed a questionnaire said that if they were concerned about unsafe clinical practice they would know how to report it. Around half said they would feel secure raising concerns about unsafe clinical practice. However around 40% of respondent would not. Around half were not confident their organisation would address their concerns once reported.

"There have been numerous, all reported. Yet again, managers or health and safety officer do nothing about it."

Around half of respondents said that management did not act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

A few staff reported having personally experienced discrimination by service users, their relatives or other members of the public. Nearly a third of respondents said they had personally experienced discrimination by a manager / team leader or other colleagues. Those who reported discrimination said it had been on grounds of gender, sexual orientation, age and "other" grounds. Comments included:

"We have issues on a weekly basis with patients/families being verbally aggressive towards staff."

Improvement needed

The health board and local authority must ensure that:

- All staff complete all aspects of mandatory training and are familiar with the requirements of the Social Services and Well Being (Wales) Act 2014

- Relevant staff receive CBT and DBT training

- Staff are able to meet all the conflicting demands on their time

- Staff are able to make suggestions to improve the work of the team and that they are involved in deciding on changes introduced that affect their work

- A culture of openness and learning is encouraged and supported with the team

- Positive action is taken in respect of staff health and well-being

- All errors, near misses and incidents are treated confidentially

- Staff involved in errors, near misses and incidences are treated fairly

- Appropriate action is taken as a result of errors, near misses and incidences and staff are kept informed about changes made in response to reported errors, near misses and incidents

- Staff feel secure in raising concerns about unsafe clinical practice and that they feel confident that management would address their concerns once reported

- Staff are not subjected to discrimination.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection

- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking

- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed

- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation

- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect community mental health teams

Our inspections of community mental health teams are announced. The service receives up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how CMHTs are meeting the [Health and Care Standards 2015](#), [Social Services and Well-being Act (Wales) 2014](#) comply with the [Mental Health Act 1983](#) and [Mental Capacity Act 2005.](#) We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within community mental health teams.

Further detail about how HIW inspects [mental health](#) and the [NHS](#) can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Wrexham Community Mental Health Team

Date of inspection: 15 and 16 October 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
No immediate assurance issues were highlighted during this inspection.					

Appendix C – Improvement plan

Service: Wrexham Community Mental Health Team

Date of inspection: 15 and 16 October 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Quality of the patient experience					
The health board and local authority must ensure that all service users are afforded enough time to discuss their needs and treatment with staff.	3.2 Communicating effectively Social Services and Well Being Act (Wales) 2014 Part 3 Code of Practice (assessing the needs of individuals) points 16, 17, 18, 23.	Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020
The health board and local authority must ensure that delays,	5.1 Timely access; Well-being priority 1	Review the Duty system to ensure that there is a more robust process in	Community Service Manager	Head of Operations & Service Delivery	April 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
from point of referral to when service users are assessed, are reduced.	Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs) point 20

Social Services and Well Being (Wales) Act 2014 Part 8 Code of Practice on the Role of the Director of Social Services (social services functions) | place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers. | | (BCUHB) & Service Manager Initial Response & Mental Health (WCBC) | |
| The health board and local authority must ensure that the current duty system is reviewed, and that adequate staff cover is secured. | | Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers. | Community Service Manager | Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC) | April 2020 |
| The health board and local authority must ensure that sufficient resources are secured | | Internal processes are to be reviewed to | Head of Occupational Therapy | Assistant Director of Therapies | March 2020 |

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
in order to improve access to psychology, psychotherapy, Occupational Therapy and healthcare support workers' services.		improve access to Occupational Therapy. Business case to be developed for additional Psychological Therapies staff which will explore the opportunity to introduce Band 4 Assistant Psychologists to the teams. Review the current Health Care Support Worker provision allocated to the teams based on demand and if there is a need for additional support, review what resource is available that can be moved to support the team on a	Consultant Clinical Psychologist Community Service Manager	Director of Clinical Psychology & Psychological Therapies Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	July 2020 July 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		short/medium/long term basis.			
The health board and local authority must ensure that all service users are aware of how to contact the CMHT out of hours service.		All Service Users are to receive a copy of their Care & Treatment Plan which includes details of contact details out of hours. Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that all		All Service Users are to receive a copy of their	Community Service Manager	Head of Operations &	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
service users are aware of who to contact in the CMHT if they have a crisis and that they receive timely support.		Care & Treatment Plan which includes details of contact details out of hours. Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.		Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	

Delivery of safe and effective care

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The health board and local authority must ensure that the ligature point risk assessment is reviewed and updated in order to reflect all risks and to highlight actions to be taken to reduce risks.	2.1 Managing risk and promoting health and safety Social Services and Well Being Act (Wales) 2014 Part 3 Code of Practice (assessing the needs of individuals) Point 53, 63, 64 Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs)	Review anti-ligature assessments, update current risks and ensure these are included at the Local Health & Safety Group Meeting for review. Agree routine reviews of the risk assessments.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
The health board and local authority must ensure that individual service users' risk assessments are reviewed and updated in line with specified timescales.		Raise staff awareness through an immediate memo and Team Meetings. Carry out an audit of case notes as part of Supervision and discuss with staff the	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 May 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		importance of timely reviews and to update paperwork accordingly.			
The health board and local authority must ensure that care plans are regularly reviewed and updated to reflect the changes in service users' condition.	3.1 Safe and Clinically Effective care Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs) points point 113, 114, 120, 121	Raise staff awareness through an immediate memo and Team Meetings. Carry out an audit of case notes as part of Supervision and discuss with staff the importance of timely reviews and to update paperwork accordingly.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 June 2020
The health board and local authority must ensure that all service users are able to access support from the CMHT when they need it.		Develop posters for within the waiting area and clinic rooms which clearly display out of	Community Service Manager	Head of Operations and Service Delivery Head of Operations & Service Delivery (BCUHB) & Service	February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.		Manager Initial Response & Mental Health (WCBC)	
The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed.	Application of the Mental Health Act	Ensure that the process in place to scrutinise and check Mental Health Act papers is followed. Ensure that all staff are up to date with their Mental Health Act mandatory training.	MHA Manager Community Service Manager	Head of Governance Head of Operations and Service Delivery Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
			Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
		Ensure that staff utilise the expertise of the Approved Mental Health Practitioner Team that is co-located in the CMHT and also that of the Mental Health Act Team.			
Quality of management and leadership					
The health board and local authority must ensure that all staff complete all aspects of mandatory training. Also, that all staff are familiar with the requirements of the Social Services and Well Being (Wales) Act 2014.	Health and Care Standards - Governance, Leadership and Accountability; Social Services and Well-being (Wales) Act - Part 8	Review mandatory training during supervision to ensure compliance of all staff.

Ensure that there is specific focus around the Social Services and Well Being (Wales) Act within Team Meetings and share guidance with all staff. | Community Service Manager

Community Service Manager | Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC) | April 2020

February 2020 |

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		Training and Development Officer to meet with Local Authority Staff to ensure that staff know how to access the learning hub and community care inform. Training opportunities to be shared with staff by Team Managers.	Local Authority Team Manager Team Managers		March 2020 February 2020
The health board and local authority must ensure that relevant staff receive CBT and DBT training.		Review staff training and development needs through supervision and Performance Appraisal Development Review (PADR) and encourage staff to apply for CBT/DBT training if this is relevant to their role.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The health board and local authority must ensure that staff are able to meet all the conflicting demands on their time.		Ensure that discussions are held in supervision and team meetings and clearly documented and that staff are encouraged to manage their time appropriately.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that staff are able to make suggestions to improve the work of the team and that they are involved in deciding on changes introduced that affect their work.		Senior Leadership Team to attend regular Team Meetings to share developments and receive suggestions for service improvements. Staff to be encouraged to be involved in local communication programmes such as Listening Leads or the Be Proud campaign.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020
The health board and local authority must ensure that a culture of openness and learning		Staff are to be encouraged to attend and participate in local	Community Service Manager	Head of Operations & Service Delivery	February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
is encouraged and supported with the team.		meetings and feed back to their teams the learning from such meetings. Continue to share the Strategy, Service & Re-Design (SSRD) Monthly Update with Teams and ensure this is being discussed in Team Meetings. Ensure that learning from Serious Untoward Incidents are shared with the Teams.	Community Service Manager Community Service Manager	(BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 March 2020
The health board and local authority must ensure that positive action is taken in respect of staff health and well-being.		Staff are to be encouraged to complete Wellbeing Action Plans as part of their supervision. Managers to discuss individual staff requirements during supervision and make any reasonable	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		adjustments to support individuals.		Head of Operations & Service Delivery	
The health board and local authority must ensure that all errors, near misses and incidents are treated confidentially.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed to assure staff that these are treated confidentially.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that staff involved in errors, near misses and incidences are treated fairly.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response &	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		understand how incidents, etc. are reported, discussed and managed and individual staff involved in such incidents, etc. are supported by Managers utilising the systems and services that are in place. Set up a peer support system for staff.	Community Service Manager	Mental Health (WCBC)	March 2020
The health board and local authority must ensure that appropriate action is taken as a result of errors, near misses and incidences and staff are kept informed about changes made in response to reported errors, near misses and incidents.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed. Share Lessons Learned Bulletin and ensure this	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		is clearly displayed and discussed within Team Meetings.			
The health board and local authority must ensure that staff feel secure in raising concerns about unsafe clinical practice and that they feel confident that management would address their concerns once reported.		Ensure that raising concerns is a standing item at Team Meetings and that staff are encouraged to raise concerns as this is the process for learning and improving our service.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
		Ensure that staff are aware of how to raise concerns through their Line Management and Senior Managers.	Community Service Manager		February 2020
		Ensure that staff are aware of the Safe Haven process.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
The health board and local authority must ensure that staff		Staff are to be made aware of the process for raising concerns if they	Community Service Manager	Head of Operations & Service Delivery	February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
are not subjected to discrimination.		feel discriminated against. Staff to attend Equalities Training and Dignity at Work Training. Signage to be developed in the waiting area in relation to there being a zero tolerance for discriminatory abuse on staff.	Community Service Manager	(BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.
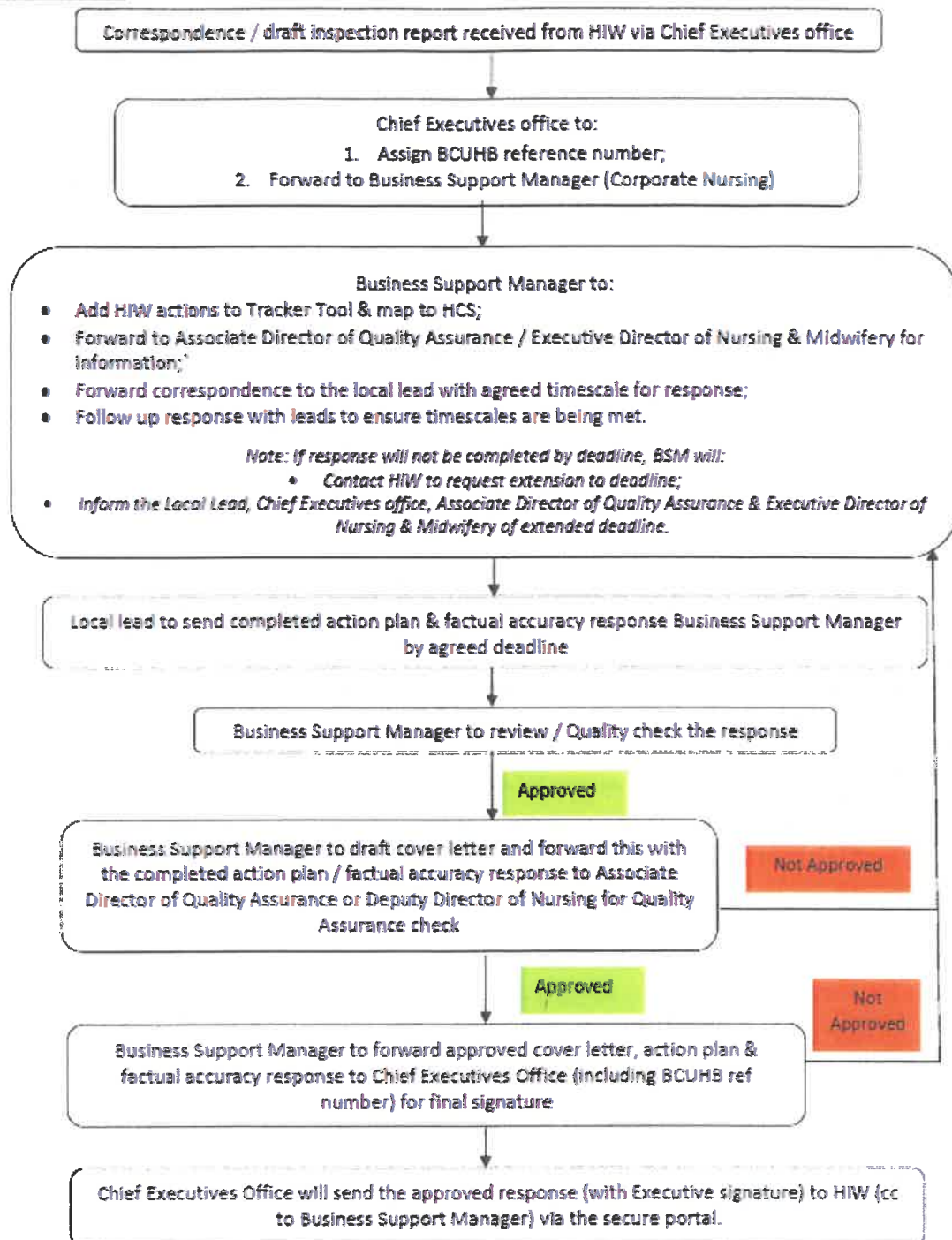
Service representative

Name (print): Hilary Owen

Job role: Head Of Governance and Compliance, Mental Health & Learning Disabilities

Date: 4th February 2020

| Appendix C | BCUHB – Internal Process for HIW inspection reports (May 2018) |

Correspondence / draft inspection report received from HIW via Chief Executives office

Chief Executives office to:
1. Assign BCUHB reference number;
2. Forward to Business Support Manager (Corporate Nursing)

Business Support Manager to:
- Add HIW actions to Tracker Tool & map to HCS;
- Forward to Associate Director of Quality Assurance / Executive Director of Nursing & Midwifery for information;
- Forward correspondence to the local lead with agreed timescale for response;
- Follow up response with leads to ensure timescales are being met.

Note: If response will not be completed by deadline, BSM will:
- *Contact HIW to request extension to deadline;*
- *Inform the Local Lead, Chief Executives office, Associate Director of Quality Assurance & Executive Director of Nursing & Midwifery of extended deadline.*

Local lead to send completed action plan & factual accuracy response Business Support Manager by agreed deadline

Business Support Manager to review / Quality check the response

Approved

Business Support Manager to draft cover letter and forward this with the completed action plan / factual accuracy response to Associate Director of Quality Assurance or Deputy Director of Nursing for Quality Assurance check

Not Approved

Approved

Business Support Manager to forward approved cover letter, action plan & factual accuracy response to Chief Executives Office (including BCUHB ref number) for final signature

Not Approved

Chief Executives Office will send the approved response (with Executive signature) to HIW (cc to Business Support Manager) via the secure portal.

BCUHB – HIW Internal Process (May 2018 – V0.2)

4.1   POST INSPECTION

Figure 1 - HIW "How we inspect"